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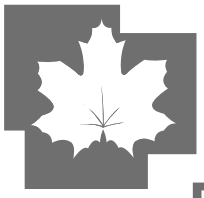

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Violence against older adults in the context of the coronavirus pandemic

The older population in Brazil is living for longer, with an especially significant increase in the group aged over 80 years of age. If, on the one hand, living longer can be an achievement, on the other, it can mean more people dependent on caregivers and care[1]. Unfortunately, most older adults in Brazil do not have the basic right of guaranteed access to health care, and also have to fight for the right to housing, income, food security, social security, and access to social care, among others. The right to grow old with dignity in the country has generated significant pressure on public policies, which are either non-existent or fail to consider the complexity of the diverse, and often adverse, conditions of life of such individuals[2]. Thus, discussing the heterogeneity of aging requires approaches and perspectives that contemplate the specifics of what it is to be old in a country with immense and striking structural inequalities and which is, for this very reason, extremely violent.

In 2020, with the advent of the Covid-19 pandemic, the difficulties that many older adults faced in complying with the recommendations of health authorities in relation to hygiene and social distancing became clear, especially those in long-term institutions, incarcerated older adults, and those who lacked the socioeconomic conditions to maintain the required distancing because they lived in single-room houses, without drinking water. Since the beginning of the pandemic, older adults have been those most affected by the disease, and have suffered the most severe forms of Covid-19, as well as the highest mortality rates. Although they were part of the priority group for vaccination, to date not everyone has been vaccinated. There is a shortage of vaccines, and older adults with functional limitations have great difficulty in obtaining them, the subject of a report that demands the prioritized inclusion of these individuals and their caregivers, the vast majority of whom are family members, and also older women[3].

Given these circumstances, it is estimated that many of the situations of violence to which older adults were already subjected have become more intense, while new situations have emerged, due to the difficulties of the reality imposed by the pandemic and the subsequent economic crisis.

The Statute of the Older Adult (Law 10.741, dated October 1, 2003), defines violence against older adults as "any action or omission carried out in a public or private place that causes death, physical or psychological harm or suffering". The World Health Organization, meanwhile, classified the nature of violence against older adults as physical, psychological, sexual or financial violence, neglect, self-neglect and abandonment. In addition to interpersonal violence, structural violence resulting from socioeconomic, racial, gender-based, cultural, religious and institutional inequalities is also contemplated.

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As noted, there are several and distinct approaches and subjects that can be adopted within the scope of academic reflections focusing on violence against older adults. In this thematic issue of the Brazilian Journal of Geriatrics and Gerontology (the *Revista Brasileira de Geriatria e Gerontologia*, or RBGG), we hope to contribute to a greater understanding of the violence suffered by older adults, as well as to identify and propose strategies and solutions for this harsh reality, which causes injury, generates suffering and leads to death.

The scope of this thematic issue embraces articles that:

- *Characterize the cases (victim and aggressor dyad) and dynamics of the contexts in which violence occurs.* It is known that a significant part of violence against older adults occurs in the places where they live and that the main aggressors are those who deal most directly with care – family members and caregivers, whether professional or otherwise;

- *Seek to discuss and show how structural violence, which is expressed in inequalities in living conditions, has impacted the vital process of different groups of older adults.* In this case, for example, for an older adult to be born, live and die in societies with extreme inequalities, such as Brazil, is ultimately to be subjected to many situations of violence, the background of which is the structural violence that privileges some and subjects others to conditions without dignity;

- *To identify and bring about a greater understanding of how institutions (public and private) have acted in relation to the rights of older adults.* It is known that older adults have frequent contact with certain institutions – health services and banks, among others, and that there are laws and regulations that should guarantee prioritization, qualified listening and integrated care for these people, which is not always the case, representing in turn a practice of institutional violence;

- *Analyze how the response to cases of violence against older adults functions.* The services that provide care for older adults in situations of violence should have trained professionals to carry out the initial reception, qualified listening, diagnosis and registration of suspected or confirmed cases, as well as referral for the activation of the care and protection networks. It is important to show and discuss whether the services operate in a network, and whether the service provided is comprehensive, among other issues;

- *Analyze and identify how and which public policies can prevent and reduce situations of violence.* Identify which policies include the theme of violence as an important issue for the health of the older population, with what scope they address this theme and whether they have been evaluated to assess how they are responding to the needs of this population, when faced with experiences of violence, and what results have been achieved.

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Violence against old people in the city of Campinas, São Paulo, in the last 11 years: a temporal analysis

Emmanuel Dias de Sousa Lopes[1]
Maria José D´Elboux[1]

Abstract

Objective: To analyze the notifications of cases of violence against old people in the period from 2009 to 2019 using data obtained from the Violence Notification System (SISNOV) in the city of Campinas, State of São Paulo, Brazil. *Method:* This is an epidemiological research with a quantitative, descriptive approach and temporal trend. For the analysis of the notifications, information was observed according to the sociodemographic variables characteristic of violence and its aggressor, and according to the annual temporal analysis: age group, types of violence, means of aggression, and gender of the author. *Results:* 1,217 old people suffered aggression, (69.5%) of which were female, with a predominance of the age group between 60 and 69 years (35.8%), widows (37.7%), and whites (64.4%). The most prevalent type of violence was neglect (33.1%), with the residence (92.9%) being the place of greatest occurrence. Most of the aggressors were male (55.6%), and the way to do it was with body strength (24.4%). The temporal trend analysis showed an increase in the age group: 60-69 years, physical violence, means used for that - body strength, objects, and poisoning -, and gender of the aggressor - both. *Conclusion:* The results obtained were in line with other studies, indicating a trend in the profile of victims and aggression, and it is important for this group to know their rights and be encouraged to make complaints, as well as health professionals so that increasingly effective public policies are developed to address this issue.

Keywords: Domestic Violence. Health of the Elderly. Elder Abuse. Health Information Systems.

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INTRODUCTION

The phenomenon of family violence permeates the entire history of mankind. However, it was only from the mid-twentieth century that it began to deserve due attention by health professionals as they began to report cases[1]. Currently, studies related to violence have progressively sought to understand the situations of abuse faced by the old people in different settings. This fact is motivated both by the increase in the number of victims in our country and by national and international surveys indicating the family as being the main source of occurrence of cases of violence against this age group[2].

According to the World Health Organization (WHO), violence comprises the intentional use of physical force or power (in fact or threatening) against oneself or another person, group, or community, resulting in or the possibility of injury, death, psychological damage, developmental disability or deprivation, or all of them. Regarding its classification, violence can be classified as physical, psychological, sexual, financial abuse, neglect, abandonment, and self-neglect[3].

In Brazil, violence against old people is reflected in the bidirectional nature of dependence imposed on the generations usually due to economic factors, as they all reside in the same household. This interaction based on differences and shared values can be a burden to the caregiver who generally works in an unpaid way and has other duties, especially when family financial resources are scarce, and in the presence of difficulties of locomotion, behavioral disorders, and cognitive deficits, often inherent to senescence and senility. These situations set the scene for the establishment of conflicts in the domestic space, usually resulting in violence[4,14].

Violence against old people is a social and health problem within the scope of public policies and on the rise in Brazil, but with recent compulsory notification. *Estatuto do Idoso* (the statute for old people) is created in 2003, a great accomplishment for this population which, among other guidelines, determines that suspected or confirmed cases of abuse must be reported to the competent authorities. In 2011, other legal provisions emerged to assist in the increase of notifications in Brazil: the inclusion of cases in the list of diseases and conditions of compulsory notification in all public and private health services in the national territory, and the requirement of communication to the epidemiological surveillance. Despite this, the formalization of a policy alone does not provide protection guarantees, since for the consolidation of a right it is necessary for it to be taken over by the population so that they do not become vulnerable victims of aggressors[5].

Concerned with the population's vulnerability to exposure to violent acts, the municipality of Campinas, State of São Paulo, implemented in 2005 the Violence Notification System (SISNOV) in an electronic, integrated, intersectoral, and interinstitutional way, for disclosing cases of domestic and sexual violence against children and adolescents, women and old people[6]. In 2009, information began to be shared by annual newsletters about cases of violence against old people[6].

However, violence against old people has been poorly reported to the competent bodies (police authorities, Public Ministry, or the State and Municipal Councils for the Old People), remaining disguised in the context of secrecy or family arrangement. Among the obstacles to the act of notifying are the precariousness of public resources to investigate and solve the situations reported, the lack of a protective network, the lack of notification flow, as well as the low training of professionals to identify the cases. The multiplicity and failure to integrate information sources and the high rates of under-registration are also challenges to be overcome, aiming at obtaining estimates of violence occurrence to assist surveillance and assistance for this population[7,10].

Bearing in mind that violence against the old population is a serious public and social health problem, little reported and of multifactorial causes, the need to investigate the data referring to these cases in the city of Campinas, State of São Paulo arose, since it has its coverage system for reporting cases of violence. Also, no study on this topic was found in the literature for the municipality.

Given the need for an investigation leading to thinking of ways to guarantee the care of this population and ensure that the law is effectively

enforced, the present study aimed to analyze the sociodemographic aspects, characterize violence and the aggressor by the analysis of notifications of cases of violence against old people from 2009 to 2019, also comprising a historical series of time trends, through data obtained from the Violence Notification System (SISNOV) in the city of Campinas, State of São Paulo, Brazil.

METHOD

This is an epidemiological research with a quantitative, descriptive approach and temporal trend carried out in the municipality of Campinas with secondary data obtained from the SISNOV on violence against individuals aged 60 years or over in the period from 2009 to 2019.

Campinas, located in the countryside of the State of São Paulo, Brazil, has an estimated population of 1,220,146 inhabitants in 2019[8], of which 146,368 are old people, 62,538 are male, and 83,830 are female, representing about (12%) of the municipality's residents.

Data was collected via access to the SISNOV *website*: http://sisnov.campinas.sp.gov.br/. Then, a database containing all the variables to be analyzed and the respective years was subsequently prepared by the authors. The variables were analyzed according to the sociodemographic profile of the old people (age, gender, marital status, education level, and race/color), and also according to the characterization of violence (types of violence, place of occurrence, the gender of the author, means used for that, relation with the victim, and occurrence).

The description of the notifications for the period analyzed for the sociodemographic variables and characterization of violence and aggressor included the creation of tables with values of absolute frequency (n) and percentage (%).

To analyze the annual time trend of notifications of cases of violence against old people, the variables of interest (age group, types of violence, means of aggression, and gender of the author) were used, chosen by the authors according to the relevance indicated by the scientific literature and presented in the format of figures. The Chi-square trend test of *Cochran-Armitage* was used, and the level of significance adopted for the statistical tests was (5%), that is, $p<0.05$.

RESULTS

The total notifications identified for the study period comprised 1,217 victims of violence, of which (69.5%) were female and (30.3%) male, with a predominance of (35.8%) in the age group between 60 and 69 years old, (37.7%) of widowed marital status, and (64.4%) white of race/color. Regarding education, (31.9%) had incomplete/complete elementary school (Table 1).

Regarding the characterization of cases of violence, the most prevalent types are neglect and abandonment (33.1%), followed by psychological and moral (24.9%), with the own household (92.9%) being the place of highest occurrence. Most of the aggressors were male (55.6%), and the way to do it was with body strength and beating (24.4%). Regarding the relation with the victim, it was identified that the children are the main responsible (56.6%), and in (46.8%) of cases the act was repeated (Table 2).

The analysis of the annual time trend of the variable age group (Figure 1) showed a significant increase for 60-69 years ($p<0.001$), and a significant decrease for 70-79 years ($p=0.011$) over time.

For the types of violence practiced (Figure 2), the time trend analysis over the years showed significance for physical ($p<0.001$) and others ($p<0.001$), showing an increase over time, and psychological/moral ($p<0.001$), torture ($p<0.004$), and financial/economic ($p<0.001$) decreased.

Regarding the means used for the aggression (Figure 3), there was a significant time trend for body strength/beating ($p<0.001$), objects (blunt, sharp, hot, firearm) ($p<0.001$), poisoning ($p<0.001$), and other ($p<0.001$), increasing over time.

For the analysis of the gender of the aggressor, the time trend analysis showed a significant decrease over time for females ($p<0.031$), as both genders ($p<0.001$) increased over the years.

Table 1. Sociodemographic profile of old people (N = 1217) from 2009 to 2019 in Campinas, SP.

Characteristics of victims	n (%)
Age group (years old)	
60 - 69	436 (35.83)
70 - 79	422 (34.68)
80≥	359 (29.50)
Gender	
Male	369 (30.32)
Female	846 (69.52)
Ignored	2 (0.16)
Marital status	
Ignored/blank	163 (13.39)
Single	137 (11.26)
Married	337 (27.69)
Widow/er	459 (37.72)
Divorced	121 (9.94)
Education Level	
Ignored/blank	489 (40.18)
Illiterate	115 (9.45)
elementary school 1st - 4th grade incomplete/complete	389 (31.96)
elementary school 5st - 8th grade incomplete/complete	102 (8.38)
Incomplete/complete high school	85 (6.98)
Incomplete/complete higher education	37 (3.04)
Race/color	
Ignored/blank	161 (13.23)
White	784 (64.42)
Black	128 (10.52)
Yellow	10 (0.82)
Brown	134 (11.01)

Source: The authors.

Table 2. Characterization of cases of violence (N = 1217) from 2009 to 2019 in Campinas, SP.

Characterization of violence	n (%)
Types of violence	
Physical	332 (20.22)
Psychological/moral	410 (24.97)
Torture	11 (0.67)
Sexual	21 (1.28)
Financial/economic	211 (12.85)
Neglect/abandonment	544 (33.13)
Others	113 (6.88)
Place of occurrence	
Ignored/blank	31 (2.55)
Residence	1131 (92.93)
Thoroughfare	27 (2.22)
Collective householding	11 (0.90)
Others	17 (1.40)
Gender author aggression	
Blank	10 (0.82)
Ignored	74 (6.08)
Male	677 (55.63)
Female	374 (30.73)
Both genders	82 (6.74)
Means of aggression	
Body strength/beating	297 (24.40)
Hanging	14 (1.15)
Objects (blunt, sharp, hot, firearm)	57 (4.68)
Poisoning	39 (3.20)
Threat	252 (20.71)
Other aggression	103 (8.46)
Ignored/blank	455 (37.39)
Relation with the victim	
Child	689 (56.61)
Friend	36 (2.96)
Former spouse	14 (1.15)
Caregiver	19 (1.56)
Unknown	40 (3.29)
Grandchild	42 (3.45)
Sibling	28 (2.30)
Spouse	130 (10.68)
Other relations	219 (18.00)
Occurred other times	
Ignored/blank	283 (23.25)
Yes	570 (46.84)
No	364 (29.91)

Source: The authors.

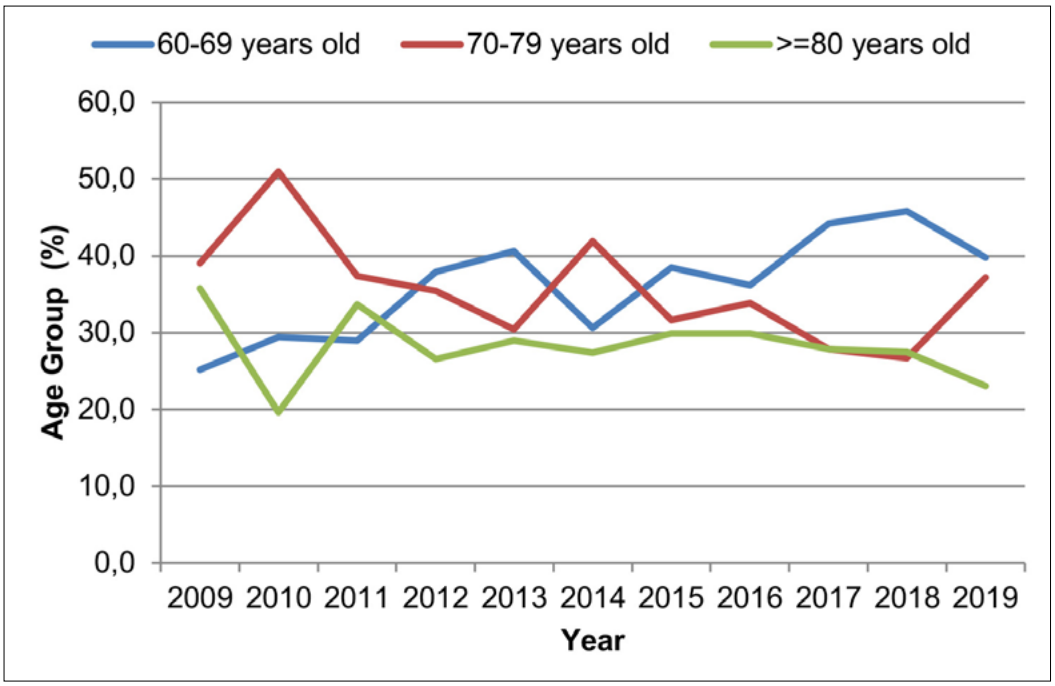

Figure 1. Analysis of the time trend for the age group of old people victims of violence in the period of 2009-2019, Campinas, SP.

Source: The authors.

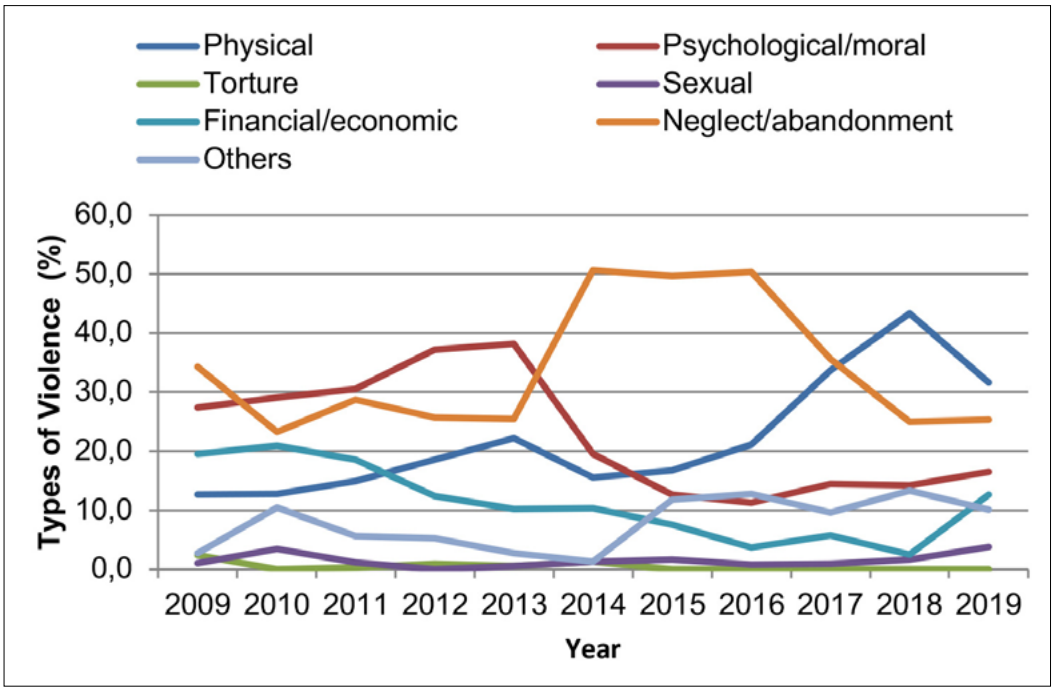

Figure 2. Time trend analysis of the types of violence against old people. 2009-2019, Campinas, SP.

Source: The authors.

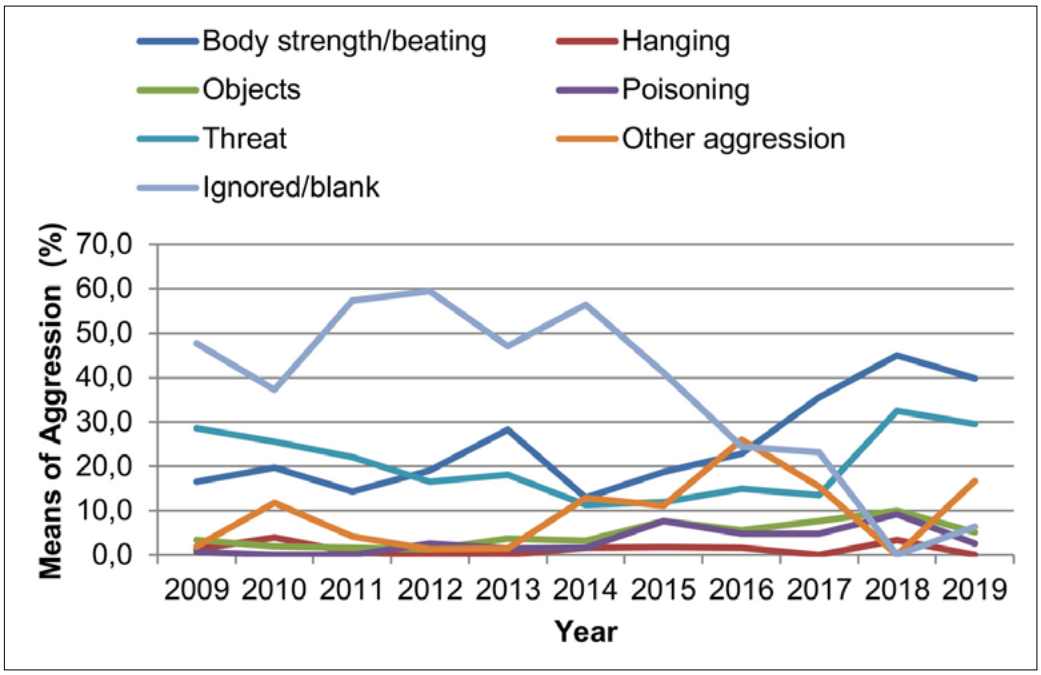

Figure 3. Time trend analysis of the means of aggression. 2009-2019, Campinas, SP.

Source: The authors.

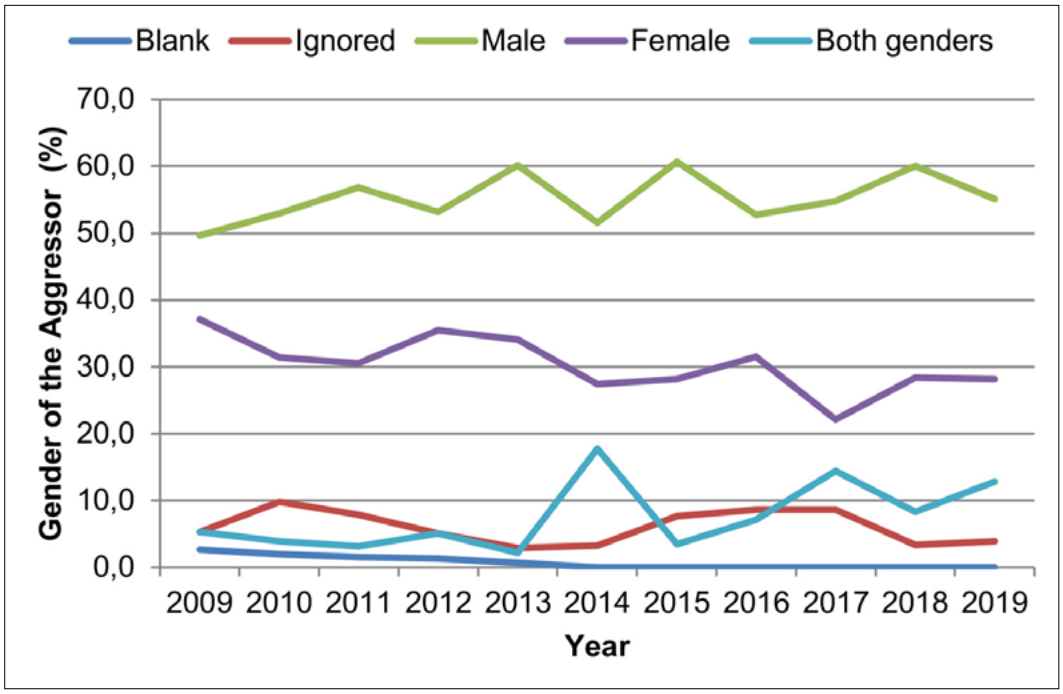

Figure 4. Time trend analysis of the gender of the aggressor, 2009-2019, Campinas, SP.

Source: The authors.

DISCUSSION

This historical series study identified 1,217 notifications of cases of violence against old people in the municipality of Campinas, State of São Paulo, Brazil, over the past 11 years.

Regarding the sociodemographic profile of the old people abused, the main results found showed the following prevalence: age group between 60 and 69 years old, women, widows, with a low level of education, and white race/color, which is consistent with other similar studies carried out[9-11] such as the one developed in three Brazilian municipalities (Ribeirão Preto, SP, Teresina, PI, and João Pessoa, PB) aiming to identify the sociodemographic characteristics of victims and aggressors, types of violence, and places of occurrence by the analysis of police reports. The researchers found the prevalence of cases in the age group of 60 to 69 years old, female, married, and with low education[9], differing from the present study about marital status, as the prevalence was of widowed women.

An investigation carried out in the city of São Paulo[11], an integral part of the SABE study (Health, Well-being, and Aging) with 1,126 old people, found a prevalence of (10%) of violence against this age group. Regarding the sociodemographic characteristics, (59.8%) were female and (59.1%) of white race/color; the findings were similar to the present study.

The predominance of old females observed in the vast majority of studies about violence has been described in the scientific literature as the feminization of old age, being characterized by an increase in the number of women in relation to the number of men in this age group[12]. Some factors contributing to this discrepancy can be related to gender inequality in relation to life expectancy. Despite the greater longevity, women have more functional limitations, biological aspects, the difference in exposure to mortality, occupational risk conditions, and use of legal drugs. Also, women tend to take better care of their health, dedicating more time and attention to self-care and seeking more specialized services. The world trend towards the feminization of old age was seen in the last demographic census carried out by IBGE in 2010, when it demonstrated that females represent (55.5%) of the old population in Brazil[12].

Another variable having an important association with violence in old people is education. In the present study, there was a predominance of the low level of education, corroborating the findings from international and national studies[9] in which subjects with more years of education are less likely to suffer aggression when compared to those with less education[13]. On the other hand, the results presented here contradict those presented in a research carried out in Betim, Minas Gerais, where old women with the complete elementary school had a lower risk of suffering violence when compared to those with a higher level of education - above the 5th grade[13]. However, it is worth emphasizing and supporting the findings of Avanci, Pinto, and Assis[10] that education favors tolerance and acceptance of human rights.

The predominance of neglect/abandonment (33.13%) and psychological/moral violence (24.97%) reaffirms the findings of Matos et al.[14] who identified (56%) of cases of neglect and (21%) of abandonment in a study carried out at a reference center in geriatric and gerontological health at Distrito Federal. In a literature review[15], the most common types of violence identified by the authors were the psychological, physical, and financial ones.

The time trend analysis of the present study showed an increase in physical aggression and other types of violence over the age of 11. Said increase can be explained by the dependence of the old people on carrying out their daily activities, becoming increasingly dependent on their caregivers, a fact that is considered a public health problem as it causes important losses in the quality of life of the old people.

In the findings of the present study, attention is drawn to the characteristics of the means of aggression, comprising body force/beating, use of objects (sharp, hot, firearm), and poisoning, which have shown important growth, especially between the years 2016 and 2018 representing the main means of abuse. In a study on intrafamily violence with old people seen in urgent and emergency services in 24 Brazilian capitals and the Federal District, the authors found that (28.6%) of them were victims of

body strength/beating, (18.3%) of blunt objects, and (10.5%) of poisoning[10].

Intrafamily violence has peculiarities that deserve careful attention, especially by the professionals involved in investigating and addressing this type of occurrence. Each family has a life history built over the years and based on beliefs, personal values, behaviors, and attitudes inherent to each family component that, in turn, are related to each other. Thus, the recording of a violent situation may become just another number in the statistics. It is necessary to understand the entire context, family interrelationships, and their dynamics to be used as the basis for more effective and efficient interventions by specialists[3,10].

The literature points out that the higher frequency of aggressions in households also observed in the present study may be due to the shock of generations imposed by living together, permeated by disputes over physical space, financial difficulties, and lack of knowledge about the aging process and changes caused by the same. Besides, it is noteworthy that in our country (28%) of the homes have at least one old person and (90%) of them live with their close family members[14].

Still in this context, the literature shows that the family concentrates the greatest number of cases of violence against old people, and those who live with family members with problems of alcoholism, drug addiction, or emotional difficulties are subject to a high risk of aggression, usually by male relatives. People who lived in violent environments during childhood or who witnessed the abuse of old people tend to reproduce these behavior patterns[16].

In a study[10] analyzing the data on intrafamily violence of old people treated in urgent and emergency services collected via the Accident and Violence Surveillance System (VIVA) Survey, the male gender was predominant among the aggressors. The study by Meirelles et al.[17] analyzed 14,900 notifications extracted from the Information System for Notifiable Diseases (SINAN) and 18,228 cases from the Mortality Information System (SIM) from 2012 to 2017 in the state of Minas Gerais, Brazil, identifying the child as the main aggressor (26.4%).

In the present study, the time trend analysis over the years showed an increase in both genders (male and female) with regard to the perpetrators of aggression. This fact can be explained based on the new family models where the children return to live with their parents, and in which the old person becomes responsible for the family support with the money from their retirement or alimony[18]. In an ecological study carried out to understand the meanings and possible factors of violence, old women recognized that it is a product of multiple levels of influence on human behavior, especially intergenerational relationships[19].

As Minayo points out[20], violence in Brazil has historically been structured into nuclei: structural (inequality, poverty, misery, discrimination), institutional (inefficient public policies and domination), and interpersonal (forms of communication and daily relations of indifference). Given this, several old people are victims of these forms of violence, often concomitantly, causing physical and mental impairments and making intra-family coexistence difficult[21].

As a limitation of the study, it is evident that there may be an underreporting of cases of violence in Campinas, SP, due to factors such as neglect in health care because of the difficulty of professionals in detecting their indicative signs[22], lack of monitoring and guidance for continuous reporting[23], fear of the old people in making complaints against their aggressors[24]. Also, there were some variables in the SISNOV database, making it difficult to interpret the data.

To face violence against old people, an adequate protection network for the care of victims is suggested, reinforcing their greater dimension where other public policies are urgent to guarantee effective rights to old people. In this sense, one way that can be used to guarantee such rights is social control[25], composed of family members, friends, people from the community, and existing services. Basic Health Units (UBS) are an example of this, emerging as a potential source of support since professionals working in primary care are important subjects in detecting and managing situations of family violence due to access, proximity, and continuity of care

that this model of assistance offers the population, strengthening the support network for vulnerable people, especially the old people who generally use these services more frequently and regularly[26].

CONCLUSION

The present study showed, through the analysis of cases of violence against old people, that the majority of abuse is against old women aged 60-69 years, widows, white race/color, with a low level of education. Regarding the characterization of the aggressions, neglect/abandonment was identified as being the most common type, with the use of body strength and beating as a means of physical aggression practiced by a male individual, with the place of occurrence being the own household. The temporal trend analysis showed an increase in the age group: 60-69 years, physical violence, means used for that - body strength, objects, and poisoning -, and gender of the aggressor - both.

The results obtained corroborate other research on the same topic, indicating a trend in the profile of victims and types of aggression. We emphasize the importance of this group knowing their rights and being encouraged to make complaints, as well as health professionals so that increasingly effective public policies are developed to face this problem.

Still, the present study contributes to expand the knowledge about the topic and to provide subsidies for the development of public policies directed to vulnerable old people and those victims of violence in the city of study.

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Quality of life of older women and men in situations of intimate partner violence

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Abstract

The present paper sought to investigate the association between intimate partner violence (IPV) and the levels of quality of life (QoL) and its domains (control and autonomy; personal fulfillment and pleasure), in older people. A population-based cross-sectional study of the second wave (2013/2014) of the EpiFloripa Study was carried out with older people (n = 649) living in Florianópolis, SC, Southern Brazil. The average QoL score and their domains were described according to the adjustment variables (age, income, cognitive deficit, depressive symptoms, and dependence on activities of daily living) stratified by gender. The relation between IPV and QoL was analyzed using multiple linear regression with a statistical significance of 5%. The average scores of QoL, personal fulfillment, and pleasure were similar between genders, while control and women's autonomy were significantly lower compared to men (p= 0.04). Lower QoL scores were observed in women exposed to violence in the three directionalities analyzed: perpetrated (-3.15; 95%CI: -4.84; -1.45), bidirectional (-2.59; 95%CI: -4.10; -1.09), and suffered (-1,62; 95%CI: -3.06; -0.17); the most affected ones were those who were aggressive. The control and autonomy were affected for the perpetrators and those involved in bidirectional violence, while lower scores of personal fulfillment and pleasure were seen among the older women in any violent situation. Men did not have their QoL impaired due to IPV, neither as victims nor perpetrators of this violence. It was concluded that IPV has an asymmetric impact on the QoL of older people when it comes to gender with women being the most affected ones.

Keywords: Intimate Partner Violence. Quality of life. Men. Women. Health of the Elderly.

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INTRODUCTION

With the sharp aging of the population, it is necessary to provide older people with positive experiences and quality of life during this period. Therefore, they need to be free from all forms of violence and live in safety and dignity[1]. Intimate partner violence (IPV) is defined as any act of violence, whether physical, sexual, psychological, or economic abuse[2].

Exposure to violence can result in unnecessary suffering, injury or pain, loss or violation of human rights, post-traumatic stress disorder, and somatization, tending to severely affect the physical and mental health of the victims, which influence the quality of life (QoL) at lower levels[3]. For older people, QoL is defined by satisfaction in four domains: control - related to the ability to actively intervene in their environment -, autonomy - related to the right to be free from unwanted interference from others -, pleasure - which refers to the search for pleasant activities -, and lastly personal fulfillment - describing the full personal development[4,5].

To reach QoL, social relationships are emphasized, including well-being in intimate relationships. However, although still disguised among older people, IPV presents as a form of communication and can be an alternative to conflict resolution[6], which often starts in adulthood.

IPV is a human rights violation with great magnitude in the world population[7]. Studies estimate that more than 30% of women and about 25% of men suffer this type of violence worldwide[8], although victimization of men is less investigated and explored in the literature. The analysis of physical IPV prevalence showed that more men (6.4%) suffered said aggressions in Denmark compared to women (5.0%)[9]. This finding exposes the aggressions against men, transcends the unidirectionality of violence, and reinforces the need to investigate both genders as probable victims or aggressors in the intimate relationship.

The analysis of the effect of physical[9]and psychological violence and controlling behavior in intimate partners showed a loss of QoL of older women. A Danish study exploring the association between IPV and QoL in different age groups concluded that older people had a greater QoL reduction when exposed to violence by their partners compared to adults, emphasizing the relevance of investigating the phenomenon also in this age group.

Although studies on the effects of IPV on the QoL of older people are still scarce in the literature, the subject has been gradually explored in European studies[3,9] and North American studies[10] in which the context of aging is more present. However, none of the studies analyzed the impact of IPV on QoL and its domains, according to the directionality of violence and the gender of the older people. In Brazil, no publications were found on the topic referring to the older population, which explains the gap of knowledge and the novelty of the present study. In this context, we seek to investigate the association between IPV (suffered, perpetrated, and bidirectional) and the levels of QoL in its domains (control and autonomy, personal fulfillment, and pleasure) in older women and men living in Florianópolis, Santa Catarina.

METHOD

This cross-sectional study is part of a longitudinal population and household study carried out with older people (60 years and over) living in the urban area of Florianópolis, in the State of Santa Catarina, Southern Brazil. The data in the present study come from the research 'Condições de Saúde de Idosos de Florianópolis' (Health Conditions of Older People in Florianópolis), the so-called EpiFloripa[11,12]. According to the 2010 demographic census, the municipality had a total population of 421,239 inhabitants, with older people corresponding to 11.4% of this total. The municipal human development index (MHDI) was 0.847 that same year, which is considered high and takes third place among the municipalities and the first among the Brazilian capitals[13,14].

The baseline sample was selected in two stages by conglomerate. The first unit was the census tracts. Florianópolis has 420 urban tracts, 80 of which drawn systematically corresponding to 8 tracts in each income decile (R$192.80 - R$13,209.50). The units in the second stage were households. It was necessary

to update the number in each tract (enrollments) and only residential addresses permanently occupied were registered. The number of households ranged from 61 to 725, and small tracts were grouped to reduce the variation coefficient from 52.7% (n = 80 tracts) to 35.2% (n = 83 tracts) taking into account the geographic location and the corresponding income decile, as well as the division of very large areas. It was estimated that 60 families per tract would need to be visited.

The sample size was estimated using the EpiInfo program version 6.04 (*Centers for Disease Control and Prevention*, Atlanta, USA). It was based on the prevalence calculation formula and the parameters of population size (44,460), confidence level (95%), unknown prevalence (50%), sample error (4 percentage points), design effect (estimated at 2), plus 20% for estimated losses and 15% for association studies. This resulted in a minimum sample of 1,599 individuals. The sample was expanded to 1,911 individuals due to the availability of resources, but 1,702 older people were interviewed. Of those respondents of the first wave, 376 losses (22.1%) were identified, which included 217 deaths and 129 refusals (7.6%), accounting for 1,197 participants in 2013/2014 (response rate of 70.3%).

Data were collected through individual interviews conducted by trained interviewers. Validated instruments were used and a pilot study was developed (n = 99 in the first wave, n = 76 in the second). The interviews were recorded on portable digital devices (PDA) in 2009/2010, and netbooks in 2013/2014.

The quality control of the *EpiFloripa Idoso* study was carried out by a short telephone questionnaire (with eight questions) to about 10% of the older people in the sample selected at random. The reproducibility of the questions showed satisfactory to a good agreement (first wave, kappa between 0.6 and 0.9; and second wave, kappa between 0.5 and 0.9).

For the present study, the following inclusion criteria were applied to the sample of the second wave: the older person must have answered exclusively in full the QoL (CASP-19)[4] and IPV (CTS-1)[14] questionnaires, and have had an intimate partner during the last twelve months. Of the 1,197 participants, 458 had no intimate partner during the last 12 months, 57 interviews were answered by informants, there were 31 refusals to respond to CTS-1, and 2 incomplete CASP-19 interviews, accounting for 649 eligible older people with a response rate of 54.2%. The sample flowchart is shown in Figure 1.

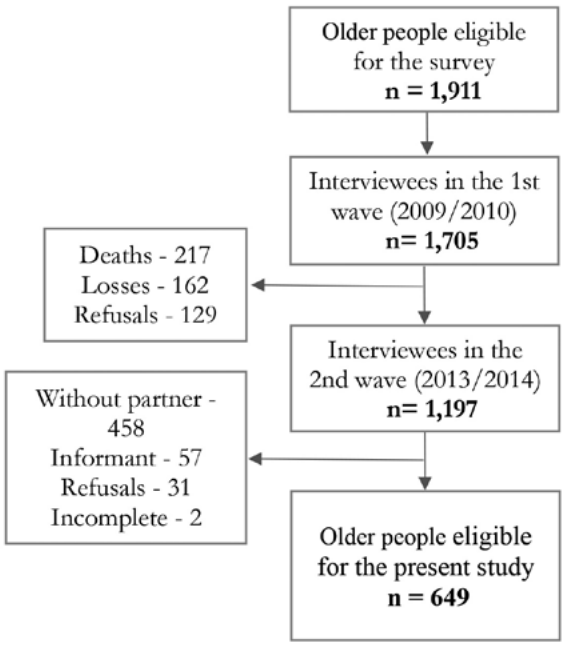

Figure 1. Flowchart of the study sample size. Epi Floripa Study. Florianópolis, SC, 2013/2014.

In the present study, the outcome quality of life (QoL) was measured using the CASP-19 instrument. This scale comprises four domains divided into 19 items: *control* (age is a limitation; there is no control over what happens to the individual; they feel free to plan their future; they feel excluded from everything), autonomy (they can do whatever they want; family responsibilities prevent them from doing what they want; they feel free to do stuff; health conditions and lack of money are limitations), *personal fulfillment* (they feel excited; they realize life has a meaning; they like what they do; they like the company of others; they feel happy looking at the past), and *pleasure* (they feel full of energy; they choose to do new things; they are satisfied with the direction that life has taken; they feel that life is full of opportunities and the future looks good). Such domains have the same level of importance, there is no hierarchical organization. For each item, there are four response options on the *Likert* scale (often, sometimes, rarely, never). A score was assigned to each response, the overall score of CASP-19 ranges from 0 representing the complete absence of QoL to 57 when there is full satisfaction[4].

QoL was measured by the total score (CASP-19), and its domains were grouped into control and autonomy (scores from 0 to 27), and personal fulfillment and pleasure (scores from 0 to 30). This division has theoretical support in the literature[15,16] where it was found that the four domains of CASP-19 were not sufficiently distinct for their isolated analysis. Psychometric analyzes carried out in Eastern Europe[17] and Ireland[18] concluded that control and autonomy related to the individual ability to initiate and achieve goals, and personal fulfillment and pleasure representing the full reach of the human potential, when grouped, better represent the QoL of the older people.

The exposure variable was the IPV measured by the cross-cultural adaptation of the instrument *Conflict Tactics Scales Form R* (CTS-1)[15] developed to measure violence between the couple. The questionnaire investigates the presence of verbal aggression in 6 items of insults and threats (cursed or insulted, sulked, left the place, did/said things to irritate, threatened to hit or throw things, destroyed/threw objects) and physical aggression in 9 items of physical or explicit strength (throwing objects, pushing/grabbing, slapping, kicking, biting or punching, hitting or trying to hit with objects, spanking; strangling/suffocating, threatening with knife or weapon). It was possible to verify the directionality of violence as the interviewee was asked if they committed the act against their partner (perpetrated violence) and if the partner committed it against them (suffered violence). When violence was suffered and perpetrated by the same individual, it was classified as bidirectional violence. The presence of IPV was considered when the response was positive for at least one of the items on the scale in the reminiscent period for the last 12 months. This variable was transformed into a dummy variable considering values equal to 0 or 1 and stratifying the sample into *yes* and *no*. The CTS-1 was used in other Brazilian studies[19,20] with good reliability and a low refusal rate.

The adjustment variables were age group (60-69, 70-79 and 80 years and over), family income *per capita* in minimum wages (<1, 1-5, 5-10,> 10), cognitive deficit (none or probable), depressive symptoms (none or suspected depression), dependence on activities of daily living (ADL) categorized as absent, mild, moderate, severe. The cognitive deficit was measured by Folstein's Mini-Mental State Examination (MMSE)[21], the presence of depressive symptoms was assessed by the Geriatric Depression Scale (GDS-15)[22], and dependence on ADL by the Scale of Activities of Daily Living by BOMFAQ/OARS[23].

Initially, descriptive statistics of the adjustment variables (age group, income, cognitive deficit, depressive symptoms, and dependence on ADL) were performed, presenting absolute and relative frequencies stratified by gender. The QoL level was presented by the total score and the domains comprising control and autonomy, personal fulfillment, and pleasure. Measures of central tendency (average) and dispersion (standard deviation) were used according to the adjustment variables for men and women. QoL was expressed by average and 95% confidence intervals (95%CI) according to the independent variables. The averages were compared using the *Student t* (gender), *Mann-Whitney* (depressive symptoms and cognitive deficit), and *Kruskal-Wallis* tests (age group, income, and dependence on ADL), and non-parametric trend for the variables of age, income, and dependence on ADL.

The IPV variables (suffered, perpetrated, and bidirectional) and the QoL scores and their grouped domains (control and autonomy, personal fulfillment and pleasure) were analyzed using multiple linear regression. In the unadjusted and adjusted analysis, results were presented in beta coefficient (β) and their respective 95% confidence intervals (95%CI). Three regression models were conducted: total QoL score, control and autonomy, and personal fulfillment and pleasure stratified by gender. In the adjusted analysis, each exposure referring to IPV (suffered, perpetrated, and bidirectional) was controlled by the adjustment variables to estimate its effect on the QoL scores and domains. The level of statistical significance was set at 5% for the association.

In the adjusted linear regression models, à the residues were analyzed by the evaluation of the heteroscedasticity and normality, the verification of the standard residues, and the variance inflation factor (VIF). For data analysis, *statistical software* was used. The effect of the sample design by conglomerates was considered, and the sample weights were incorporated.

The EpiFloripa Idoso study was approved by the Human Research Ethics Committee of Universidade Federal de Santa Catarina (protocol 352/2008 and CAAE 16731313.0.0000.0121). All participants signed the free and informed consent terms.

RESULTS

Of the 1,197 older people in the second wave, 649 were part of the study with a response rate of 54.2%. The study participants (n=649) had higher QoL scores (46.3) when compared to non-participants (44.9), with statistical significance (p=0.008). The majority of non-participants (n=548) were female (85.2%) older than 70 years (76.4%) with less than 4 years of education and income below five minimum wages, with a higher prevalence of depression, cognitive deficit, and dependence on ADL when compared to the participants.

The descriptive analysis of the sample and average QoL scores and their domains according to demographic, socioeconomic, and health conditions in men and women are described in Table 1.

The majority of participants were men (52.4%), 45.1% of which aged 70-79 years, 58.6% with family income above five minimum wages, and 43.2% had no dependence on ADL. Among women, the age group of 60-69 years (47.2%), family income of 1 to 5 minimum wages (50.5%), and dependence on light ADL (47.1%) were predominant. For both genders, depressive symptoms and a probable cognitive deficit in most individuals were absent.

The average QoL scores measured was 46.8 (SD=7.5) among men, and 45.8 (SD=8.1) among women (p=0.093). Women had significantly lower scores (20.5; SD=5.0) for control and autonomy when compared to men (21.3; SD=4.6) (p=0.042). In the domain of personal fulfillment and pleasure, the averages were 25.5 (SD=4.2) for men and 25.2 (SD=4.2) for women (p=0.405), with no statistically significant difference between genders.

The overall QoL was higher according to the income only for women (p=0.021). The levels of personal fulfillment/pleasure were higher both for men and women according to increased income and lower according to increased age, presenting a linear trend. In the presence of depressive symptoms, cognitive deficit, and dependence on ADL, lower QoL scores and their domains were found, except for control/autonomy in women.

When measuring the average scores of QoL, women in a situation of IPV in the three directions analyzed (suffered, perpetrated, and bidirectional) showed lower levels of QoL. Women who perpetrated IPV had lower QoL scores (-3.15; 95%CI: -4.84; -1.45), followed by those involved in bidirectional IPV (-2.59; 95%CI: -4, 10; -1.09) and those who suffered violence (-1.62; 95%CI: -3.06; -0.17) in the adjusted analysis (Table 2). nThe QoL is compromised when women are involved in a situation of IPV, especially when they are responsible for acts of aggression.

When analyzing the adjusted QoL domains, the control and autonomy scores were lower among women who perpetrated violence (-1.62; 95%CI: -2.70; -0.55) and for those in situations of bidirectional violence (-1.36; 95%CI: -2.41; -0.31) (Table 3). Regarding the domain of personal fulfillment and pleasure, the scores were lower for women perpetrating violence (-1.52; 95%CI: -2.50; -0.54), followed by those involved

in bidirectional violence (-1.23; 95%CI: -2.12; -0.34) and those who suffered IPV (-0.81; 95%CI: -1.58; -0.04) in the adjusted analysis (Table 4).

Regarding men, the unadjusted and adjusted analyzes showed that there were no differences in the QoL score and its domains among those in situations of IPV in the three directions analyzed compared to those not exposed to violence. Note that experiencing IPV brought negative effects only on the QoL of women, while men were not affected.

In the analysis of residues, it was found that they showed normal distribution, there were no specification errors in the regression models according to the analysis of standard residues, and multicollinearity was not identified using the variance inflation factor (VIF).

Table 1. Descriptive analysis and quality of life scores stratified by gender according to demographic, socioeconomic, and health conditions in women and men. EpiFloripa Idoso, Florianópolis, Santa Catarina, 2013/2014.

			CASP-19		Control and Autonomy		Personal fulfillment and Pleasure	
	Men n (%)	Women n (%)	Men Mean (SD)	Women Mean (SD)	Men Mean (SD)	Women Mean (SD)	Men Mean (SD)	Women Mean (SD)
	340 (52,4)	309 (47,6)	46,8 (7,5)	45.8 (8,1)	21,3 (4,6)	20,5 (5,0)	25,5 (4,2)	25,2 (4,2)
*p****			0,093		0,042		0,405	
Age group (years)	n= 340	n= 309						
60- 69	135 (37.5)	147 (47.2)	47.9 (6.9)	46.6 (7.8)	21.9 (4.2)	20.8 (5.0)	26.0 (4.3)	25.8 (4.0)
70- 79	146 (45.1)	129 (42.0)	46.5 (7.4)	44.8 (8.4)	21.2 (4.6)	20.1 (5.3)	25.3 (4.0)	24.7 (4.3)
80 or more	59 (17.4)	33 (10.8)	44.9 (8.7)	45.6 (7.7)	20.1 (5.1)	21.1 (4.7)	24.7 (4.4)	24.4 (4.5)
*p**			0.053	0.171	0.084	0.491	0.030#	0.016#
Income (minimum wage)	n= 329	n= 288						
Less than 1	9 (3.3)	15 (4.2)	45.4 (7.2)	43.1 (8.6)	21.2 (3.7)	19.0 (5.4)	24.1 (4.5)	24.0 (4.0)
Between 1- 5	138 (38.1)	142 (50.5)	45.8 (8.6)	44.9 (8.5)	21.0 (5.0)	20.1 (5.4)	24.8 (4.8)	24.8 (4.6)
Between 5- 10	77 (24.8)	76 (26.3)	46.7 (6.4)	45.9 (7.3)	21.4 (4.4)	20.9 (4.2)	25.2 (3.5)	25.0 (4.0)
Greater than 10	105 (33.8)	55 (19.0)	48.0 (6.8)	48.5 (6.7)	21.5 (4.2)	21.6 (4.9)	26.4 (3.8)	26.9 (2.9)
*p**			0.242	0.021#	0.933	0.166	0.003#	0.003#
Cognitive Deficit	n= 340	n= 307						
No	290 (87.3)	243 (80.0)	47.4 (6.9)	46.3 (7.8)	21.6 (4.2)	20.8 (5.0)	25.7 (3.9)	25.5 (4.1)
Probable	50 (12.7)	65 (20.0)	43.3 (9.7)	43.7 (8.8)	19.3 (5.9)	19.5 (5.4)	24.0 (5.2)	24.2 (4.5)
*p***			0.005	0.021	0.016	0.075	0.021	0.033
Depressive Symptoms	n= 340	n= 308						
No	290 (85.7)	243 (80.8)	48.5 (5.9)	48.1 (6.7)	22.0 (4.2)	21.9 (4.3)	26.4 (3.0)	26.2 (3.5)
Suspected depression	50 (14.3)	65 (19.2)	36.6 (8.3)	37.1 (7.2)	16.7 (4.4)	15.5 (4.5)	19.8 (5.9)	21.7 (4.9)
*p***			< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Dependence on activities of daily living	n= 340	n= 309						
Absence	146 (43.2)	83 (26.7)	51.0 (4.1)	50.6 (5.5)	23.6 (3.0)	23.5 (3.8)	27.3 (2.2)	27.1 (2.6)
Mild	135 (39.6)	138 (47.1)	45.4 (7.6)	46.4 (7.4)	20.7 (4.3)	21.0 (4.3)	24.7 (4.6)	25.4 (4.4)
Moderate/Severe	59 (17.2)	88 (26.2)	39.6 (7.5)	40.2 (8.0)	16.8 (4.6)	17.1 (5.2)	22.7 (5.1)	23.1 (4.3)
*p**			< 0.001#	< 0.001#	< 0.001#	< 0.001#	< 0.001#	< 0.001#

* Kruskal-Wallis test; ** Mann-Whitney test; *** Student's t-test, comparison of average quality of life and domains for men and women; # trend according to non-parametric trend test for the ordinal groups.

Table 2. Unadjusted and adjusted analysis of the total quality of life score (CASP-19) according to intimate partner violence suffered, perpetrated, or bidirectional stratified by gender. EpiFloripa Idoso, Florianópolis, Santa Catarina. 2013/2014.

	Unadjusted analysis				Adjusted analysis*			
	Quality of Life - CASP 19							
	Men		Women		Men		Women	
	β (95%CI)	p	β (95%CI)	p	β (95%CI)	p	β (95%CI)	p
Suffered violence								
No	1		1		1		1	
Yes	0.14 (-2.16;2.45)	0.901	-2.37 (-4.37; 0.37)	0.022	0.31 (-1.24;1.86)	0.691	-1.62 (-3.06;0.17)	0.021
Perpetrated violence								
No	1		1		1		1	
Yes	-0.73 (2.33; 0.86)	0.364	-3.90 (-5.66; 2.15)	<0.001	-0.08 (-1.38;1.21)	0.900	-3.15 (4.84; -1.45)	<0.001
Bidirectional violence								
No	1		1		1		1	
Yes	0.35 (-1.90; 2.62)	0.751	-3.58 (-5.58; -1.59)	0.001	0.31 (-1.27;1.91)	0.693	-2.59 (-4.10; -1.09)	0.001

* Model adjusted by age group, income, cognitive deficit, depressive symptoms, and dependence on activities of daily living; 95%CI = 95% confidence interval.

Table 3. Unadjusted and adjusted analysis of the domain of quality of life - control and autonomy - according to intimate partner violence suffered, perpetrated, or bidirectional stratified by gender. EpiFloripa Idoso, Florianópolis, Santa Catarina, 2013/2014.

	Unadjusted analysis				Adjusted analysis*			
	Control and Autonomy							
	Men		Women		Men		Women	
	β (95%CI)	p	β (95%CI)	p	β (95%CI)	p	β (95%CI)	p
Violence suffered								
No	1		1		1		1	
Yes	0.09 (-1.13;1.33)	0.870	-1.22(-2.57; 0.11)	0.073	0.20 (-0.66;1.02)	0.637	-0.80 (-1.89; 0.27)	0.140
Perpetrated violence								
No	1		1		1		1	
Yes	-0.32 (-1.28; 0.62)	0.490	-2.18 (-3.24;-1.11)	<0.001	-0.01 (-0.81; 0.77)	0.963	-1.62 (-2.70; -0.55)	0.003
Bidirectional violence								
No	1		1		1		1	
Yes	0.15 (-1.03; 1.39)	0.801	-1.95 (-3.20;-0.69)	0.002	0.07 (-0.83; 0.98)	0.872	-1.36 (-2.41; -0.31)	0.012

* Model adjusted by age group, income, cognitive deficit, depressive symptoms, and dependence on activities of daily living; 95%CI = 95% confidence interval.

Table 4. Unadjusted and adjusted analysis of the domain of quality of life - personal fulfillment and pleasure - according to intimate partner violence suffered, perpetrated, or bidirectional stratified by gender. EpiFloripa Idoso, Florianópolis, Santa Catarina, 2013/2014.

	Unadjusted analysis				Adjusted analysis*			
	Personal fulfillment and Pleasure							
	Men		Women		Men		Women	
	β (95%CI)	p	β (95%CI)	p	β (95%CI)	p	β (95%CI)	p
Suffered violence								
No	1		1		1		1	
Yes	0.02 (-1.23; 1.28)	0.964	-1.14 (-2.10; -0.18)	0.022	0.10 (-0.84; 1.05)	0.821	-0.81 (-1.58; -0.04)	0.035
Perpetrated violence								
No	1		1		1		1	
Yes	-0.42 (-1.34;0.50)	0.371	-1.72 (-2.70; -0.74)	0.011	-0.06 (-0.90; 0.77)	0.872	-1.52 (-2.50; -0.54)	0.003
Bidirectional violence								
No	1		1		1		1	
Yes	0.18 (-1.01; 1.38)	0.766	-1.63 (-2.68; -0.59)	0.002	0.24 (-0.68; 1.17)	0.697	-1.23 (-2.12; -0.34)	0.007

* Model adjusted by age group, income, cognitive deficit, depressive symptoms, and dependence on activities of daily living; 95%CI = 95% confidence interval.

DISCUSSION

The present study is relevant to understand the association between IPV and QoL in older people in Brazil by the analysis of suffered, perpetrated, and bidirectional violence by men and women. The main findings are the distinct impacts produced by exposure to IPV on QoL according to gender. Only women had their QoL impaired when they were in situations of violence. Lower QoL scores were identified among older women who perpetrated violence against their partners, followed by those involved in bidirectional violence, and lastly among those who suffered aggression by their partners. But men did not have their QoL affected when perpetrating or suffering violence.

The older people in Florianópolis showed high QoL (men =46.8; women =45.8) when compared to population-based studies carried out in other countries[16,24] using the same measurement instrument (CASP-19). In Ireland, the QoL of older people was lower (43.8), as well as in England (42.5). The average QoL scores were similar between genders in the current study, differing from other population surveys[16,23]. Said results may be related to the fact that the present study includes only older people with partners who had a high level of QoL when compared to non-participants. Older people married or with a partner had a higher QoL than single women. The partner's presence is considered positive when there is social support and personal appreciation in the relationship[25].

It was found that women had their QoL impaired in situations of violence, which remained impaired even after the analysis adjusted by the factors of age group, income, cognitive deficit, depression, and dependence on ADL, while for men the QoL remained unchanged regardless of whether they suffered or committed such acts. This finding shows that the impact of violence on QoL differs significantly between older women and men. Gender differences may be the result of disparities in health and the different ways in which older women and men respond and deal with health problems and adverse

experiences. In our culture, the male and female roles contribute to conflicts between couples and are often associated with violence in the relationship[26,27]. The binomial masculinity and violence has traditionally been understood as if the second term was part of the first. In this scenario of association between being male and being violent, gender relations are built and reproduced, thus legitimizing violence as a reference to distinguish men from women[28]. This construction corroborates the differences in the impact of IPV on QoL between genders found in the present study.

For older women, both committing and suffering violence result in lower QoL scores. A greater negative impact on QoL is emphasized for women who perpetrate violence against their partners (-3.15; 95%CI: -4.84; -1.45) when compared to those who suffered the aggression (-1.62; 95%CI: -3.06; -0.17). It seems paradoxical that older women who perpetrate IPV have their QoL more compromised compared to those who suffer it since literature[26,27] shows that serious consequences of violence are related to women being the victims. The suffering caused can work as a catalyst for installed or predisposed illness processes such as impaired physical health, dependence on activities of daily living, cognitive deficit, and a greater likelihood of mental health problems such as anxiety and depression, and social isolation in older age[28,29] in addition to lower self-perceived health[30] which compromise the QoL of people involved in violence.

Note that although collecting data on perpetrators is challenging, understanding the role of factors such as socioeconomic status as the perpetrator's financial dependence is an important barrier to seeking help, others such as mental health and abuse substance abuse as well as dependence and interdependence between perpetrators and victims require attention since understanding these characteristics is important to predict and prevent abuse of the older people[27,31].

In the present study, the role of women in IPV situations affects both QoL domains - control and autonomy, personal fulfillment and pleasure. Note that women are constantly held responsible for the care and success of relationships, being more likely to feel guilty for their partner's violent behavior, which impacts their well-being. The expectation that women should be caregivers, sensitive, and conciliatory in the family environment not admitting that they become aggressive and violent [32] results in their QoL being even more compromised when they play the role of IPV perpetrators. Some authors[33,34] describe the perpetration of IPV by women as a defense reaction against aggressions they previously suffered. Adopting violence to resolve marital conflicts evidences the lack of other resources to mediate problems, exposing the vulnerability of the relationship. In line with these results, an American study[27] found an association between low self-esteem and perpetration of this violence only for women.

It should be noted that IPV among older people is nothing new emerging in this age group. A population-based study carried out with adults in Florianópolis[32] found that the prevalence of suffering physical violence was high for both men (17.5%) and women (16.1%), but with negative consequences in greater levels on women's health, evidencing that violence in intimate relationships and their effects is maintained throughout life. An Australian longitudinal study stated that IPV had a lower QoL for women over the 16 years of study, perpetuating for three generations and explaining that the damage caused by violence to those who experience it is intergenerational[35].

It emphasizes the negative impact of IPV on the well-being of the older women interviewed, compromising positive and healthy aging and pointing to the need for strategies to prevent this form of violence at this stage of life. Women in situations of violence are more susceptible to remain socially isolated, away from friends and family, remaining restricted to the domestic environment, and living with the perpetrator of violence[31]. The consequences of IPV are hugely impacting the health and happiness of those involved, extending and affecting the well-being of families and even entire communities[7].

Although the prevalence of IPV in older people shows gender symmetry[33], the effects produced by exposure to violence QoL are asymmetric since being in a situation of IPV did not have any impact on men's QoL. However, this impact on women's QoL

is permeated by a gender inequity that must be fought since acts of aggression, abuse, and humiliation in the relationship are socially tolerable[30].

Based on the gender theory[29], men being violent against their partner corresponds to the correct way of behaving, a historically constructed and valued way to solve problems. The violence perpetrated by the partner remains naturalized and trivialized, being often not even considered as such[34]. Moreover, violence is usually recognized by men only in situations of public life: in urban, impersonal, and/or anonymous relationships. Aggressive behaviors and acts of violence in the family and conjugal spheres are considered the role of the head of the family, therefore relationship violence remains invisible and neglected[34].

To reduce the IPV on men and women, it is necessary to deconstruct the hierarchical roles of gender and the reduction of structural factors supporting these inequalities, which are certain interventions of great value to cope with violence and the achievement of healthy aging, promoting QoL among the older people, especially women who are most affected[35,36]. Acknowledgment of situations of intimate relationship violence among older people in healthcare services is still an incipient practice in the Brazilian context[30]. There are services to care for older people who are victims of abuse and mistreatment, but a larger part of this population may be suffering the consequences of IPV in their relationships.

Regarding the QoL, a specific definition transcending health-related issues and measuring the aspects of subjective perception of life was adopted for the older population. The analysis of a representative population-based sample of a capital of southern Brazil carried out by validated instruments and high reliability – CTS-1 and CASP-19 – achieved reliable results allowing to conclude that women had their QoL impaired by IPV and that being a perpetrator had a greater negative impact than being a victim, while for men this form of violence did not alter their levels of QoL.

The age profile of the sample is among the limitations found, which included older people aged 63 years and over. This group differs from the target population of the study which was planned to be applied to individuals aged 50 years and over. This limitation potentially implied a lower variability in the responses to the items, attenuating the magnitude of all the parameters estimated in the present study. Another limitation refers to the use strategy of CASP-19, which was face-to-face and not by self-response which may affect the responses to the items of the instrument by overestimating the QoL assessment resulting from the process. This type of administration was adopted in the study to allow even the older people with low levels of education or low visual acuity to answer the survey questionnaire.

CONCLUSION

The present study addressed the association of IPV on Quality of Life (QoL) of older women and men. An asymmetric impact was found between the gender and only women had their QoL impaired when experiencing situations of intimate partner violence (IPV), whether suffered, perpetrated, or bidirectional. Note that there are lower QoL scores for older women who have perpetrated IPV against their partners.

IPV has significant psychological and health impacts in older women, often exacerbated by the duration of violence. Prolonged abuse and essential social transitions such as children leaving home can lead to feelings of hopelessness, unfulfilled life expectations, and deep social isolation, reducing the quality of life of this population.

The importance of promoting policies to assist in the prevention of IPV of older people is emphasized, as this population faces barriers to be helped, in addition to being a topic that has not been investigated especially in terms of interventions. From the importance of QoL for the area of gerontology and the advance that CASP-19 represents – because it is aligned with new theoretical constructs on aging – it is expected that the present study will contribute to the notion of healthy and active aging and guide actions aimed at older populations in Brazil and worldwide.

The present study is relevant because it investigates a subject that has not been well investigated yet, addressing not only the violence suffered in the intimate relationship but also the perpetrated and the bidirectional ones. There is little research comparing the results of victimization and perpetration of IPV in men and women. Such conduct reduces the analysis bias since victims and aggressors are not previously defined, but such behaviors are analyzed in both sexes.

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The labor market scenario for older people and the violence they suffer

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Abstract

Objective: to systematically analyze publications referring to the labor market for older people and the violence situations faced by active older people. *Method:* an integrative literature review in the databases Web of Science, Scielo (Scientific Electronic Library Online) PubMed and Science Direct. *Results:* 19 papers were found, 89.4% of the cases of international origin, 52.6% with a quantitative approach; 31.5% with a qualitative approach; and 15.7% with both. The areas of knowledge comprising most of the studies were health, psychology, and gerontology with 15.7% of them, and most studies were published in 2019, with 31.5% and 26.3% of recurrences, respectively. *Conclusion:* the studies showed that older people have difficulties to remain in the labor market due to the inadequacies of the workplace and their health condition. On the other hand, there are government initiatives aimed at improving the working conditions for older people, and their presence is beneficial both for their health and for the market. Regarding violence at work, studies are scarce, and the existing ones emphasize the difficulties of older people to enter and remain in the market to the detriment of ageism and stereotypes related to aging. Finally, as the population is aging, it is important to think about public policies to provide older people with adequate conditions to remain active and protect their health and quality of life.

Keywords: Aging. Work. Population Dynamics. Elder Abuse.

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INTRODUCTION

The increased number of older people around the world reflects on demands of a political, social, and economic nature and affects the labor market as it increases the presence of older people among the Economically Active Population (EAP)[1]. In this context, there is a need for structural changes in organizations such as offering flexible working hours, adequate ergonomic conditions, management of intergenerational groups, and the creation of strategies to deal with ageism in the companies[2,3].

As population ages differently in developed and developing countries[4], some are more prepared than others to absorb their older workers. According to Cepellos Filho[5], the Brazilian labor market is not been prepared to include the older population in the EAP. On the other hand, developed countries like Denmark and Canada have greater initiatives to restrain this active population such as increasing the age for retirement and public policies to encourage older people to remain working[6].

In addition, the increased number of older people compared to the total population contributed to increase the number of cases of violence against older people. According to Morilla and Manso[7], violence against older people has become a global trend, being a worrisome reality as it affects one in every six individuals aged 60 years or over[8].

Violence affecting older people occurs in the home environment, on the streets, and in institutions such as the labor market[9], and can cause physical, emotional, psychological disorders and negative effects on well-being and quality of life[10]. According to Bialowolska et al.[11] violence against older people in the labor market has grown more and more due to management policies aimed at profit and cost reduction, leaving violence-driver issues such as intergenerational relationships in the background.

In this sense and considering the increasing presence of older people in the labor market as well as the growing violence against this population, the need to know the labor market scenario for older workers and the situations of violence they face in this environment is justified.

Thus, the present study aimed to analyze the publications referring to the labor market scenario for older people and situations of violence experienced by active older people.

METHOD

The present study is an integrative systematic literature review. According to Botelho et al.[12] the integrative review enables the systematization of scientific knowledge on a given topic, enables the creation of the state of the art on it, in addition to pointing out gaps in the literature that may become topics for future studies. In the present case, the topics of interest are the violence to which economically active older people are subject, and the labor market scenario for older workers.

The integrative review followed the steps of choosing the topic of interest, establishing the inclusion and exclusion criteria for studies, definition of the information to be extracted from the studies selected, evaluation of the studies meeting the inclusion and exclusion criteria, and the analysis, interpretation, and presentation of the summary of results[13].

The descriptors used for the research were "Demographic Aging" AND "Violence" AND "Labor" OR "Workers age". The search was performed in the databases Web of Science, Scielo, Pubmed, Science Direct, Scopus, PsychInfo, Jstor, Springer, and Nature.

The inclusion criteria used to select the articles were those dealing with the topic in question covering the different areas of knowledge with full text available online, without filtering the language and year of publication. The exclusion criteria were literature review articles of incomplete access, and duplicate articles. The information extracted from the texts were the article authors, journal names, types of study, database used for research, field of knowledge, country of publication, year of publication, aspects related to the labor market scenario, and situations of violence experienced by active older people. Finally, data were organized in tables.

The literature was analyzed from August 2020 to January 2021 by accessing the PubMed, Science Direct, Web of Science and Scielo platforms, the latter two being through the institutional login of Universidade Federal de Viçosa on Capes Journal Portal (Coordination for the Improvement of Higher Education Personnel) accessing CAFE (Federated Academic Community), which gives access to articles in full. For databases other than had open access, articles had to be searched on the internet to avoid loss of content. Therefore, although there was an attempt to identify as many studies as possible related to the proposed topic, some papers may have been unintentionally excluded, with the selection bias being the main bias of the present study.

RESULTS

The search in said databases showed no results for Scopus, PsychInfo, Jstor, Springer, and Nature. And the search for papers in the other databases using the descriptors previously mentioned found 780 studies, of which only 355 had open access. After selecting the open access papers, the abstracts were read to verify which ones really fit the topic of interest, with 332 studies being discarded for not being suitable, besides three literature review studies and one duplicate article. Finally, the sample comprised 19 papers from national and international literature. Therefore, it was found that literature on older people in the labor market and violence situations to which they are subject is scarce (Table 1).

Most of the studies in the sample (19) were published in international journals, and regarding the perspectives work, most presented a quantitative approach - nine; six, a qualitative one; and three, both.

Regarding the area of knowledge, research showing the presence of older people in the labor market and the violence situations they face run through several areas. The most recurrent were health, psychology, and gerontology - which appeared in three studies -, followed by economics and engineering, which appeared in two studies. The remainder social work, sociology, management, environmental studies, industrial and labor relations, and ergonomics were present in one paper each.

Most publications comprised the years 2019 with six recurrences and 2020 with five, followed by 2015, 2016, and 2018, all with 2 papers each; 2001 and 1997 presented 1 paper each. Regarding the databases, 12 publications descended from the Web of Science, one from Scielo, five from Science Direct, and one from PubMed (Table 2).

Regarding the nationality of the research, the United States presented six studies. The Netherlands, Brazil, Norway, Australia, Denmark, and the United Kingdom presented two studies each. And Belgium, Stockholm, Poland, and the Netherlands presented one research each (Table 3).

Table 1. Methodological path followed to search for papers in Web of Science, Scielo, PubMed and Science Direct, Scopus, PsychInfo, Jstor, Springer, and Nature.

Descriptors = "Demographic Aging" AND "Violence" AND "Labor" OR "Workers age"						Total
	Scopus, PsychInfo, Jstor, Springer, and Nature	PubMed	Science Direct	Web of Science	Scielo	
	0	242	248	289	1	780
Free access	0	201	23	130	1	355
Off-topic	0	198	16	118	0	332
Review papers and duplicates	0	2	2	0	0	4
Following the criteria	0	1	5	12	1	19

Table 2. Profile of studies carried out on the presence of older people in the labor market and the violence faced by them from 1997 to 2021.

Authors	Journal	Type of study	Area of knowledge	Year/Base
Damman, and Henkens[14]	Journal of Applied Gerontology	Qualitative	Gerontology	2020/Web of Science
Burmeister et al.[22]	Journal of Applied Psychology	Quantitative	Psychology	2020/Web of Science
Straussner and Senreich[23]	Nature public Health Emergency Collection	Quantitative	Social Work	2020/Web of Science
Oddone[31]	Contemporânea - sociology journal of UFSCAR	Qualitative	Sociology	2019/Web of Science
Coombe et al.[16]	Workplace health & safety	Quantitative	Health	2019/Web of Science
Merkus et al.[17]	International archives of occupational and environmental health	Quantitative	Health	2019/Web of Science
Peters et al.[25]	Frontiers in psychology	Quantitative	Psychology	2019/Web of Science
Amorim et al.[27]	Rege - management journal	Qualiquantitative	Management	2019/Web of Science
Sundstrup et al.[30]	Occupational and environmental medicine	Quantitative	Health	2018/Web of Science
Talbot et al.[32]	International journal of sustainable transportation	Qualiquantitative	Environmental studies	2016/Web of Science
Findsen[26]	Educational gerontology	Qualitative	Gerontology	2015/Web of Science
Jonsson; Kielhofner; Borell[28]	American journal of occupational therapy	Qualitative	Psychology	1997/Web of Science
Schreurs et al.[29]	SA Journal of Industrial Psychology	Quantitative	Industrial relations and work	2001/Scielo
Kerr et al.[18]	Plos One	Quantitative	Gerontology	2016/Pubmed
Bartkowiak et al.[24]	Journal of Cleaner Production	Qualitative	Economics	2020/Science Direct
Vigtel[21]	Labour Economics	Quantitative	Economics	2018/Science Direct
Dimovski et al.[19]	Procedia Manufacturing	Quantitative	Engineering	2019/Science Direct
Sundstrup et al.[20]	Safety and Health at Work	Qualiquantitative	Engineering	2020/Science Direct
Case et al.[15]	Procedia Manufacturing	Qualitative	Ergonomics	2015/Science Direct

Source: The authors, 2021.

Table 3. Countries and Main results to support the response to the objectives of the studies carried out on the presence of older people in the labor market and the violence faced by active older people in the years 1997 to 2021.

Authors	Country	Main results supporting the response to the objectives
Damman and Henkens[14]	The Netherlands	The flexibility of working hours is a way of keeping the older people active for a longer time. However, it is different between men and women.
Burmeister et al.[22]	United States	The presence of employees from different age groups at work provides exchange of knowledge, satisfaction, and worker motivation.
Straussner and Senreich[23]	United States	Working is presented as beneficial for older workers as it provides well-being and satisfaction.
Oddone [31]	Brazil	Ageism is one of the factors to define the early withdrawal of the older people from the labor market, as well as the economic health of companies.
Coombe et al.[16]	United States	The sleep health of workers is a predictor of good performance at work.
Merkus et al.[17]	Norway	The health condition of older workers can be preserved depending on the effort required at work throughout their lives.
Peters, et al.[25]	Australia	The negative stereotyping of aging in the labor market compromises the permanence and/or return of the older person to work. Therefore, it is important for the human resources department to focus on issues related to stereotypes to aging.
Amorim et al.[27]	Brazil	Violence against older people in the labor market can be observed in the absence of managerial practices to hire and retain older workers.
Sundstrup et al.[30]	Denmark	The individual's cognitive ability is not a factor to influence their exit from the labor market.
Talbot, et al.[32]	United Kingdom	Strategies to reduce problems arising from transportation to work are important to reduce worker evasion.
Findsen[26]	United States	Stereotypes of aging mainly related to the ability to learn have impaired the permanence of older people on the market. Thus, intergenerational learning initiatives play an important role in age management practices.
Jonsson; Kielhofner; Borell[28]	Stockholm	In addition to structural and environmental factors, the health condition of the older person influences the decision to retire early.
Schreurs et al.[29]	Belgium	To keep the older person on the labor market for longer it is necessary to provide work conditions to keep them motivated.
Kerr et al.[18]	United States	Reducing the amount of time spent sitting at work is one way to reduce retirement due to health problems, considering that reducing the sitting time contributes to reduce the sedentary lifestyle.
Bartkowiak et al.[24]	Poland	Entrepreneurs have kept their older people workers on their teams as they understand they have a human and social capital of great importance to the market.
Vigtel[21]	Norway	Lowering the minimum retirement age has positive effects on the hiring of older workers.
Dimovski et al.[19]	United States	Since the minimum retirement age has been reduced, older people have been working longer.
Sundstrup et al.[20]	Denmark	The early withdrawal of older people from the labor market is related to environmental factors such as hard work and exposure to noise and dust.
Case et al.[15]	United Kingdom	From the human digital modeling, it is possible to verify whether the work environment is harmful to health to older people. Therefore, it is possible to avoid their early withdrawal from work for health reasons.

Source: the authors, 2021.

DISCUSSION

From the studies found, the approaches given to research on the topic of interest were verified. Studies were detected dealing with aspects influencing the older person's permanence at work, benefits of working to the worker and the labor market, violence faced by older people in the labor market, and factors influencing the early withdrawal of older people from the labor market.

Regarding the aspects influencing the permanence of older people at work in different countries**,** we identified seven studies (Damman e Henkens[14], Case et al.[15]**,** Coombe et al.[16], Merkus et al.[17], Kerr et al.[18], Dimovski et al.[19], Sundstrup et al.[20], Vigtel[21]). Damman and Henkens[14] in a study carried out in the Netherlands emphasizing that the older person's permanence at work is associated to the working conditions. In this sense, to offer better conditions and prevent the withdrawal of older people, the Dutch government created a policy of work flexibilization offering to older people the opportunity to work with flexible hours or from home.

Working conditions as a way of keeping older people at work were also mentioned in a study carried out in the United Kingdom. This, in turn, pointed to human digital modeling to improve the working circumstances of older people[15].

Another aspect also mentioned for keeping older people at work is their health status. According to Coombe et al.[16], health conditions especially regarding sleep health of older people are related to their performance and permanence at work. Thus, keeping a good level of sleep among workers is a way to keep them healthy and in the labor market for a longer time[16].

The health situation of older people was also mentioned in a Norwegian study carried out by Merkus et al.[17] demonstrating that maintaining the worker's physical capacity throughout life is the key to keeping good health and activity until retirement. Therefore, adaptations are necessary to prolong the older person's work life, thus requiring less physical effort and consequently causing less health distress[17].

Health was once again mentioned as an important factor to keep the older person at work in an American research carried out by Kerr et al.[18] demonstrating that the sedentary lifestyle of older people is one of the biggest causes of disease. Thus, they sought to reduce it by reducing daily sitting hours and increasing transitions such as standing/sitting to improve their quality of life and consequently prolong their active life**.**

Also concerned about the active life of older workers given their greater presence in the market and the scarcity of workforce, Dimovski[19] estimated the limit productive age of older people aiming at the productive return of older people to work.

Still referring to health, but this time to the cognitive ability of the older person, Sundstrup et al.[20] conducted a study to estimate the relationship between individual cognitive ability and temporary or permanent market withdrawal. It was verified that, in this case, the cognitive ability did not interfere in the work withdrawal.

Finally, a Norwegian article found that another factor to influence the permanence and hiring of older people is the government management of the country, which can encourage companies to hire and maintain older workers by means of the current legislation. For example, by opting for the flexibilization of the minimum retirement age, Norway encouraged greater hiring of older people in the labor market[21].

Another approach found in the studies deals with the benefits of work for the market and for the older worker. With the population aging there are greater social interactions between people of different ages in the labor market. An American study carried out by Burmeister et al.[22] showed that the presence of older people in the company becomes advantageous because it provides exchange of knowledge between generations, motivates employees, and provides greater yearning of the older person to remain active.

An American research developed by Straussner and Senreich[23]showed that to work is beneficial for the older person because despite having health complications - which in this case are due to the

natural aging process -, older people express more satisfaction with their profession, their life, and have a positive perception of the work environment.

The presence of older people at work is still beneficial for the market because according to Bartkowiak et al.[24] company managers recognize that these workers can offer the company a good collaborative spirit, skills, intellectual and social capital, characteristics that are not found in most young workers.

Another category found describes the situations of violence faced by older workers in the labor market. Violence with older people in the labor market is presented by the unpreparedness of companies to deal with the new worker profile. A Dutch study pointed out that, even though the age group is changing with more and more older people compared to young people in the market, the human resources management of companies is not prepared to deal with the demands arising from intergenerational coexistence. Furthermore, the actions of managers tend to a negative stereotyping based on age, as they consider older people to be unproductive and not trained. Said stereotyping prevents the older person from making good use of employment opportunities and from staying at work.[25].

Violence anchored in aging stereotypes was also mentioned in an American study. According to Findsen[26], prejudice surrounding aging especially related to the ability to learn has hampered the permanence of older people at work. In this sense, it is important that organizations fight attitudes of age discrimination and encourage mutual learning initiatives through intergenerational activities[26].

Violence with older workers can also be observed in managerial practices. According to Amorim et al.[27], a Brazilian study identified that companies that are part of the Best Places to Work do not have managerial practices to encourage the hiring and retention of older workers. In addition, they do not pay attention to the adaptation of the environment and the working hours, and do not have health insurance plans with special attention to the needs of older people. Furthermore, it was observed that Human Resource Management professionals do not show interest in the subject, which is once again configured as structural violence Furthermore, it was observed that Human Resource Management professionals do not show interest on the topic, which is once again configured as structural violence[27].

Another category that emerged from the studies refers to the factors influencing early withdrawal of older people from the labor market. In a study carried out in Stockholm with older workers, Jonsson et al.[28] showed that there are many internal and environmental factors influencing the older person's early retirement decision, but the ones generally influencing the most are decreased energy and chronic diseases.

A survey carried out in Belgium examining the elements involved in early retirement intentions found that one of the main factors responsible for the desire to retire is the pleasure of working. In this sense, it seems that keeping an older employee motivated is as important as keeping them healthy so that they can continue working[29].

Another factor pointed out by a Danish study as a predictor of the older person's early withdrawal from the labor market is the circumstance of the work environment. According to Sundstrup et al.[30], the older worker's early withdrawing from the labor market is related to environmental factors such as physical work requirements, weightlifting, exposure to noises, dust and vibration[30].

The changes brought about by globalization also influence the early withdrawal of the old person from the market. For example, technological updates, temporary jobs, and fixed-time contracts do not provide favorable conditions to remain at work. The continuity of the older person is also influenced by the economic situation of companies and the macro-systemic crises affecting them. Therefore, age is no longer the only interruption limitation in the active life of older people[31].

In the United Kingdom, a study looked at the relationship between early retirement intentions and transportation to the workplace. The elements that interfered the most on the possibility of retirement regarding transportation were high costs, stress, health conditions, fatigue, and the time spent in the transportation. To ensure that transportation does not influence market withdrawal, companies have

been using carpooling strategies, specific parking spots, work shift adjustments, and remote work[32].

Similarly, Nomiyama et al.[33] carried out a research in Japan to show that the way in which the older person imagines the transition process to retirement varies according to the meaning that work has in their lives. Therefore, older people who see work as a burden will be happy to retire and be able to spend their time in other ways. On the other hand, older people who work as part of their identity will have greater difficulties to retire. Thus, the meaning of work is a considerable factor for the older person's decision to retire.

Finally, a limitation of the study is the incomplete research concerning the labor market scenario for older people as well as situations of violence occurred due to the unavailability of the full text online, which prevented us from using them in our study.

CONCLUSIONS

Most studies on the presence of older people in the labor market and the violence suffered by them have been carried out in developed countries, and they may refer to the gradual aging process occurred in these countries which may have provided a greater temporal range to think and deal with the issues coming from longevity. It is also believed that this may be related to the fact that developed countries are the most responsible for scientific publications in general. In Brazil, studies indicate that older people face difficulties to remain in the labor market due to the inadequacies of this environment due to the worker's health condition, although there are examples of government initiatives in other countries to improve their working conditions such as labor flexibilization policy and human digital modeling. The presence of old people at work is beneficial for both the market and the older person. Regarding violence at work, studies are scarce, and the existing ones emphasize the difficulties of older people to enter and remain in the market due to ageism and stereotypes related to aging. Given the above, it is important to think about public policies to provide older people with adequate conditions to remain active and protect their health and quality of life.

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Doctors' competences in caring for older people in situations of violence: scope review

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Abstract

Objective: describing by means of the evidence in the literature, the competences of doctors in hospital services in situations of violence against older people (VAOP). *Method:* scope review with search in databases/platforms/searchers and grey literature covering Medline; VHL; Embase; CINAHL; Web of Science; BDTD, OpenGrey, OpenThesis, RCAAP, Portal de Teses e Dissertações da CAPES, DART-Europe E-theses Portal and Theses Canada Portal (Aurora and Voilà catalogs). The descriptors and keywords used, combined with the Boolean operators OR, AND, NOT were: "Physicians", "Doctors", "Attitude", "Attitude", "Knowledge", "Knowledge", "Behavior", "Medical Care", "Medical Care", "Medical Care", "Hospital Services", "Hospital Services", "Hospital", "Hospitalists", "Hospital Doctors", "Older People Abuse", "Older People Abuse", "Physical Abuse", "Older People Neglect ", "Aged Abuse", "Older People Mistreatment". *Results:* six papers were selected. There was a lack of knowledge on the topic and the approach, and of specific training. As for skills, the findings that most led doctors to suspect abuse were physical findings linked to appearance, hygiene and injuries - communication and relationship problems were little mentioned. In the attitude, there was a research of abuse in only 44% of the suspicions and low or null percentages on case reporting. Only one study explored the attitude towards negligence, where 24.8% reported to social services and 21.3% informed the police. *Conclusion:* most cases of VAOP remain unnoticed and therefore unreported or unhandled. There are multiple problems regarding the competences of hospital doctors when dealing with such situations, a scenario that exposes the demand for measures to raise awareness, training, and encouragement to adequately deal with VAOP.

Keywords: Health Services for the Aged. Elder Abuse. Clinical Competence.

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INTRODUCTION

The percentage of older people in the population is growing fast. In Brazil, it is expected to increase over the world average: the 60 year older people or more in 1950 corresponded to 4.9% of the total population and reached 14% in 2020[1]. This growth, associated with changes in families and social transformations has translated into a rise in Violence Against the Older People (VAOP)[2].

Multiple types of violence victimize them: physical, emotional, financial, sexual abuse and mistreatment, as well as abandonment, neglect, and self-neglect in any environment. Such aggressions, regardless of the type, can cause intense psychological distress, increase in physical illnesses and the use of health services, trauma and even lead to death[3,4]. The question is therefore multifactorial, coated with great complexity and usually underreported[5].

The Statute of the Older People typifies VAOP, recommends compulsory notification even in suspicions and advocates punishment[6]. The Ministry of Women, Family and Human Rights (MDH) reveals via Disque 100 that the number of complaints jumped from 8,224 in 2010 to 37,454 in 2018, the main ones being: Negligence (79.54%), Financial and Economic Abuse / Property Violence (41.7%) and Physical Violence (26.49%)[7].

Since VAOP is frequent, impactful and little diagnosed, the contact of the older people with the medical team can be an unique opportunity for detection and approach[8,9]. There is evidence that older people victims of violence and neglect are less likely to receive Primary Health Care (PHC) than other older people. However, they will probably receive hospital care, usually emergency, more frequently[8].

The doctor's performance transcends the diagnosis and management of physical effects of violence. It should participate in the organization of the multiprofessional approach, sensitize professionals and refer the treatment of repercussions and the accountability of the causative ones[8]. To do so, one must have the necessary competences to address VAOP.

In Healthcare, competences are considered as knowledge, skills and attitudes required to solve problems efficiently and effectively. These three aspects are known by the acronym KSA. Knowledge is the theoretical knowledge, acquired with schooling, experience and facilitators. Skill is knowing how to do, putting knowledge into practice, and it depends on training and experience. Attitude is willingness to do, implementing practice, making it happen. Doctors need to develop the essential ones (knowledge, interest and research of cases, ability to identify and manage them), which ensures expertise and confidence to work with patients, family members/caregivers, colleagues, and health systems in the face of VAOP[10].

In the literature there are few studies emphasizing the medical care of VAOP, many focused on urgency/emergency contexts[8]. In view of this scenario, the present study justifies a scope review whose objective is describing, by means of literature evidences, the competencies of doctors in hospital services in relation to VAOP, divided into knowledge, skills and attitudes[11].

METHOD

This is a scope review with analysis of information on medical care in hospital services for older people victims of violence, according to the method proposed by the Joanna Briggs Institute (JBI). This type of study maps the main concepts, elucidates areas of research and identifies knowledge gaps[12].

In the preparation, the protocol Preferred Reporting Items for Systematic Reviews and Meta-Analysis - Extension for Scoping Reviews (PRISMA-ScR) was followed, to add reliability to the review by refining the analysis and reporting process of the included studies[13]. Systematic search was conducted between August and October 2020 in medline databases/platforms Medline; Biblioteca Virtual em Saúde (BVS); Embase; Cumulative Index to Nursing and Allied Health Literature (CINAHL); and Web of Science.

The search for grey literature and unpublished studies included: Digital Foundation of Theses and Dissertations (BDTD), OpenGrey, OpenThesis,

Repositórios Científicos de Acesso Aberto de Portugal (RCAAP), Portal de Teses e Dissertações da CAPES, DART-Europe E-theses Portal and Theses Canada Portal (Aurora and Voilà catalogues). Additionally, the search strategy Snowballing was used in the references of the articles selected for this revision[14] .

This study followed the PCC strategy, acronym for Population (P), Concept (C) and Context (C)[11]; being P (hospital service physicians), C (knowledge, attitudes and skills of hospital doctors on VAOP) and C (older people victims of violence treated in hospital services). From this arose the main question: what are the competencies presented by hospital doctors in the face of VAOP cases?

This was followed by the definition of the descriptors and keywords contained in the MeSH (Medical Subject Headings) and in the DeCS (Descriptors in Health Sciences), used combined with Boolean operators OR, AND, NOT: "Physicians", "Doctors", "Attitude", "Attitude", "Knowledge", "Knowledge", "Behavior", "Medical Service", "Medical Care", "Medical Care", "Hospital Services", "Hospital Services", "Hospital", "Hospitalists", "Hospital Doctors", "Older People mistreatment", "Elder Abuse", "Physical Abuse", "Elder Neglect", "Aged Abuse", "Elder Mistreatment", applied in the search strategies explained in Table 1.

Table 1. Search strategies used in databases/libraries/search engines and grey literature included in the scope review on the competencies of hospital doctors in VAOP cases. João Pessoa, PB, 2021.

Database/ Grey Literature	Search Strategies
BVS (BIREME)	(tw:(older people mistreatment)) AND (tw:(doctors)) AND (tw:(hospital)) AND (tw:(knowledge OR attitudes OR skills OR medical conduct))
PubMed Central: PMC	((elder abuse[Title/Abstract] OR elder neglect[Title/Abstract] OR aged abuse[Title/Abstract]) AND (physicians[Title/Abstract] OR doctors[Title/Abstract] OR hospitalists[Title/Abstract] OR medical staff, hospital[Title/Abstract])) AND (attitude[Title/Abstract] OR knowledge[Title/Abstract] OR behavior[Title/Abstract] OR practice[Title/Abstract] OR management[Title/Abstract] OR approach[Title/Abstract] OR treatment[Title/Abstract])
Web Of Science Main Collection	AB=("elder abuse") AND AB=(Knowledge OR Attitude OR Hability) AND AB=(Hospital OR "Medical Staff, Hospital" OR Hospitalist) AND AB=(Physicians OR Doctors)
Scopus (Elsevier)	TITLE-ABS-KEY (("elder abuse") AND (knowledge OR attitude OR ability) AND (hospital OR "Medical Staff, Hospital" OR hospitalist) AND (physicians OR doctors))
EMBASE (Elsevier)	(('elder abuse':ti,ab,kw OR 'elder neglect':ti,ab,kw OR 'aged abuse':ti,ab,kw) AND physician:ti,ab,kw AND 'medical staff':ti,ab,kw OR hospital:ti,ab,kw) AND attitude:ti,ab,kw AND (elder:ti OR older:ti OR aged:ti) AND [2004-2020]/py
CINAHL (EBSCO)	(elder abuse or elder mistreatment or elder neglect) AND (physicians or doctors or clinicians) AND hospital AND (attitudes or perceptions or behavior or knowledge)
BDTD	(Summary Portuguese:older people abuse And Summary Portuguese:doctors And Summary Portuguese:hospital)
OpenGrey	(elder abuse OR aged abuse OR elder neglect) AND (physicians OR doctors) AND hospital
OpenThesis	text((physicians OR doctors OR "medical care") AND hospital AND ("elder abuse" OR "elder neglect" OR "aged abuse")
RCAAP	physicians AND (attitudes OR knowledges OR skills) hospital AND older people abuse
Portal de Teses e Dissertações da CAPES	("medical care" OR "medical care" OR doctors) AND hospital AND ("older people abuse" OR "older people neglect" OR violence against older people")
DART	(physicians OR doctors OR "medical care") AND hospital AND ("elder abuse" OR "elder neglect" OR "aged abuse")
Library and Archives Canada (Theses Canada Portal)	"physicians" AND hospital AND ("elder abuse" OR "aged abuse" OR "elder neglect" OR "physical abuse")

We included studies that met the theme, including scientific papers (quantitative, qualitative and mixed) and grey literature (dissertations and theses, medical guides, expert texts and medical or legislation related to the subject); in English, Portuguese or Spanish; published from October 1, 2003 to October 20, 2020 - a limit defined as immediately after the enactment of the Statute of the Older People in 2003. Studies that: did not address the theme studied; integrative or systematic reviews; did not present the possibility of being located in full in electronic or printed media; and those who demonstrated no ethical conduct were excluded.

The selection of the studies took place in two stages: an initial screening, by reading the title and the abstract, and a second screening, by reading the full text, selecting the papers according to the criteria mentioned above. Data extraction occurred through an instrument developed by the reviewer, which included title, author(s), year of publication/country, objective, method, professional categories of participants, main results related to the competencies of hospital doctors on VAOP. The methodological quality of the articles and the level of scientific evidence were not considered for the exclusion of papers, because this type of review seeks to gather all the production found on the object of study[12].

RESULTS

The searches in the databases revealed 161 papers, 36 found in the BVS, 40 in PubMed, 2 in Web of Science, 16 in Scopus, 60 in EMBASE and 7 in CINAHL. In the research of grey literature, 119 papers were found, 4 in BDTD, 61 in OpenThesis, 6 in the Portal de Teses e Dissertações da CAPES and 32 in RCAAP. No material was obtained from DART-Europe E-theses Portal, OpenGrey and Theses Canada Portal.

Thirty seven out of the 280 records found were duplicated and they were excluded, remaining 193 for reading the respective titles and abstracts. This process led to the exclusion of 175 publications for not adapting to the inclusion criteria, and to the pre-selection of 18 papers for full reading, where two papers were obtained by the Snowballingstrategy. At the end there were 06 papers that fit this study[15–20]. The result of the search and selection process is described in Figure 1.

One study came from Italy, two from Turkey, one from Israel, one from Canada and one from Ireland, produced from 2007 to 2018, all published in medical journals. Regarding methodological characteristics, the studies selected in this review are all quantitative descriptive, and used convenience sampling.

Regarding the professional categories addressed, only in two studies (33%) the Doctor was the only professional approached, while 6 studies (50%) included the Nurse. Other professionals such as the Social Worker and the Nursing Technician were considered in two studies (33%). These data and the objectives of the studies can be observed in Table 2.

The competencies of doctors in the studies involved general knowledge on the subject and approach, as well as specific training; detection and management skills, as well as experience with cases; and attitudes towards real or hypothetical cases, emphasizing case report and the identified barriers.

Knowledges

Table 3 presents the description of the competence of doctors' knowledge faced with VAOP assessed in the studies.

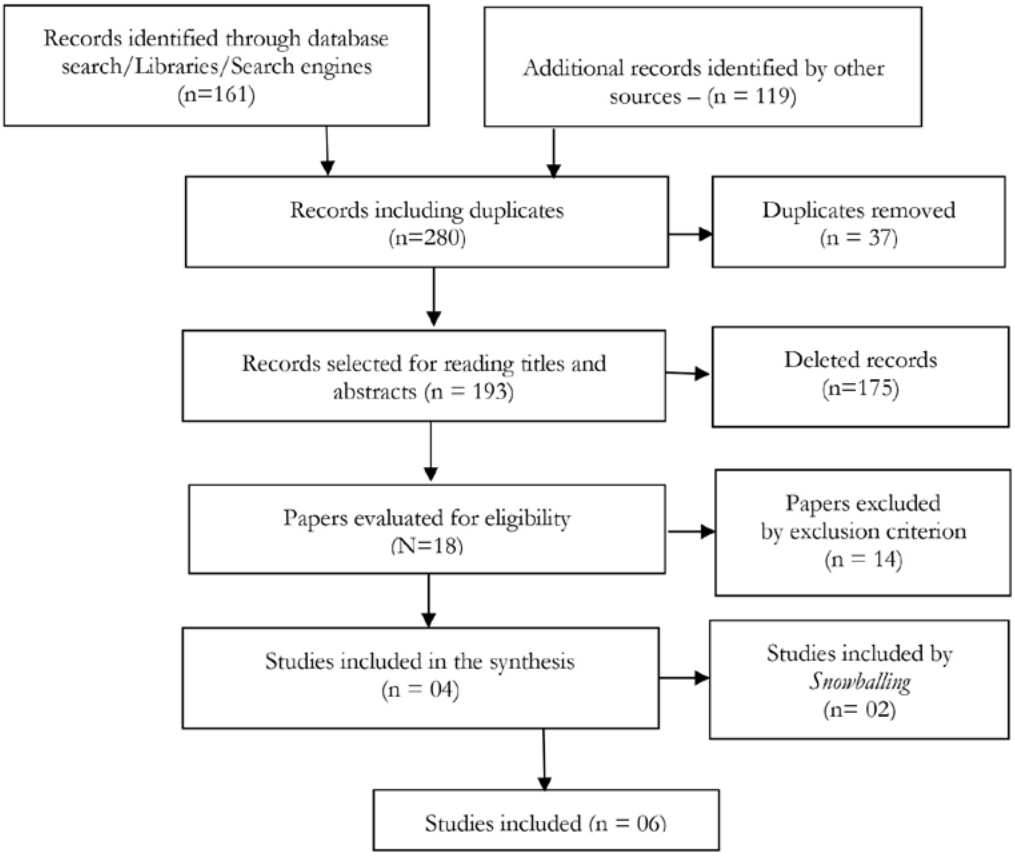

Figure 1. Flowchart of search and selection of studies on the competencies of hospital doctors in the face of VAOP cases. João Pessoa, PB, 2021.

Source: adapted from PRISMA-ScR[12].

Table 2. Characteristics of the studies included in the scope review on the competencies of hospital doctors in the face of VAOP cases. João Pessoa, PB, 2021.

Authors, year of publication, type of study	Education of the main author, country	Professional category(ies) addressed	Study Objective(s)
Corbi et al., 2019[15], descriptive comparative study	Doctor, Italy	Doctors, nurses and nursing technicians	Establish the level of awareness and perception of abuse to older people by health workers, and understand whether they were able to properly identify and report abuse, also to identify physical signs of abuse and negligence
Eraslan et al., 2018[16], descriptive quantitative study	Doctor, Turkey	Clinical doctors, specialists and resident doctors	To assess doctors' perspectives on abuse and neglect of older people and to understand their knowledge and approaches, to raise awareness of the subject, and to identify abuse and offer possible solutions
Caines et al., 2017[17], descriptive study	Doctor, Canada	Doctors	Examine the depth of knowledge and approach of Canada's emergency doctors on older people abuse
Almogue et al., 2010[18], , descriptive comparative study	Doctor, Israel	Nurses and doctors	To assess the level of knowledge and attitudes of doctors and nurses regarding older people abuse in Israel, comparing doctors and nurses and analyzing the results according to workplace, specialization and professional and geriatric experience

to be continued

Continuation of Table 2

Authors, year of publication, type of study	Education of the main author, country	Professional category(ies) addressed	Study Objective(s)
Kennelly et al., 2007[19], descriptive comparative study	Doctor, Ireland	Doctors and Medicine social workers	To assess the awareness of health professionals about older people abuse
Mandiracioglu et al., 2006[20], descriptive comparative study	Doctor, Turkey	Doctors, nurses and other specialties	To assess the definition of older people abuse, level of knowledge, attitudes and practices of emergency medical service personnel

Table 3. Knowledge of hospital doctors in the face of older people in situations of violence in the studies included in the scope review. João Pessoa, PB, 2021.

Studies	Knowledge of hospital doctors in the face of older people in situation of violence
Corbi et al., 2019[15], Italy	All aware that many older people are victims of abuse, and 93.8% of the sample put the abuse of older people as a violation of human rights. Of the total, 44.7% knew the standard procedures for reporting and approaching, and 40% of the doctors did not believe that negligence is a form of abuse.
Eraslan et al., 2018[16], Turkey	Specific training was received by 14.9% of the doctors. The trained group reported more than the untrained group ($p<0.001$) and revealed a higher rate of abuse cases realization ($p=0.04$), more often felt able on the subject ($p<0.001$), and defined older people as older than 65 years ($p=0.02$). They also defined old age as a period of dependence/need less frequently than the untrained group ($p=0.02$). Doctors from public institutions had higher training on the subject ($p=0.004$) and higher rates of case communication ($p=0.005$) than those in the private sector.
Caines et al., 2017[17], Canada	Sixty-eight percent of the doctors felt able to report suspected cases of domestic abuse, and 63% in institutional cases. Regarding specific training, 35% did not complete it and 83% felt that the training was insufficient, in addition to 77% not being aware of all community services available to victims of abuse and their families. Half reported that their services did not have a written protocol to address cases of abuse, and 39% were uncertain whether there was protocol in their services.
Almogue et al., 2010[18], Israel	Doctors had no differences by service type (general or geriatric hospital). A total of 43% of the professionals knew that older people could receive state assistance if necessary, and 14% knew that there was no possible penalty if the case was not reported. There was a correlation between knowledge on the subject and that related to important laws and protocols ($p=0.006$).
Kennelly et al., 2007[19], Ireland	A total of 45% of the doctors never heard the term older people abuse, and 30% read some technical material about it, while 85% felt that abuse was common and underreported. No doctor received formal training, and only one knew guidelines for this management.
Mandiracioglu et al., 2006[20], Turkey	75% of the doctors believed that older people abuse was not common in Turkey. The scores obtained were high in understanding risk factors, intermediaries in knowledge and attitude towards cases and in diagnosis, and low in knowing their legal obligations in relation to cases. Twenty-four percent never received training.

As for general theoretical knowledge about VAOP, three[18-20] papers had low levels of knowledge. Kennelly et al. evidenced that 45% reported never having heard the term older people abuse, and only 30% read technical material[20]. In another study, they obtained only intermediate scores in knowledge[19]. Only 43% knew that the victim could receive state aid, and only 14% knew that without complaint, there would be no penalty for the aggressors[18].

Two studies evaluated the knowledge about procedures to report cases. Corbi et al. found that only 44.7% of the doctors were aware of the procedures. In another study, most doctors felt able to report domestic (68%) and institutional cases (63%)[17].

An aspect considered central in acquiring knowledge to face the problem was having received specific training to manage cases; it was measured

by four studies. In one of them, only 14.9% received specific training[16], while another pointed out a percentage of 24%[19]. The Irish study pointed out no formal training[19]. Caines et al. evidenced that 35% did not complete training on older people abuse, 83% felt that the training was insufficient, 50% reported that their services did not have a written protocol to address cases of abuse, and 39% were uncertain whether there was a protocol in their services[17].

Comparing trained doctors with those who were not, one study highlighted that the former reported more than the others ($p<0.001$), with a higher case finding rate ($p=0.04$) and, more often, they felt able to address the topic ($p<0,001$)[16].

Comparing doctors from public and private institutions, one study revealed that the former had higher education on the subject ($p=0.004$), with higher rates of reporting cases ($p=0.005$)[18]. Another study showed that those in university hospitals outperformed those in private hospitals[20]. However, the study by Almogue et al. did not find this difference[18].

Regarding case experience, in two studies doctors never worked with a case of abuse or neglect[15.16]. In the Irish study[19], 65% said they had treated at least one suspected case of abuse in the last year. In the study by Caines et al., 78% suspected cases in their careers[17].

Skills

Table 4 presents the description of the competence doctors' Skills faced with VAOP assessed in the studies.

The situations that led doctors to suspect abuse were raised in two studies. One revealed that physical findings related to older people's appearance and hygiene were the main indications for 91.4%. The problematic communication between older people and family/caregivers was the least pointed out, with 56.8%[17]. The other study also highlighted physical findings, emphasizing burns, bruises, abrasions, and varied stages of healing of bruises and fractures[15].

Attitudes

Table 5 presents the description of the competence doctors' Attitudes faced with VAOP assessed in the studies.

Table 4. Hospital doctors' skills faced with older people in situations of violence in the studies included in the scope review. João Pessoa, PB, 2021.

Studies	Hospital doctors' skills faced with older people in situation of violence
Corbi et al., 2019[15], Italy	As potential signs of abuse, doctors often indicated physical findings such as burns, bruises, abrasions, and varied stages of healing bruises and fractures. All personal negligence was a form of abuse for 60% of the doctors, and 48.7% suspected abuse less than 3 times in their careers.
Eraslan et al., 2018[16], Turkey	45% of the doctors witnessed cases in their practices. They were able to suspect abuse more frequently in the face of physical findings related to the appearance of the older people (91.4%), such as inadequate care in hair, nails, mouth and body hygiene; communication between older people and family members/ caregivers was the least pointed out, with only 56.8%. The most frequently found types of abuse were negligence (37.4%), emotional (25.1%), financial (22.2%), physical (15.7%), and sexual (1.1%).
Caines et al., 2017[17], Canada	Regarding the perception of cases, 85% considered that abuse occurred sometimes, and 78% suspected cases in their careers (73% in the last 5 years, and 45% in the last 12 months). The type of abuse considered most common was negligence, followed by financial.
Kennelly et al., 2007[19], Ireland	As for the experience, 65% had come across at least one suspected case in the last year.
Mandiracioglu et al., 2006[20], Turkey	Half of the sample would not know what to do faced with a case. Doctors had low scores in performing anamnesis and physical examination focused on the diagnosis of abuse, and on knowing their legal obligations in facing cases. The least identified risk factors were linked to sexual and financial abuse.

Table 5. Hospital doctors' Skills faced with older people in situations of violence in the studies included in the scope review. João Pessoa, PB, 2021.

Studies	Hospital doctors' Knowledge faced with older people in situation of violence
Corbi et al., 2019[15], Italy	In both suspected and witnessed cases, doctors neither reported it to the authorities nor notified the protection agencies - 22.4% of the doctors witnessed abuse 1-3 times during their careers, but never reported it to the authorities, although 88.2% considered it a duty to report abuse.
Eraslan et al., 2018[16], Turkey	90.6% of the doctors said they had an obligation to notify the authorities. 24.3% of the doctors who found abuse and neglect reported it to the authorities. The main reason for not reporting (62.3%) was the concern that older people could suffer even more damage after the complaint, while 49% considered as insufficient the resources offered by the government to address the issue, and 35.2% thought that the legal process would be stressful for them. Faced with confirmed cases, 55.1% claimed having reported cases to the police without informing the family, 23.1% met the older person's wishes, and 17.5% spoke to the family, warning about the subsequent complaint to the police in the case of recurrence. When the same question was repeated for negligence to older people, 24.8% reported to social services, 21.3% reported to police agencies and 19.5% consulted the multidisciplinary team.
Caines et al., 2017[17], Canada	Regarding the performance of VAOP research, doctors "always" or "often" asked directly about abuse in 44% of the suspects, and 64% did not report suspected cases, but 83% considered as a medical responsibility to report.
Almogue et al., 2010[18], Israel	Of the total, 79% indicated that it was their responsibility reporting cases of abuse; and 88.5% agreed that all health professionals have a legal responsibility of reporting it. There was a general tendency towards neutrality in relation to older people abuse: given the allegation that only the interventions of legal authority will prevent older people abuse, the opinions were neutral. There was disagreement about the statement that placing the victim of abuse in a nursing home against their will is an effective intervention. Forty-one percent ~~41%~~ considered that reporting abuse would make the aggressor angrier. Twenty-eight percent agreed that family members would assume that the whistleblower was a member of the team and 59% of respondents were sure that if they reported, their relationship with the patient would not be impaired. Now, 30% were certain that victims would generally deny abuse. The main reasons pointed out for not reporting the cases were the desire of not being legally involved, the denial of abuse by the victim, the non-recognition of abuse in consultation, lack of clarity in the definition of case of abuse or negligence and uncertainty about how to proceed with the complaint.
Kennelly et al., 2007[19], Ireland	The usual conduct pointed out was to seek advice from senior colleagues when managing suspected cases of abuse, and 46% would feel uncomfortable using the label of "older people abuse."
Mandiracioglu et al., 2006[20], Turkey	They had low scores in disposition to report. Most considered it an unacceptable invasion asking about abuse and that it would affect the professional-patient relationship.

Regarding attitudes, all studies reported doctors' considerations on several VAOP aspects. Opinions on certain management behaviors appeared in a study that included doctors and nurses. They were neutral faced with the claim that only interventions of legal authority would prevent VAOP. Placing victims in nursing homes has been seen as beneficial provided it is voluntary - there have been conflicting opinions about compulsory institutionalization. The majority found it helpful to obtain a restraining order against an aggressor[18].

In this study, 41% considered that reporting abuse would make the aggressor angrier, and 28% agreed that families would consider that it was a team member who reported the abuse. Near 30% were certain that the victims would generally deny abuse[18].

There was no unanimity regarding the doctor's responsibility to report VAOP cases in the four studies that evaluated this aspect[15–18]. Percentages ranged from 79%[15] to 90%[16]. The effect of reporting on the doctor-patient relationship on the victim

was considered negative in a study[20], with doctors considering invasive asking about abuse. In the Israeli study, 59% evaluated that the bond would not be impaired[18].

Contrary to what was found in the other studies, 75% of the doctors in the study by Mandiracioglu et al. believed that older people abuse was rare in Turkey[20]. In the Irish study, although 85% of the doctors considered abuse as common and underreported, 46% felt uncomfortable defining cases as older people abuse[19].

The VAOP research when there was suspicion was addressed by only one study, where doctors "always" or "often" asked directly about abuse in 44% of suspicions[17].

Regarding the reporting of cases, doctors did not report it in 75% of the studies. One study showed that they reported no suspected or witnessed cases, neither to authorities nor regulatory agencies[15]. In another study, 24.3% reported VAOP cases to the authorities, although 45% witnessed it[16], a finding similar to that of Caines et al[17]. In another study, there was a general tendency towards neutrality[18]. Another study revealed low scores in disposition to report and to know their obligations faced with the cases[20].

In investigating the reasons why doctors did not report the cases, one study detailed the reasons. Concerns were highlighted about the possibility of the older person suffering more damage, insufficient resources to manage the issue, and the probable stress with the complaint process[16]. Another study pointed out the desire of not being legally involved, abuse denial by the victim, non-recognition of abuse in consultation, lack of clarity of VAOP case definition and uncertainty about how to proceed with the complaint[15].

The specific actions in the face of VAOP cases were related by a study where 55.1% reported cases to the police without informing the family, while 23.1% met the older person's wishes, and 17.5% spoke to the family, warning about the subsequent complaint to the police in the case of reccurrence[16]. In another study, they reported customary seeking advice from more experienced colleagues to manage cases[19].

In terms of approach in cases of negligence, one study pointed out that in 24.8% of the responses the doctors reported to social services, 21.3% reported to police agencies, and 19.5% consulted a multidisciplinary team[16]. No other study specifically explored the attitudes towards negligence cases.

DISCUSSION

The results made clear the shortcomings in the competencies necessary for hospital doctors in properly tackling VAOP. Lack of knowledge on the subject and its approach, absent or insufficient specific training, little appreciation of communication problems and relationship between older people and their guardians, case research in the minority of suspicious situations, and few or null complaints emerged among the problems found.

VAOP is an important public health issue[15,17] and, in this scenario, it is expected an increasing number of vulnerable people. Yon et al. estimated the overall VAOP prevalence at 15.7%, one out of 6 adults over 65 years[21]. However, a study carried out by Cornell University and the New York City Department of Aging revealed that only one out of 24 cases is reported[22].-

Hospital medical services play a crucial role in detecting and managing these cases, as they are usually the first service with medical back-up accessed by this population[9,15,23] and may provide necessary conditions for the evaluation of the case, such as confidentiality, privacy and multidisciplinary approach. Therefore, VAOP's routine and comprehensive approach in these services is vital, with research on event's evidences, initial measures, follow-up, referrals for protection and long-term care and recurrence prevention[2].

VAOP cases are underreported and poorly documented due to the lack of knowledge and awareness on the topic[24]. The lack of knowledge exposed by the studies covers general knowledge[18-20] and procedures necessary to approach cases[15,17]. It is probably one of the main reasons for the low number of diagnoses and case notifications and for the often neutral attitude on that matter[18]. Evaluations conducted with PHC doctors endorse this finding[25,26].

This lack of knowledge scenario is endorsed by the low percentages of doctors who received specific training[16,19,20], by the perception that this had been insufficient[17] and the idea that negligence does not mean abuse for 40%[15]. When comparing VAOP-trained doctors to untrained doctors, one study highlighted that the former detected and reported more, besides feeling more able to address the question[16]. Similarly, conflicting perceptions and opinions about the subject were revealed, about the relevant legislation and conduct[18].

The lack of training also appeared in studies with family doctors and it was determinant for the insecurity of doctors in detecting and reporting cases[25-28]. In the review conducted by Cooper et al. most professionals were unaware that many cases are not seem by serious damages[29]. Doctors' awareness and perception level is still low, especially on how to report[15]. These facts reiterate the importance of approach protocols and multidisciplinary teams to ensure adequate, comprehensive and timely care, assistance and legal support[17].

Educational activities involving group practical teaching can increase the knowledge of doctors[30]. The training broadens the understanding of the theme, with greater sensitivity to it[17]. Studies are lacking to assess how much detection and management could improve, but there are findings associating reinforcement training and higher reporting rates, although without proof that there were more abuse diagnoses[29,30].

It should be noted that training professionals to identify signs of abuse is more complex than teaching bureaucratic reporting and referral procedures[29], and these processes must move forward together. More opportunities for continuing medical education are vital to improve VAOP approach. However, there is often a lack of resources to address this problem properly[17].

Regarding the experience with cases, the low and variable percentages of doctors who worked with or suspected VAOP brings suspicion of the association with the lack of knowledge mentioned above and the barriers in dealing with VAOP. This possibility is echoed by the low notification of suspected cases demonstrated in two studies[16,17] and in the absence of notifications, despite the suspicion, in another study[15], despite the ethical and legal obligation to do so.

Given the high frequency of cases, mostly in physically and mentally ill individuals[29], and by the studies that assessed professionals of reference services at hospital level, it was expected that they had found several cases throughout their careers. This is repeated in PHC, where services' offer, the accessible and widely used doorways, does not result in detection in the same proportion[25,28,31].

Addressing factors that generated suspicion of abuse, physical findings of appearance, hygiene and injuries were highlighted, to the detriment of clear problems in communication between older people and family members/caregivers[16]. Many social and emotional demands are neglected by the rational use of time, a fact emphasized by training that ends up limiting communication between the doctor and other entities[23], an important barrier to VAOP approach as a routine[9,28]. This practice targeting without prioritizing VAOP research is more natural and easier than dealing with legal and social issues[28].

All studies evaluated the attitude of doctors on different aspects of the subject. Conflicting opinions and tendency towards neutrality prevailed, without researching the reasons. PHC studies had similar results, attributed to influences from personal or professional values[25,28]. Family doctors tended to believe that social service professionals would have more chances of facing cases, and they would be the experts on the subject[25].

Given the technical information, the clinical experience and the privileged position of hospital doctors in finding older people abuse, it is remarkable that, even though the doctor's responsibility of reporting cases is acknowgedgeable, there was no unanimity in the four studies that had assessed that aspect[15–19], what confirms the education and practice shortcomings regarding clinical matters.

Doctors' attitudes revealed the barriers in notifying cases faced with the duty of reporting, generating obstacles to the approach itself, hindering both the overall necessary management as the pursuit of ending violence[25,26,28,32]. In the meantime, professionals need to be fully secure before reporting

a case, a scenario where insecurity due to lack of knowledge further reduces the proportion of reported cases[18,29]. In line with this reality, the low notification was the keynote in all studies, including a sample where no cases were reported, in no form[15].

The obligation to inform the competent authorities of cases of abuse is provided for in the Statute of Older People[6], which also determines that non-communication by the assistant health professional is an administrative offence punishable by a fine. Health workers should consider legal complaints as an exception to confidentiality, the importance of which comes from the need to investigate crimes, identify perpetrators and maintain the health of victims, without keeping any confidential information[16]. Hospital doctors, even though primarily aware of the responsibility to report VAOP, although not fully aware that it is a social issue[15].

The results also pointed out that few ask about abuse, a finding similar to that of studies conducted in PHC[25,26]. Family doctors also emphasized that cases were not reported because they were unable to hold the suspicion with evidences[25,26]. As revealed by a systematic review, U.S. doctors who questioned VAOP were more likely to detect and report, corroborating the evidences that questioning older people and caregivers about it is probably the most effective isolated strategy for detection[29]. However, it is clear once again that doctors are not familiar with identification, management, protocols, legislation and referral[16].

Personal values appear as barriers to the approach, such as fears that the complaint would stress VAOP or affect the bond with the family or the older person, who could deny the fact[15,19]. The fear of getting legally involved was also highlighted[17], as well as the idea of questioning being invasive[20]. Such perceptions are also explained at other levels of attention with similar difficulties and fears, preventing doctors from defining signs of abuse or negligence as VAOP situations[26,28].

Only one study[16] addressed attitudes and barriers to cases of negligence. The underestimation of this might result from the common sense that the perception of older people abuse is something uncertain, based on physical signs[15]. Physical examination findings can serve as warning signs for doctors to pay attention to the possibility, but they should not be considered diagnoses without circumstantial information supporting the fact[2], where negligence is often observed.

Important knowledge gaps, misperceptions and lack of translation of knowledge into better attitudes and skills, as well as better attitudes and skills after training. Barriers permeate the three aspects of competence and are interrelated, pointing to needs for qualified and continuing medical education. Many services do not even have VAOP protocols[17].

Furthermore, the results showed that when there was a suspicion, action was seldom taken. Awareness campaigns, so fashionable in the media and in academia and recommended by the Ministry of Health should also reach doctors, encouraging them to constantly improve their approach.

Despite the contributions described, this study has limitations related to selection bias, due to restrictions on the inclusion of papers only in English, Portuguese and Spanish; texts available in full; and with temporal limitation. The fact that grey literature was included was considered a positive point.

The practical behaviors of doctors faced with abuse cases, exercising the role of articulating care, properly managing VAOP repercussions, and collaborating to hold the perpetrators accountable were not addressed in the studies. In addition, small samples with low response rates and questionnaires that are sometimes not very comprehensive due to the complexity of the topic compromise the accuracy of the findings of the selected studies in faithfully portraying reality. Such facts, associated with the small number of papers found and the lack of national studies on this theme constitute limitations to the extrapolation of the results to our reality, while elucidating extremely relevant facts to this confrontation.

There is a clear need for more studies to elucidate these aspects and enable the establishment of evidence-based strategies for broad professional training and the development or refinement of instruments to approach and evaluate cases, as well as their incorporation into clinical practice.

CONCLUSION

This study obtained concerning findings about the competences of hospital doctors in the face of VAOP cases. Because they are closely interrelated, the shortcomings identified in one sphere affect the others. As a result, there is a substantial loss of the capability to properly identify and address VAOP.

Low levels of knowledge were clearly evident, which directly impacted skills. The characteristics of medical training and practice focused on clinical diseases and the rational use of time, without specific training, as well as unprepared services largely devoid from action protocols result in a lack of preparation, confidence and a proactive attitude from doctors who attend this large and vulnerable population.

The result is the sad scenario where there is still little research on abuses in the face of suspicions and allegations of VAOP, reinforcing the various barriers to the approach instead of mitigating them. Therefore, there is a lot of work to be done in medical education and in studies evaluating different forms of training and encouragement and the practical impact of these measures on medical skills, seeking to train professionals able to ensure care and protection for this vulnerable population.

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Conflict mediation: proposed solutions to deal with cases of violence against older people

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Abstract

Objective: To describe the reasons for violence against older people and the solutions proposed for conflict mediation in an outpatient clinic specialized in geriatrics and gerontology in the Federal District, Brazil, between 2008 and 2018. *Method*: A retrospective, documentary, descriptive study with a quantitative approach developed with the analysis of information obtained in the unit's minutes books via the records of conflict mediation meetings in cases of violence against older people. The collection covered the reasons for violence against older people and the solutions proposed for conflict mediation. *Result:* We analyzed 111 cases. The main reasons for the violence were main caregiver burden (77.4%), children thinking that their older parents were able to take care of themselves (27%), resentment of children towards their older parents (24.3%), and being unaware of the older person's disease (14.4%). The main solutions proposed were regular follow-up with a doctor (82.8%), social worker and/or psychologist (58.5%), the commitment of all children in sharing care and expenses of their older parents (52.2%), introducing the older person to social activities in the community (27%), and hiring a formal caregiver (24.3%). *Conclusion:* The caregiver burden was the main cause for conflict found, and the proposals identified were related to the greater need for health care for the older person and their caregiver. In this regard, the importance of a multidisciplinary team available in situations of violence was perceived. Conflict mediation made it possible to establish real and targeted strategies to achieve results in cases of violence.

Keywords: Elder Abuse. Violence. Negotiating. Caregivers.

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INTRODUCTION

The aging of the population poses challenges to the public healthcare service, as new demands and specific needs of this population group are increasingly present in the services[1]. Aging involves a gradual loss of functionality, which may lead to cognitive decline, greater global dependence, and many times the onset of chronic diseases. Besides all these common characteristics, this age group is also vulnerable to the phenomenon of violence[2].

Violence against older people is defined by the World Health Organization (WHO)[3]as a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to the victim and it can be classified as physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect.[4].

In Brazil, 28% of households have at least one older person, and the main aggressors are children and spouses[5,6]. The structure of the contemporary family with the insertion of women in the labor market, fewer children, and more divorces contribute to the marginalization of the older person and the occurrence of violence[2,5]. On the other hand, the family represents the older person's main support network, being a concrete reference according to the Brazilian legislation[7].

Given the above, the complexity of the phenomenon of violence has demanded progress regarding stereotyped, fragmented, and ineffective health care models. There is the need for team approaches with intersectoral and articulated work to allow the detection and notification of violence, besides proper attention and interdisciplinary care to interrupt or minimize conflicting situations[8,9].

Conflict mediation is a non-legal, effective technique, although still incipient in Brazil. It is based on meetings with the participation of family members and other people involved in taking care of the older person and may be conducted by health professionals from different areas once they are trained for that. The approach aims to identify the roles of each individual in the older person's support network, outline the difficulties pointed out by the participants, and articulate care commitments[6,10].

The mediation method is based on identifying the motivations causing violence so that with the dialogue and cooperation between the parties possible means of resolving the conflict are outlined in order not only to suppress violent situations against older people, but to prevent new injuries, minimize risks, and make positive agreements[6,7,10].

The analysis of data obtained by conflict mediation offers guidance for further studies and applicability in health care practice. It is also noted that the scientific productions about conflict mediation and its results are incipient. Thus, the present study aims to describe the reasons for violence against older people and the solutions proposed in conflict mediation meetings between 2008 and 2018 in an outpatient clinic specialized in geriatrics and gerontology in the Federal District (DF), Brazil.

METHOD

Retrospective, documentary-descriptive study with a quantitative approach developed from the analysis of information collected from minute-books with the reports on mediation meetings in cases of violence against older people. The appointments were between 2008 and 2018 in an outpatient clinic specialized in geriatric and gerontological health in the Federal District (DF), Brazil. This outpatient clinic has an interdisciplinary team specialized in older people's care, being the only one with integrated outpatient care referenced to this population in the city.

The cases received and referred to the unit comprised specific situations, such as unaccompanied dependent older people, older people, and caregivers without knowledge on the health condition of the older person, older people with significant cognitive decline in a situation of neglect, older people who reported financial exploitation by family members or other caregivers, abandoned older people, older people suspected of physical and psychological

violence, among others. These situations were reported by the older person, a family member, acquaintances, the older person's formal caregiver, or anyone from the community including a healthcare professional during the appointment.

Any member of the healthcare team could send a case report to the social service recording the situation of violence or suspected violence. Family meetings took place once a week on a pre-set date after the family members and other people involved in elderly care were invited by the social worker to come to the healthcare unit.

The conflict mediators (social worker, nurse, psychologist, or another professional from the team) conducted the mediation meeting whenever at least two healthcare professionals were present. The minutes were drawn up in the open field, usually by the social worker who in turn also carried out the notification of violence and the follow-up of cases and results achieved.

The inclusion criteria used were cases of older people aged 60 years and over treated at the specialized unit and registered in the minutes of conflict mediation meetings.

The meeting minutes recorded between 2008 and 2018 were independently analyzed by three properly trained researchers in the period from June 2018 to January 2019. Open information regarding the reasons and proposed solutions were collected. The divergences that occurred due to the limitations found in the records were jointly discussed among the six researchers. Data were analyzed based on the synthesis of all meetings held for each case of violence, with new information and results found later on being added when a second meeting took place.

There were 143 cases in the minute books with one or more family meetings per case, excluding situations in which there was no violence and/or treatment of individuals under 60 years of age, totaling 111 cases in the analyzed sample.

For data analysis, a descriptive statistical analysis was performed accounting for data on the reasons for violence and the solutions proposed (agreed) for solving cases of violence against older people, and two tables were prepared with the absolute and relative frequencies of answers.

The present study was approved by the Ethics Committee of Fundação de Ensino e Pesquisa em Ciências da Saúde (FEPECS) under Opinion No. 1.798.579, of October 29, 2016, with an addendum to continue the study in 2017 and 2018. It was also developed following Resolutions No. 466/2012 and No. 510/2016 of Conselho Nacional de Saúde (the Brazilian National Health Council).

RESULTS

We analyzed 111 cases reported in the minute book. During the 10 years of reports, we observed a decrease in the number of violence occurrences identified in the unit, as shown in Figure 1. Note that between 2015 to 2018 there were periods of unavailability of a qualified professional (social worker), consequently reducing the number of conflict mediation meetings during this period.

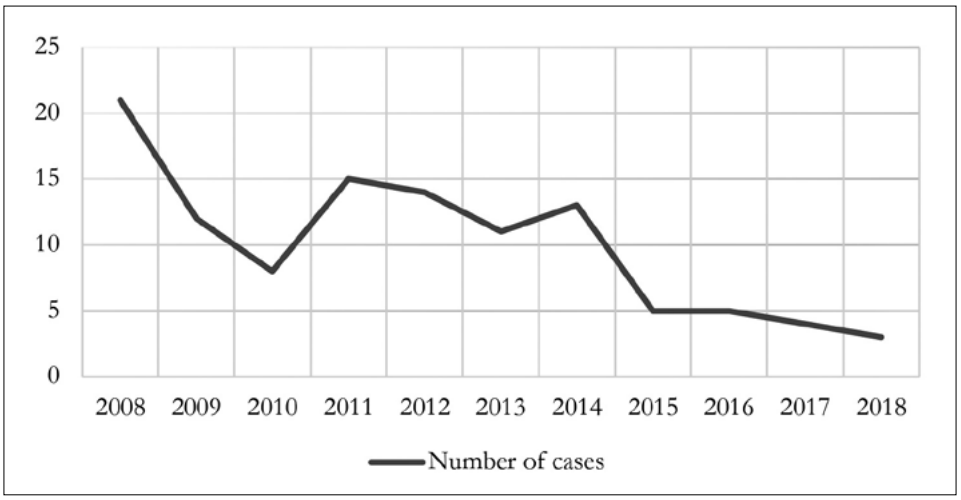

Figure 1. Number of cases of violence reported between 2008 and 2018 in a specialized geriatrics and gerontology outpatient clinic (N=111). Federal District, DF, Brazil (2008-2018).

Regarding the older people who were victims of violence, 72% were women, the predominant age groups were from 81 to 90 years old (45%) and 71 to 80 years old (39%), and 5% were nonagenarians. Most older people lived in their own homes with an income of one minimum wage (46%). Regarding the comorbidities identified, 54% of older people had dementia, 31% had systemic arterial hypertension, and 13% had diabetes mellitus. Of the older people with dementia, 32% of the individuals involved in care were unaware of the disease symptoms.

Children were the main aggressors identified (72%), with 62% of the aggressors being male and 38% female. Regarding the aggressor's age group, there was a predominance between 51 to 60 years (37%) and between 41 to 50 years old (30%).

Regarding the type of violence suffered, there was a higher prevalence of negligence (56%), followed by psychological violence (29%), physical violence (8%), and financial abuse (6%). Neglect associated with abandonment represented 21% of the cases.

As shown in table 1, the main caregiver's burden was identified as the most common reason (77.4%). Another frequent finding was the lack of knowledge on the functional capacity of the older person, leading to negligence for believing that they would carry out their activities without supervision or intervention, which represented 27% of the sample.

Data obtained in cases of violence by children showed that 24% resented the older person or the fragility of the affective tie built during the life of both, thus resulting in frequent conflict situations and violent acts. Another 27% believed that their older parents were able to carry out their activities alone.

At the same time, 6.3% of caregivers did not provide continuous care to the older person when they needed help and care 24 hours a day due to their health condition.

Regarding the older people with dementia, it was observed that in 14.4% of the cases caregivers were unaware of the older person's diagnosis or had no understanding about the disease, common reactions, and how to behave when facing situations resulting from this situation.

Among the motivations related to the main caregiver, 6.3% had depression and 4.5% were addicted to alcohol.

Regarding the solutions proposed during the conflict mediation meeting, it can be seen in Table 2 that there was more than one solution agreed upon in the mediation for each case analyzed.

For the most part (92 cases), regular follow-up with the medical team available at the healthcare unit was recommended. More than half of the cases analyzed also required referral and follow-up by the social assistance and psychology service (58.6%).

Of the 111 cases, 38 set a cooperation agreement between the children during a meeting with the team and family members. In 27 cases, it was decided to hire a formal caregiver. The inclusion of the older person in community activities represented 27% of the solutions proposed to the cases.

Table 1. Reasons for violence against the older person in the specialized geriatric and gerontology outpatient clinic in the Federal District, DF, Brazil (2008-2018).

Reasons for violence against the older person	Number of Cases (%)
Primary caregiver burden.	86 (77.4%)
Children believed that older parents were capable of taking care of themselves.	30 (27%)
Resentment of children towards the older person or fragility of the affective tie.	27 (24.3%)
Unaware of the older person's disease (dementia cases).	16 (14.4%)
Caregiver lack of interest in the supervision of the older person's medication and/or neglect of chronic diseases.	15 (13.5%)
Caregiver's behavior changes.	8 (7.2%)
Main caregiver with depression.	7 (6.3%)
Unaware of the need for continuous care (24h/day)	7 (6.3%)
Main caregiver addicted to alcohol.	5 (4.5%)

Source: Prepared by the authors.

Table 2. Solutions proposed by the conflict mediation in the specialized geriatric and gerontology outpatient clinic in the Federal District, DF, Brazil (2008-2018).

Proposed solutions by the conflict mediation team	Number of cases (%)
Regular follow-up with a doctor (family doctor or geriatrician) regarding the progression of diseases, especially dementia, and the control of chronic diseases.	92 (82.8%)
Regular monitoring of the older person with a social worker and/or psychologist.	65 (58.5%)
Commitment of all children to share the care and/or expenses of their older parents.	58 (52.2%)
Older person's introduction in community social activities.	30 (27%)
Hiring a formal caregiver.	27 (24.3%)

Source: Prepared by the authors.

The caregiver was referred to a healthcare service that met their demand (psychologist, psychiatrist, and physician) in 12 cases in which severe depression and alcoholism were detected.

In 18 cases, the older person with dementia was included in cognitive therapy groups led by an occupational therapist and a nurse, in addition to the practice of manual activities (handicraft) available in the specialized outpatient clinic.

DISCUSSION

The motivations related to the violence process against the older person vary, and it is possible to observe the presence of more than one reason mentioned in several cases in the present study. Among them, the burden imposed on caregivers during the process stands out, reported in 77.4% of cases. Prolonged emotional stress is related to the caregiving responsibility of only one individual who generally did not choose to play this role nor is properly trained for that[11].

The older person's high level of dependence for activities of daily living (ADL) and instrumental activities of daily living (IADL) comprises a higher risk for violence[12] and a higher rate of caregiver burden, which in turn is a triggering factor for care negligence of the person under care, with the omission of basic needs to the older person[11].

The impact generated by continuous care can be mitigated by sharing it with the other support networks of this older person, whether in family arrangements or psychoeducational support groups. It is known that the appropriate balance between the demand for care and the time offered for care can produce better results when this caregiver is duly prepared and trained[11].

The caregiver is represented in studies as a female relative with an average age of 53.9 years who lives in the same household as the older person[11,13]. Living in the same household favors violence[11], which in turn is disguised in the attempt to preserve ties or is justified by the feeling of guilt on the part of the older person. Sometimes violence goes unnoticed and is seen as a behavior pattern or interpersonal stress of the caregiver[13,14].

The resentments of the children towards the older person or fragility of the affective ties were also motivations found in the present study (27%). Other reasons presented in different studies involve financial issues, conflicts of interest between generations, and interdependence among those involved[12,15].

In this sense, conflict mediation is an essential resource for restoring relationships and reflecting the reality lived. A study on family mediation by Martins[7] addresses the current family as a social institution not having information and support to perform the task of caring. In this sense, a resolutive approach demands to look at the social context and the whole process in which the subjects are inserted[7].

Among other reasons for violence detected in the present study, 14.4% of the cases showed a lack of knowledge about dementia and its presentations. When analyzing risk factors for violence, the studies relate dementia to up to four times more violence against the older person[12,16].

Older people affected by dementia can act aggressively and generate a reciprocal violent act of the caregiver[12]. Knowledge of possible behavioral changes favors the caregiver's understanding and protects the vulnerable older person from harm and suffering. The healthcare professional duly trained for proper handling and management of the disease becomes indispensable[15].

A recent study about caregivers of older people with dementia found a prevalence of depression and panic syndrome in 8%[16]. The caregiver getting sick was also reported in the present study; depression was reported in 6.3% of the cases.

Caring for an individual requires biopsychosocial commitment, and studies show that the caregiver's quality of life directly interferes with the quality of care provided by them. Generally, healthcare professionals do not give due attention to the caregiver, who lacks social support. Positive interpersonal relationships and manifestations of

affection and love are examples of what others can offer to the caregiver to contribute to improving their quality of life[13,17].

When analyzing other caregiver-related factors contributing to a higher incidence of violence, Lino et al.[15] identified alcoholism as an important variable causing an increase of 3.8 times the risk of violent acts. Alcohol addiction can be identified when it generates social consequences from its consumption.

The offer of follow-up and treatment to this caregiver becomes mandatory to interrupt a habit that generates conflicts, distress in the relationships, and human suffering[18]. In the present study, the caregiver's medical and psychological follow-up was established as a proposed solution since there were five cases of alcohol addiction reported.

The challenge to identify the violence perpetrated in the family environment is sometimes disguised as a common relationship pattern. Despite this, we perceived the importance of continuous training of health professionals for sensitive and attentive listening of older people and caregivers in each appointment.

Regarding conflict mediation, it is possible to detect important social, financial, and emotional frailties in caregivers who lack professional and social support and have little or even no support and guidance to work.

A possible limitation in the study was regarding the low systematization of the questions for the record because the production of minutes did not aim to be a research instrument. Thus, some data from the mediation practice may not have been reported or were reported with inaccuracy. We suggest the development of semi-structured minutes so that no relevant information is lost.

CONCLUSION

The analysis of the results obtained by conflict mediation shows the need for interventions directed to the main caregiver, such as actions to promote physical and mental health since burden was a frequent finding related to the cases of depression and alcohol addiction found. Regarding the lack of knowledge about the older person's disease, we emphasize the importance of training the people involved in care to prevent the forms of violence resulting from negligence. The availability of a multidisciplinary team becomes essential regarding the care of the old person who is a victim of violence since among the main solutions proposed was a great demand for treatment with a psychologist, social worker, and geriatric physician available in the unit.

Violence towards the older person corresponds to a multifactorial phenomenon, and the analysis of motivations allows entities and healthcare professionals to draw care plans to prevent situations generating violence, and enabling real and plausible possibilities of resolution according to the situation presented. We observed the great need to create new initiatives and health methodologies aimed at the older public since comprehensive care focused on the needs of each individual allows better results.

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Analysis of the direct and indirect risk of intrafamily violence against older people

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Abstract

Objective: To analyze the direct and indirect risk of intrafamily violence against older people in the city of Manaus (AM), Brazil. *Method:* Population-based, quantitative, cross-sectional, descriptive and analytical study, developed in six urban areas of this city from November 2019 to April 2021. The sample consisted of 2.280 older people, using a margin of error of 5% and a Confidence Coefficient of 95%. The Hawlek Sengstock Elder Abuse Screening Test (H-S/EAST), adapted for Brazil, was used. *Results*: 67.4% were women, mean age 69 years (±6.9), 48.6% were married and 79.9% earned less than 2 minimum wages; 73.6% shared the expenses of the house and 60.9% co-lived with children and grandchildren; it was identified that 99.8% suffered violence (direct and indirect) and 88.8% are constantly at high risk for some type of violence; 44.7% do not have someone to keep them company; 95.3% support someone; 66% feel sad or lonely; 42.6% report excessive use of alcoholic beverages by family members; 45.8% were recently hurt or injured by family members. Women and the oldest were the most violated. *Conclusion:* it was evident that the experience of intergenerational co-residence brought to light the reality of intrafamily violence practiced against older people, present in 99.8% of respondents, mainly linked to negligence, omission and financial abuse. Respondents were able to point out problems arising from intra-family relationships, possibly resulting from the absence of a better emotional bond, which puts them in situations of direct and indirect violence.

Keywords: Elderly. Violence. Domestic Violence. Exposure to Violence.

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INTRODUCTION

In approximately 26% of Brazilian homes there is at least one older person, many of whom are dependent on care because they have comorbidities, weaknesses in physical, cognitive and emotional/psychological health; most receive some social security benefit, becoming a financial reference in the household where they live[1-3]. Given these facts, older Brazilians live at constant risk of suffering violence and abuse at home or outside.

Violence against older people is a universal problem, still little studied because it occurs mainly within the family, imputed by children, spouses or caregivers. Thus, the silence and complicity in the occurrences of violence become a challenge for public and social policies[4]. According to Minayo et al.[5], although the Brazilian population has acquired health and life improvements, social problems still persist in an important portion of this population that has low income, which makes older people more vulnerable to suffering violence.

Research shows that the prevalence of domestic violence against older people is higher than in other contexts, related, in most cases, to dependence on family care, low social conditions and time spent at home after retirement[6-8]. Poltronieri et al.[9] state that violence against older people leads to increased morbidity and mortality and institutionalization, in addition to prolonged hospitalization; they generate serious consequences in terms of mental health and family and social relationships.

The World Report on Violence Prevention points out that Brazil is not among the countries that investigate violence against older people, showing that strategies to combat violence are created without the problem having been studied and that there is a gap in statistics on violence, observed through underestimated data[7]. Therefore, it is clear that Brazil lacks a public agenda that presents several modalities and possibilities of protection services, so that longevity does not seem to be a burden but a bonus that the older person wants to experience[10].

There are few population-based studies that directly investigate older people themselves, whether or not they were victims of violence. When they exist, the prevalence rates of these studies differ greatly and their scarcity prevents a more accurate view of the magnitude and characterization of violence against older people.

In order to learn more about the risk of violence against older people in the city of Manaus, Amazonas, Brazil, and the need for a protective service, this study sought to analyze the direct and indirect risk of intrafamily violence against older people in the city. It is believed that the systematic identification of older people in situations of violence or in life contexts that promote a greater risk to suffer is the first step to visualize the phenomenon and seek to develop intersectoral actions that respond with effective solutions to this problem.

METHOD

This is a population-based, quantitative, cross-sectional, descriptive and analytical study.

In 2018, the urban area of the city of Manaus, AM, Brazil, had a population of 2,145,444 with a projection of 108,081 older people, distributed in the six administrative zones of the city[1]. Based on the universe of this older population, a sample size calculation was performed, reaching 380 individuals per zone, making a total of 2,280 older people who corresponded to the final study sample, with an estimated prevalence of 50%[11], 5% margin of error and 95% Confidence Coefficient.

The convenience sample was initially obtained by inviting older people to participate in the research in community centers, churches, associations and other senior care services in the neighborhoods of the respective zones. Due to the pandemic, some senior care services were paralyzed and the research continued with an approach to older people who sought health services in the districts of the city's administrative areas. Data collection took place from November 2019 to April 2021.

For data collection, the *Hawlek Sengstock Elder Abuse Screening Test* (H-S/EAST), adapted for Brazil, was used. It is an instrument aimed at identifying signs of presence (direct) and suspicion (indirect) of violence/abuse in older people. Most of the items that

make up the instrument not only focus on specific symptoms of violence, but also identify conditions related to events associated with abuse that may precede the violence itself and, thus, be preventable[12]. The instrument was replicated on the *Survey Monkey* Platform, accessed from tablets for interviews and data production.

The variables investigated in the H-S/EAST identify the risk of physical and psychological abuse, violation of personal rights, isolation and financial abuse by third parties. One point was assigned for each affirmative answer, with the exception of items, in which the point was given for the negative answer. A "no" answer to items 1, 6, 12 and 14; an "other person" answer to item 4; and a "yes" answer to everyone else was scored in the "abused" direction. In the clinical context, a score of three or more indicates an increased risk of some type of violence[12].

Eligibility criteria were: older people aged 60 years or more, living in the urban area of the city of Manaus (AM), and able to respond coherently to the instrument's questions. As an exclusion criterion, all those who showed some manifestation of suffering during the application of the instrument (such as crying or others), who declared themselves indigenous and who showed difficulty in understanding the questions inherent in the form were considered. The study was submitted to the Research Ethics Committee of the State University of Amazonas, as recommended in the ethical precepts of Resolution 466/2012 of the National Health Council (CNS) and approved under Opinion: 3,173,698. All signed the Informed Consent Form (TCLE).

Data were presented through tables, where the simple absolute and relative frequencies for categorical data were calculated. In the analysis of quantitative data, when the hypothesis of normality was accepted using the *Shapiro-Wilk* test, the Mean and the Standard Deviation (SD) were calculated, however, when the hypothesis of normality was rejected, the Median and the Quartiles Q_1 (25%) and Q_3 (75%).

In the analysis of categorical data, *Pearson's* chi-square test was applied and the *Odds Ratio* (OR) was calculated in 2x2 tables, and if it was impossible to apply the *Pearson* test, *Fisher's* exact test was applied. In comparing the means, the Analysis of Variance and *Tukey's* test were applied to the parametric data. In the analysis of non-parametric data, the *Kruska-Wallis* test was applied.

RESULTS

Of the 2,280 older people who participated in the survey, 67.4% were female, aged between 60 and 70 years (60%), mean age of 69 years (±6.9), 48.6% were married and 79.9% earned less than two minimum wages, 76.3% reported knowing how to read and write minimally, 73.6% shared household expenses and 60.9% cohabited with children and grandchildren.

Regarding the data obtained through the application of the specific instrument to identify direct and indirect abuse/violence, it is highlighted that only the answers that score for the direction of abused/violent or at risk for violence were presented in the following tables[12].

The main characteristics of the violation of personal rights or direct violence identified in the survey were: is helping to support someone; was forced to do something he didn't want to; someone have already taken your belongings without your consent; and someone close recently tried to physically or psychologically hurt him (Table 1).

Regarding indirect violence, the following characteristics were identified: there is no one who keeps him company, who takes him shopping or to the doctor; often feel sad or lonely; someone in your family uses alcohol a lot; feel uncomfortable with a family member; not able to take his medicine and go places on his own; does not trust family members; and, at home, he does not have enough freedom to be quiet whenever he wants (Table 1).

The prevalence of violence found in this study, through the H-S/EAST, was 99.8%. It was also identified that 88.8% are at a very high risk of suffering violence of any kind, 32.6% in direct form and 56.2% in indirect form.

Table 1. Distribution according to data from the H-S/EAST instrument applied to older people in the city of Manaus (AM), Brazil, 2021.

Variables (n = 2280)	f_i (%)	95% CI
There is no one to keep you company, take you shopping or to the doctor	1019 (44.7)	42.7 – 46.7
Is helping to support someone	2173 (95.3)	94.4 – 96.1
Often feel sad or lonely	1506 (66.0)	64.1 – 68.0
Someone else makes decisions about your life, such as how you should live or where you should live	380 (16.7)	15.2 – 18.2
Feels uncomfortable with someone in your family	1153 (50.6)	48.5 – 52.6
Not able to take your meds and go places on your own	1803 (80.4)	78.7 – 82.0
Feel that no one wants you around	251 (11.0)	9.8 – 12.4
Someone in your family drinks a lot of alcohol	971 (42.6)	40.6 – 44.6
Someone in the family makes you stay in bed or tells you that you are sick when you know you are not.	138 (6.0)	5.2 – 7.1
Someone has already made you do things you didn't want to do	497 (21.8)	20.2 – 23.5
Someone has taken things that belong to you without consent	728 (31.9)	30.0 – 33.9
Don't trust most of the people in your family	1729 (75.8)	74.0 – 77.6
Someone tells you that you cause a lot of trouble	237 (10.4)	9.2 – 11.7
At home, is (not) free enough to be quiet when you want to	1795 (78.7)	77.0 – 80.4
Someone close recently tried to physically or psychologically hurt you	1045 (45.8)	43.8 – 47.9

fi = simple absolute frequency; 95%CI = Confidence Interval at the 95% level; Answers that score for the presence/risk of violence: "yes" for items 2, 3, 5, 7, 8, 9, 10, 11, 13, 14 and 15; "no" for items 1, 6, 12 and 14; and "another person" for item 4.

In the association of the HS/EAST instrument items with the gender variable, table 2 shows that older women had more occurrence or risk for direct and indirect violence than men, except for items 2, 9 and 13. With regard to men, it is observed that they help more to support other people (item 2). In evaluating this association, eight of the 15 items were significant at the 5% level, most related to older women, showing that gender violence is also present in old age.

When the items of the HS/EAST instrument are associated with the age group of older people, it is observed that the age group equal to or greater than 70 years was the most abused or is at risk of violence, highlighting items 2, 3, 6, 12 and 14, with high percentages. With the exception of item 7, all others were strongly associated (p-value <0.05), showing that the longer they live, the greater the presence of violence or the greater the risk of suffering it (Table 3).

The study sought to identify the level of significance of the variables related to the association of items from the H-S/EAST instrument and family income. Table 4 shows that older people with lower income (<1 minimum wage) are those who suffer most from violence. With the exception of items 4, 6, 7 and 9, all others had a strong association (p-value<0.05). Item 2 shows up with the highest percentage, proving that older people are constantly financially abused, regardless of earnings.

Table 2. Distribution according to data from the H-S/EAST instrument in relation to the gender of older people in the city of Manaus (AM), Brazil, 2021.

Variables	Gender (%)		OR	*p**
	Female (n=1536)	Male (n=744)		
There is no one to keep you company, take you shopping or to the doctor	46.4	41.3	1.23	**0.022**
Is helping to support someone	93.8	98.4	0.25	**<0.001**
Often feel sad or lonely	69.7	58.6	1.62	**<0.001**
Someone else makes decisions about your life, such as how you should live or where you should live	16.9	16.1	0.83	0.632
Feels uncomfortable with someone in your family	54.2	43.0	1.57	**<0.001**
Not able to take your meds and go places on your own	81.5	78.1	1.23	0.054
Feel that no one wants you around	10.7	11.6	0.92	0.559
Someone in your family drinks a lot of alcohol	44.1	39.4	1.21	**0.031**
Someone in the family makes you stay in bed or tells you that you are sick when you know you are not.	5.7	6.7	0.84	0.352
Someone has already made you do things you didn't want to do	23.3	18.7	1.32	**0.012**
Someone has taken things that belong to you without consent	32.4	30.9	1.07	0.469
Don't trust most of the people in your family	75.0	77.6	0.87	0.181
Someone tells you that you cause a lot of trouble	11.5	8.2	1.45	**0.017**
At home, is (not) free enough to be quiet when you want to	77.7	80.8	0.83	0.096
Someone close recently tried to physically or psychologically hurt you	50.1	37.0	1.71	**<0.001**

OR = Odds Ratio; * Pearson's chi-square test; p-value in bold italics indicates statistical difference at the 5% level of significance; Answers that score for the presence/risk of violence: "yes" for items 2, 3, 5, 7, 8, 9, 10, 11, 13, 14 and 15; "no" for items 1, 6, 12 and 14; and "another person" for item 4.

Table 3. Distribution according to data from the H-S/EAST instrument in relation to the age group of older people in the city of Manaus (AM), Brazil, 2021.

Variables	Age group (%)		OR	*p**
	≥70 (n=911)	<70 (n=1369)		
There is no one to keep you company, take you shopping or to the doctor	58.0	35.9	2.46	**<0.001**
Is helping to support someone	98.9	92.9	6.87	**<0.001**
Often feel sad or lonely	73.4	61.1	1.76	**<0.001**
Someone else makes decisions about your life, such as how you should live or where you should live	24.9	11.2	2.64	**<0.001**
Feels uncomfortable with someone in your family	55.8	47.1	1.41	**<0.001**
Not able to take your meds and go places on your own	88.5	68.2	0.28	**<0.001**
Feel that no one wants you around	13.0	9.7	1.38	0.156
Someone in your family drinks a lot of alcohol	45.8	40.5	1.24	**0.012**

to be continued

Continuation of Table 4

Variables	Age group (%)		OR	*p**
	≥70 (n=911)	<70 (n=1369)		
Someone in the family makes you stay in bed or tells you that you are sick when you know you are not.	10.2	3.3	3.34	**<0.001**
Someone has already made you do things you didn't want to do	28.8	17.2	1.94	**<0.001**
Someone has taken things that belong to you without consent	35.8	29.4	1.34	**<0.001**
Don't trust most of the people in your family	69.8	79.8	0.58	**<0.001**
Someone tells you that you cause a lot of trouble	12.1	9.3	1.34	**0.032**
At home, is (not) free enough to be quiet when you want to	72.4	82.9	0.54	**<0.001**
Someone close recently tried to physically or psychologically hurt you	50.7	42.6	1.39	**<0.001**

OR = Odds Ratio; *Pearson's chi-square test; p-value in bold italics indicates statistical difference at the 5% level of significance; Answers that score for the presence/risk of violence: "yes" for items 2, 3, 5, 7, 8, 9, 10, 11, 13, 14 and 15; "no" for items 1, 6, 12 and 14; and "another person" for item 4.

Table 4. Distribution according to data from the H-S/EAST instrument in relation to family income in minimum wages (MW) of older people in the city of Manaus (AM), Brazil, 2021.

Variables	Family income (%)		OR	*p**
	<1 MW (n=1.087)	≥1 MW (n=119)3)		
There is no one to keep you company, take you shopping or to the doctor	47.5	42.2	1.24	**0.011**
Is helping to support someone	90.8	99.4	0.06	**<0.001**
Often feel sad or lonely	72.3	60.4	1.72	**<0.001**
Someone else makes decisions about your life, such as how you should live or where you should live	16.0	17.3	0.91	0.420
Feels uncomfortable with someone in your family	55.0	46.5	1.41	**<0.001**
Not able to take your meds and go places on your own	81.4	79.3	0.88	0.209
Feel that no one wants you around	12.1	10.1	1.22	0.129
Someone in your family drinks a lot of alcohol	46.4	39.1	1.34	**<0.001**
Someone in the family makes you stay in bed or tells you that you are sick when you know you are not.	5.3	6.7	0.78	0.171
Someone has already made you do things you didn't want to do	24.1	19.7	1.29	**0.011**
Someone has taken things that belong to you without consent	35.2	28.9	1.33	**<0.001**
Don't trust most of the people in your family	71.1	80.1	0.61	**<0.001**
Someone tells you that you cause a lot of trouble	11.9	9.1	1.35	**0.028**
At home, is (not) free enough to be quiet when you want to	75.3	81.8	0.68	**<0.001**
Someone close recently tried to physically or psychologically hurt you	51.1	41.1	1.50	**<0.001**

OR = Odds Ratio; * Pearson's chi-square test; p-value in bold italics indicates statistical difference at the 5% level of significance; Answers that score for the presence/risk of violence: "yes" for items 2, 3, 5, 7, 8, 9, 10, 11, 13, 14 and 15; "no" for items 1, 6, 12 and 14; and "another person" for item 4.

Table 4 also shows that, although the older person is one of the main maintainers of the house, they do not have enough freedom within the home environment and a significant percentage do not trust their family members.

DISCUSSION

Intra-family violence is largely committed by children, grandchildren, great-grandchildren or the older person's partner; it involves affective bonds and daily coexistence. It is usually violence suffered in silence. In general, any intentional physical, moral, psychological and/or social harm, resulting from acts (or omissions) of the family or guardian(s), that violate the standards of respect and dignity of the older person[13,14].

With regard to direct violence, it involves at least two participants: the issuer and the victim of violence. The issuer performs a certain action that falls on the victim, the object of violence. The harm resulting from direct violence can be of a physical or psychological nature, such as bodily injury or fear and insecurity. Indirect violence are structural or cultural threats of violence, that is, it is everything that prevents the reduction of the distance between the real and the potential, reducing the victim's capacity to supply their basic human needs, putting them at risk[15].

The results of the study showed that, even in the absence of disease and need for care, 99.8% of the older people in the survey have recently suffered violence directly or indirectly, and 88.8% are at increasing risk, with a score of three or more according to the HS/EAST instrument, to suffer some type of violence. Using the same assessment instrument, a study carried out in the North[16] and another in the Southeast[17] of Brazil, found a prevalence of violence of 52% and 56%, respectively. In a study with a cohort of 3,159 Chinese older people, a prevalence of 15.8% was found[18].

Therefore, it is observed that the prevalence rates found in the study in question are much higher than the others. It is likely that the private environment during the interview favored the participants' freedom of speech, ensuring confidentiality and security, which would not happen if the interview took place in the home environment and in the presence of an abusive family member. This requires greater attention to the population studied and greater investments in public policies aimed at protecting older people and preventing violence.

Violence against older people manifests itself in different ways, reflected in social inequalities arising from poverty, misery and discrimination; in everyday communication and interaction; institutionally, in the absence of management in the execution of social policies and by institutions that provide care services to older people. This is a problem of multiple causes with devastating consequences, as it entails low quality of life and lack of security, which further favors the continuous aggressions to the physical, mental and spiritual health of older people[19-21].

According to the data presented in table 1, in the family context, violence was mainly caused by the lack of family care and attention, negligence, financial abuse and indirect abandonment (present, even in the coexistence of other family members).

The results of the study showed that older people are continually subjected to situations of direct or indirect violence by family members. The data show that, even living with other family members, they feel alone, complain about the lack of company, report feeling uncomfortable and distrustful with people in their own family, in addition to not feeling freedom in their own home. This characterizes important risks, since the family plays a fundamental role in the aging process and, even in the absence of dependence, the presence of close family members should provide security and biopsychosocial well-being to the older person[13].

Considering the results of the study, it is observed that many family arrangements formed in intergenerational co-residence are maintained from the perspective of costs and benefits, where the older person participates in general expenses, directly supports some people, however, even being the owner and maintainer of the house, they do not participate in decisions, do not have the desired freedom and are often financially exploited.

The presence of financial violence was visible as one of the most frequent forms of abuse against older people. Barros et al.[22] state that the financial profile of the older person is not a determining factor for the occurrence of violence, highlighting that violence occurs between those who contribute (90%) and those who do not contribute (94%) to the family's support. The expressive occurrence of violence against older people happens without discrimination of the social security situation, income or help to support the home.

The data point to relationships marked by conflicts and feelings of hurt, rejection and abandonment. Studies show that the success of intrafamily relationships is not a one-off achievement, on the contrary, it is built by individual and collective experiences throughout life, by sharing, by effective communication and by bonds of affection and intergenerational respect[13,19,20]. Data on intrafamily violence against older people in national and international studies confirm the results of this study[21-26].

It is known that family relationships have undergone many changes over time, however, despite the demographic, economic and sociocultural changes that most families go through, no institution can replace the role that the family plays in the life of the older person[27-29].

Another important data identified in the study was the occurrence of violence against older women. Although women play the role of caregivers even in old age and live longer than men, they weaken more, needing attention and care, generating demands on the family[29,30]. The constant exposure of older women to situations of direct and indirect violence produces a sickening context of life, reducing their years of life[30].

The issue of violence against women from a young age may be one of the reasons why older women appear at greater risk of suffering violence and of maintaining this dynamic throughout the aging process[24,31]. In Brazil, violence against women is a serious social phenomenon that needs structural confrontation and the involvement of the entire society. Studies show that older women aged between 60-69 years, widows, white race/color and with a low level of education make up the highest percentage of cases of violence against older people[8,22,32], corroborating the results of this research.

The results of this study also revealed that the longer the person is long-lived and dependent, the greater the risk of violence, and the worse the economic condition, the greater the financial abuse. For Oliveira et al, advanced age, added to socioeconomic and health conditions that cause dependence, reduce the individual's ability to maintain their autonomy, independence and quality of life, favoring greater vulnerability to violence[33].

In this study, gender, age and family income were the factors most associated with direct and indirect violence and the increased risk of suffering from them. These factors only differ from other studies in relation to the prevalence rate, keeping the same variables[21-26].

It is inferred that Brazil has advanced legislation to guarantee the rights of those over 60, including the fight against violence. Such laws, linked to public policies, need to be directed towards care for healthy aging, integrated and intersectoral actions to promote health and comprehensive care for older people.

As limitations of the study, the following are pointed out: the use of self-reported data by older people with the possibility of memory bias; the nature of the data extracted from a convenience sample, which included a smaller number of dependent older people, limiting the generalizability of the results; the ethno-cultural factor, which led to the exclusion of self-declared indigenous participants; and social distancing, as a result of the COVID-19 pandemic that limited data collection spaces.

CONCLUSION

The experience of intergenerational co-existence experienced by many families brings to light the reality of intra-family violence practiced against older people, with a prevalence of 99.8% in this research, mainly linked to negligence, omission and financial abuse, which puts at risk the lives of many of them.

It was found that older men and women were able to point out problems arising from intrafamily relationships, possibly arising from the lack of a better emotional bond, which put them at risk for violence. The individuals interviewed were mainly exposed to negligence, which generates direct and indirect violence, explaining the omission of those responsible for their protection: the family, society and the State.

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Aggressors of older people: interpreting their experiences

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Abstract

Objective: To interpret the experience of those accused of assaulting the elderly in relation to the context of violence, feelings and the dynamic emotions involved. *Methods:* This is a qualitative study, carried out based on face-to-face interviews with 16 participants who were reported for assaulting the elderly, from March to December 2019. The interviews were conducted at the women's police station in a city in the interior of the state of São Paulo, Brazil, and in some cases, at the defendant's own home. The data were analyzed using the thematic analysis technique. *Results:* The existence of mutual dependence, whether financial or care, was recognized. The aggressors deny, justify and minimize the aggression, attributing the act to the behavior of the elderly or even to the past in which they suffered aggression by them. The accused recognize that they need help and have emotional problems, then using psychoactive drugs to suppress their role as caregiver. Furthermore, they admit to having remorse for what happened, manifesting self-neglect and desire to erase the fact. *Conclusion:* The study showed that the defendants have complex health needs that deserve a close look from health professionals and actions focused on the relationship between the accused and the victim, mainly when considering that it will perpetuate itself after the occurrence.

Keywords: Violence. Aging. Health of the Elderly.

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INTRODUCTION

The growth of the older population, previously a process seen only in developed countries, is currently a challenge for the entire world. As society ages, the challenges of caring for a population that can accumulate a series of physical and cognitive limitations resulting from this process also increase[1].

The aging process can reduce the functional capacity and consequently the autonomy of the older person, who can become dependent on other people. According to the Federal Constitution, it is the duty of the State and the Family to guarantee the well-being and exercise of citizenship for older individuals, establishing the responsibility of older children to support their parents in old age[2,3]. However, although family care is still predominant, post-modernity transformations, such as changes in the composition, family insufficiency and the weakening of intergenerational ties and bonds, compromise the provision of care to the older person in need[4].

When the family bond is harmed, the family possibly fails to provide security, companionship and help to the older person, which can increase the risks to their health and survival[5]. Furthermore, in many situations, the family is insufficient, such as: contexts in which the person who should take care of the older person has physical and/or mental health problems or is a user of alcohol or drugs. This is the reality experienced by many older people in their family context, which creates greater complexity in solving the problem[6].

Thus, among the problems faced by this population, violence deserves to be highlighted, which, despite being considered a serious public health problem, is still camouflaged in society[7].

Violence against older people is an internationally recognized phenomenon and also known for a paucity of data. Among the reasons related to underreporting of these cases, the following can be considered: collusion and family secrecy, the victim's fear of breaking bonds and the impositions caused by the aggressors who are often the caregivers themselves; in addition to the cognitive and physical limitations of the victims[8,9].

According to information from the Violence and Accident Surveillance System (VIVA), in 2014, 12,297 cases of violence against older people were reported in Brazil (43.7% of which were repeated). Among the types of abuse, the following were found: physical/sexual (64%), psychological/moral (28.2%), neglect/abandonment (26.4%) and financial (7.4%) violence, most (28.4%) practiced by their children[10].

In the verification of violence against older people from police reports (BOs) registered in three municipalities in different regions of Brazil, in the period 2009-2013, it was found a predominance of the age group 60-69 years old, female and married, the aggressors being predominantly individuals between 30 and 49 years of age, male[11].

In our reality, it is essentially up to the family to provide care for the older people, since public resources aimed at this portion of the population are limited. When it comes to violence against older people, it has been observed that it occurs mainly at home and the aggressors are the family members themselves. An analysis of police incidents in a medium-sized city in São Paulo, between 2008 and 2012, found that out of a total of 572 cases, most aggressors were male (69.20%), white (56.50%), age group 31-40 years (14.20%) and without information about occupation (50.70%), with children of the victim being the main aggressors (25.30%)[7].

Given the above, motivated by the complexity of situations of violence and the difficulties of different sectors in facing this problem, especially because in many cases the denounced and attacked will continue to share the same spaces; in addition to the scarcity of studies that look at the aggressor, this study aimed to interpret the experience of those accused of aggression towards older people in terms of the context of violence and the dynamics of relationships.

METHOD

This is a qualitative study, carried out from interviews with reports of aggression towards older people, using thematic analysis as a form of data treatment, as it is considered a tool used in different methods, given its flexibility[12].

The survey was conducted in a medium-sized municipality in the interior of São Paulo, SP, Brazil, with a population of 216,745 inhabitants, of which 13.6% are older people[13]. The setting for data collection was the Police Station for the Defense of Women (DDM), of the Civil Police Judiciary Police Center.

The selection of the denounced was made by the appointment of the chief police officer responsible for the service. When the police station received the occurrence related to violence against older people, the researchers were called to carry out the interview. Reports of aggression against older people who lived in the city and who had communication conditions to provide the necessary information were included in the study. Those who represented risk of aggression or impaired cognitive ability were excluded.

Data collection took place from March to December 2019, at DDM's premises and, in some cases, at the homes of the accused in a place and at times previously agreed by telephone. The interviews were conducted by two trained researchers, one psychiatrist who was the main investigator and conducted the interviews. There was a meeting with each accused of aggression lasting between 16 and 81 minutes, with an average of 39 minutes for the interviews, which were recorded and later transcribed in full.

Data collection was carried out through semi-structured face-to-face interviews with the accused of aggression towards older people. A script containing sociodemographic data was used as a guide (age, gender, education, degree of kinship with the older person, financial dependence, if he/she lives with the older person and if he/she is the caregiver); data on the use of alcohol or illicit drugs and the presence of mental disorder. The interview consisted of 7 questions elaborated according to the objective: 1- Talk about your relationship with the older person 2- What do you attribute the fact that you assaulted the older person 3- How are you feeling about what happened? 4- Talk about which aspects the older person depends on you 5- Talk about your dependence on the older person 6- Talk about how you take care of your health.

At the end of the interviews, welcoming and listening to something that the interviewee needed to expose was carried out, ending with notes, guidelines and care directions, according to the needs presented.

The interviews were closed when there was data saturation, which, according to Minayo[14], can be understood as the moment of the research in which the collection of new data would not bring further clarification to the studied object.

According to Braun and Clarke[12], the trajectory of this analysis is presented in six phases, it is not a linear process in which one phase precedes the other, being necessary to apply flexibility and be exhaustive in the interaction with the data, so that rich and complex insights can be generated.

In proposing the phases to be followed, **familiarity with the data** is initially placed, which includes immersion through repeated readings of the data in order to approach the depth and breadth of the content[12].

The second phase involves the **production of initial codes** from the data, which represent a semantic or latent content that refers to the most basic segment or element of the data[12].

Phase three, which refers to the **search for themes**, which is developed from the list of codes and involves the screening of different codes into potential themes[12].

In phase four, it was time to **revisit the themes**, which involves their refinement, takes into account the criteria of internal homogeneity and external heterogeneity, and it is often necessary to resume coding the data until it is possible to create a satisfactory thematic map[12].

Next, the themes are **defined and named**, that is, the essence of the subject is identified.

And, finally, the last phase begins when the set of themes have already been fully worked out, starting the final analysis and writing of the report[12].

To preserve the confidentiality of identity, the participants were represented, in the transcript, by the letter D of the accused followed by a cardinal number indicating the order in which the interviews were carried out, as follows: D1, D2... and D16.

The project was approved by the Ethics and Research Committee with Human Beings of the Faculty of Medicine of Marília, in compliance with resolution 510/2016, according to Opinion Nº. 3,250,567, the objectives of the study were explained and the anonymity of the testimonies was guaranteed, when the Informed Consent Form was read and signed voluntarily.

RESULTS

Sixteen people denounced for assaulting older people were interviewed. In the data collection process, seven defendants did not accept to participate in the interview and another thirteen were not contacted, since many of them did not answer the phone, as they were in prison or hospitalized.

As for sociodemographic data, it was found that the age of the accused ranged from 38 to 86 years, and half of these are also older people. Males were predominant, with 12 (75%) of them with education ranging from incomplete primary to those who have completed higher education. Of the denounced, 11 (68.75%) live with the older person, with half of the occurrences committed by the spouse. Most reported not being financially dependent and six (37.5%) took care of the older person. It is also observed that 10 (62.5%) of the accused abuse alcohol and/or illicit drugs or have some mental disorder, whether due to drug use or not. As for the type of violence involved, it was observed that seven were physical violence, three were verbal, two were psychological and four were negligence. Data analysis led to the definition of five final themes and their respective sub-themes, as shown in chart 1:

Chart 1. Distribution of final themes and sub-themes. Marília, SP. 2021

Themes	Sub-themes
Defending themselves from the charge of assault	Denies the charge of assault Justifies the motivation of violence Minimizes the situation of violence
Mutual dependency	Financial dependency Care dependency
Attributes the occurrence to the behavior of the older person	Cursing Fact Invention Lack of understanding of what is said History of living with aggression
Recognizes their needs and seeks solutions	Aggression occurred due to being under the influence of psychoactive drugs Search for treatment to avoid aggression Compares older people care to a prison
Suffering the consequences of the aggression.	Defendant's self negligence Wishing to clear the situation Feeling emotionally assaulted Difficulty dealing with the situation

Source: Own elaboration

Defending themselves from the charge of assault

Upon being interviewed, the accused defended themselves against the aggression committed, through justifications, denial and minimization of the fact that occurred. They claimed that they were under the effects of drugs and that they were not aware of what was going on. Physical aggression is denied, even recognizing that he was feeling angry and that he took the victim's arm, there is still difficulty in recognizing types of aggression different from this one. In addition to the issues already mentioned, the fact that he never caused an aggression also seems to give the aggressor the feeling of not having committed the act, as he alleges that the injury occurred by the victim's own accident. Below are some reports:

> "We verbally fought because I asked for money to buy drugs [...] It happened that I was "high" and I didn't really know what I was doing[...] I was without treatment, now I adhered to the treatment" (D1).

> "[...]sometimes it's like this, I feel angry, but it's not that it's that anger of attacking anyone because I've never attacked her. If she said here on paper that I assaulted her, I never did" (D2).

> "How does someone who knows me[..] have the courage to pick up a day-to-day fact, go to the police station to report me as an aggressor? I never touched, I never pinched my mother [...]" (D7)

> "She didn't even fall, she did it like that, she misplaced her foot, almost fell, but gave the foot a little twist, but her alone! She got carried away and when she got carried away, then she stepped wrong" (D13).

> "It was silly, I really had a revolver in the car[...] then she reported me, but I had shot it, upwards, a day before at night [...]. I feel tremendously angry! Because I have never, after 35 years, ended up in detention. Only that part of aggression never happened!" (D14).

Mutual dependency

In the interviews, it was possible to observe that there is mutual dependence between assaulted and denounced. On the one hand, the accused needs the financial support of the older person and, on the other hand, the older person depends on their care. Also included are those who claim they cannot work because they need to provide care. Thus, it appears that this is a relationship that will be perpetuated as revealed below:

> "[...] she depends on me because of the disease[...]. I help with everything [...] I clean the house, I make lunch, sometimes she makes lunch. I take her to the doctor[..] I depend on her more than she on me because the money goes in her hand. As I can't work because of her, because I have to take care of her, so I'm in her hands (D2)".

> "It was difficult because, like, I work and I had to stop my work to help take care of (D3)".

Attributes the occurrence to the behavior of the older person

Respondents claim that the aggression occurred due to the aggressive behavior of the older person who performs verbal aggression, through cursing and invention of facts that were not practiced by them. Furthermore, they claim that the older person does not have an understanding of what is actually said, thus making their own interpretation. There are reports of important experiences of aggression by some interviewees who have also been in the role of victims and now seem to reproduce these experiences as aggressors, as follows:

> "She curses me as a bastard, devil, she curses me everything, she's not afraid! her problem is her head, she invents things [...]" (D2).

> "She is problematic in the sense that she is disturbed. You say one thing and she interprets it another way [...]" (D4).

> "He gets really violent! So my defense is to bite. So I put the teeth right on top of his chest, he still has the marks!" (D10).

> "I'm raised in this nest, what am I going to learn? Don't they say that the father is the mirror of the son? I'm going to learn this [..] I already had to separate the fight with my father, my father drank, attacked my mother[...] He stabbed my brother 32 times [...]" (D12).

> "Then we seriously discussed! I'll tell you the truth, if she can hit, she hits. My mom is tough, and I got it from her! That's why she and I don't get along, because if I go to argue with the person and the person starts to, like, make fun of me, I can't take it anymore. I'm an ignorant guy!" (D14).

Recognizes their needs and seeks solutions

The accused recognizes their weaknesses in performing this role, especially when in the role of caregiver. The burden of caring for the older person seems to be a painful task both physically and emotionally, especially for those who show that they do not have many resources to do so, even though they want to take care of and stay by the side of the older person. They also have a mental or emotional disorder or abuse alcohol, and in some cases they seek solutions through treatment in an attempt to prevent the aggression from happening again.

> "So we were stuck there for these 16 years and nobody knows how long this prison will last." (D3)

> "Everything I can do with her, I do for her, poor thing... I married her it wasn't so I could leave her, understand? Isn't there a saying that goes like this "he who eats the meat, gnaws the bone"? That's me, anyway. I married her to stay until the end, you know?" (D2)

> "I'm following up, I'm taking medication. There are times when I don't have the breath for myself, I don't have a moment of mine. I understand that I have some psychological decompensation, due to everything I've experienced and I feel like this, I have to work with it, but she's silent and deaf. [...]" (D4).

> "But, like, I know my limit. I think I know, right? But a drunk never knows the limit, does he?" (D12).

> "Depression, nervous breakdown.." (D8).

Suffering the consequences of the aggression.

Situations of self-neglect and emotional suffering permeate situations of violence. The defendants both expressed the fact that they did not treat clinical and mental illnesses properly, as they stopped eating properly after the complaint and, as a result, lost weight. They also allege the desire to erase the situation, that they are feeling emotionally assaulted or that they don't know how to deal with what is happening.

> "So I have high blood pressure, but super high! I haven't taken anything for almost 2 years now, I suspended everything!" (D5).

> "[...]I would like it to be erased, I wanted to go on with my life and that she goes on with hers". (D4).

> "Look, I'll tell you[...] I felt so emotionally assaulted because[..] the fact that you think I might have done it already bothers me!" (E7).

> "I'm terrible, psychologically shaken. I'm not able to deal with this situation, because, like, in all my life, 48 years, I've never had a problem with the law[...]" (D15).

DISCUSSION

The realization of this study, which sought to interpret the experiences of the accused of aggression to older people, constituted a great challenge, since the conditions of the accused are complex and adverse, since there is hospitalization, imprisonment or lack of lucidity of respondents; the latter due to the abuse of legal and illegal drugs or the presence of mental disorder.

In addition, the fact that it is a silenced topic covered in taboos is permeated by the difficulty of investigating the phenomenon[7], because it most often occurs within the family, which is seen as a space of protection and care, and despite the secrecy of the information and procedural non-interference of the case, the interviewees remain fearful and find it difficult to deal with the issue.

Data from this study corroborate the literature showing that the main aggressors are male and abuse alcohol and illicit drugs. Also, common characteristics are: hostile and aggressive behavior, unemployment, financial problems, cohabitation, history of difficult relationships, stress resulting from the care of the older person and the possible intergenerational

transmission of violent behavior[15,16]. Female victims suffer more aggression by spouses and male victims by their children. The main characteristics of older people who suffer aggression are: physical and/or intellectual dependence, dementia, depression or aggressive and challenging behavior.

Violence against older people perpetrated by family members in their own homes gains relevance when considering that national legislation, through the Federal Constitution and the Statute of the Older Person, provide them with full protection, ensuring opportunities and amenities for the preservation of physical and mental health, as well as their moral, intellectual, spiritual and social improvement, in conditions of freedom and dignity, given that such guarantees must be provided by the state and the family[17,18].

It is noteworthy that in recent decades the family has been undergoing changes, including its fragmentation, with less traditional experiences of conjugality, reduced birth rates and reduced time available for care, as both women and men assume extensive work activities[19,20]

As for the present study, it should be noted that half of the participants are older people and also spouses[18,19]. Therefore, although living with a spouse represents a protective factor against physical or financial abuse[21], the injustice regarding the division of housework, excessive investment in personal issues, influences of environmental factors and decision-making issues that are unilaterally[22] important to the spouse's context lead to violence.

In the analysis of the interviews with the aggressors, a pattern of speeches covered with defense mechanisms is observed, essentially including the denial of the aggression committed and rationalization. Denial is the conscious refusal to perceive disturbing facts and rationalization involves creating false excuses to justify the behavior[23].

This is due to the fact that when accepting to have assaulted the older person, the aggressor is faced with intolerable emotional damage and with the recognition that he committed a faulty act. This is a condition that needs to be considered and addressed by health professionals, so that the accused can understand the facts, considering that the conscious refusal to face disturbing facts makes it difficult for the individual to deal with challenges and establish appropriate strategies in the relationship[24]. Thus, when respondents admit that they perpetrated violence against the older person, they also recognized that they needed help to improve their aggressive behavior[25].

The role of caregiver, in turn, also represents a great challenge due to the burden it requires. One study identified that a third of them had a care overload, which was associated with age, family dysfunction and the provision of continuous care, as most of the time care falls to a single person[25].

Coming from the perspective of understanding violence, it is noticeable that it is considered a multifactorial condition, which often has its origins in childhood, due to the ineffectiveness of the behavior of parents or guardians in setting limits to bad behavior. In addition, common characteristics between victim and aggressor are identified, being the victim who molds the aggressor, thus, the abuse, which occurred in childhood, permeates the psychological functionalism in adulthood, reflecting in later family relationships[26,27].

Although violence is a culturally determined issue and, although it has a direct relationship with the intention of the act, that is, it is considered violence when the act is intentional, it may, in certain beliefs and cultures, not be considered as such[28, 29].

It is also observed that the aggressors manifest feelings of self-punishment when they report that they stopped taking the medication or eating properly, which is demonstrated through self-denial of pleasure and self-imposed penalty[30,31].

The need for an adequate approach aimed at resolving existing conflicts between the victim and the accused gains relevance when verifying that in this relationship there is mutual dependence and that it will be perpetuated after the occurrence and the appropriate legal measures, as in most cases there is a financial or care dependency between both involved in this relationship.

Finally, even given the limitations of the study, because it is an embarrassing issue and that, therefore, participants can omit or distort the information, in addition to using interviews with only a small portion of those denounced for aggression, as a result of the difficulties in conducting the interviews, this study brings important reflections, given that both the attacked and the accused need specific care from health professionals.

CONCLUSION

This study showed that giving voice to the accused of aggression to the older person is to face situations that involve socioeconomic and health needs, in a context of relationships that are difficult to manage, since in most cases the accused is a family member and that coexistence will be perpetuated by mutual dependence between them.

The accused seek to defend themselves from the aggression and, in this perspective, they deny, justify and minimize the act committed. It is also observed the existence of mutual dependence, whether financial or care, which often makes it difficult or even prevents the coexistence to be interrupted. Aggressive behavior, through insults and history of living with aggression perpetuated by the older person, in addition to the arduous task of caring for the older person, the abusive use of alcohol and illicit drugs were factors that contributed to the aggression. Respondents express feelings of guilt and regret for the aggression perpetrated, recognize their needs and seek support to cope with the situation.

In situations of aggression, there needs to be a widened listening. For this, it is necessary to give voice to the needs of both the older person and the accused, so that it is possible to move constructively towards the resolution of the conflict. Therefore, the support of a multidisciplinary health team in articulated work with other sectors is recommended.

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Characterization of self-inflicted violence committed by older people in southern Brazil from 2009 to 2016

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Abstract

Objective: To describe the characteristics of older people who committed self-inflicted violence, reported in the Notifiable Diseases Information System (SINAN) in southern Brazil, from 2009 to 2016. *Method:* This is a retrospective, descriptive study with a quantitative approach, and with secondary data. The variables in relation to the sociodemographic characteristics of the places and means of violence were selected based on the notification forms. Variables were subjected to descriptive statistical analysis using simple frequency and proportion (%), stratified by age group (60-69 years; 70-79 years; 80 years or more) and confidence intervals were performed (95%CI). Statistical significance was tested using the chi-square test (χ^2) and considered the value of $p \leq 0.05$. *Results:* The results showed that, in the southern region of Brazil, the profile of older people who committed self-inflicted violence are predominantly aged 60 to 69 years (61.3%), male (56.1%), white (90.9%), with low educational level (56.3%) and married (54.0%). Among the states, Rio Grande do Sul recorded the highest number of notifications (50.7%), urban areas (81.8%) and residences/collective housing (90.2%) predominated as places of occurrence. The most used means of violence were hanging (29.9%) and poisoning (24.9%). The occurrence of two outcomes was observed, repetition (31.5%) of self-inflicted violence and death records (43.8%). *Conclusion:* The outlining of the epidemiological profile, in the southern region of Brazil, identified groups of older people who need more attention in the actions of prevention and occurrence of self-inflicted violence, being male older people, younger and with low education.

Keywords: Violence. Suicide Attempted. Elderly. Health Information Systems.

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INTRODUCTION

Aging is a dynamic, individual, irreversible process that promotes a progressive decline in physiological functions that interfere with the organic and functional capacity of older people[1]. These changes can be perceived positively or negatively by older people, that is, their life history will determine future behaviors, which for many may culminate in self-inflicted violence[2].

Thus, self-inflicted violence can be understood as that which occurs when a person practices the conscious action of self-destruction, which is subdivided into suicidal behavior and self-harm. The first includes suicidal ideation, suicide attempts and suicides; while self-harm encompasses acts such as self-mutilation and self-injury, from mild to severe forms[3].

Therefore, suicide attempts are understood to be the deliberate act of taking one's own life, but without carrying it out[4]. Some authors consider that there is a fine line between ideation, attempt and suicide, although there is a need to understand that ideation and attempts can be alternated[5].

Trying to explain the reasons why a person commits self-inflicted violence or wants to do so comes from a range of elements that influence this behavior, such factors come from personal, social, psychological, cultural, biological and environmental situations[6]. In general, people who commit self-inflicted violence are experiencing a feeling of impossibility in identifying alternatives for solving their conflicts[3]. Cavalcante et al.[7], report that the older population has the same behaviors as other age groups related to the difficulties in solving their conflicts, as such difficulties come from different social factors[8].

It is estimated that suicide attempts are up to four times greater than suicides for people aged 60 years or more, and may reach the limit ratio of one act for one death[2]. The risk of death increases as the number of suicide attempts increases, as well as being associated with shorter time intervals between one act of violence and another[9].

Regarding self-inflicted death, an average of 11 thousand people take their own lives per year in Brazil. The southern region of Brazil concentrates 23% of suicide cases in the national territory[10]. The suicide rate in this same region in 2012 for people aged 60 years and over was 16 per 100,000 inhabitants[11]. Regarding suicides, science has already quantified numbers related to older people, but there is a lack of studies involving this population when referring to suicide attempts[12].

Thus, self-inflicted violence in older people is a social and public health problem, as there is an urgent need to invest in studies on the subject, since there is a lack of published research with this population in the southern region of Brazil.

In Brazil, one of the possibilities to establish epidemiological results regarding self-inflicted violence is using the national database of the Surveillance System for Interpersonal and Self-Inflicted Violence (VIVA/SINAN), which is fed by notifications made by health professionals or institutions[12]. More than just producing quantifiable data on self-inflicted violence, there is a need to provide professionals and health authorities with knowledge about the reality of older people in a contextualized way in order to enable the creation of new public policies[13,14]. Therefore, we aimed to describe the characteristics of older people who committed self-inflicted violence, reported in the Notifiable Diseases Information System (SINAN) in southern Brazil from 2009 to 2016.

METHOD

This is a study with a quantitative, descriptive, retrospective approach, with secondary data. The notifications of self-inflicted violence among the older people studied are concentrated in the southern region of Brazil (Rio Grande do Sul, Santa Catarina and Paraná), from January 1, 2009 to December 31, 2016. The Older People statute[15] considers as an older person in Brazil, the one who turns sixty or more years old, so this was the target population of this study.

According to the Brazilian Institute of Geography and Statistics[16], the projection of the older population in the southern region of Brazil in the year 2025 will correspond to 6,047,338 people. The percentage

perspective for the older population, referring to the mentioned year, will be approximately 18% for the states of Paraná and Santa Catarina and 22% for Rio Grande do Sul.

The period studied was delimited from 2009 to 2016, due to the notifications of violence having been entered in SINAN in 2009 and in 2016 due to the availability of the database being consolidated by the Ministry of Health (MS). The selection of the variables present in the study was based on the Individual Notification/Investigation Forms of Domestic, Sexual and/or other Violence, published in 2008 and the Individual Interpersonal/Self-provoked Violence Notification Form, published in 2015. Changes made by the MS in 2015 were considered, and most of the data were chosen in common in the two notification models[11]. The selected variables, from the forms, aimed to respond to the study objectives.

We chose to separate the variables into sociodemographic characteristics (age, sex, skin color, education and marital status), location (federal unit, area of occurrence, place of occurrence and shift of occurrence) and violence (means of violence, repeated violence and evolution), of the older people who committed self-inflicted violence.

In the 2008 notification form, the evolution field was present, which registered the outcome of the case, including death due to violence. The researchers understood that the inclusion of this data in the study was relevant, even though it was not included in the 2015 form. In this study, it was decided to use all notifications of self-inflicted violence by older people present in the database, even if some are not fully completed.

The variables were extracted from the national database of the SINAN system between November and December 2019 and submitted to descriptive statistical analysis, using simple frequency and proportion (%), stratified by age group (60-69 years; 70-79 years; 80 years or more) and confidence intervals were performed (95%CI). Statistical significance was tested using the chi-square test (χ^2) and considered the value of $p \leq 0.05$.

The database was requested by a researcher from the research group on Violence and Health at the Federal University of Santa Catarina through the information access system, and provided by the Health Surveillance Department of the Ministry of Health, after signing the term of responsibility for cession of the databases of the health surveillance department, with the approval of the General Coordination of Surveillance of Non-Communicable Diseases. As for ethical care, the research used secondary data, so it did not need to be submitted to the ethics committee due to the resolution of the National Health Council (CNS) 510/2016, article 1, sole paragraph and subparagraph V, states that research with databases, whose information is aggregated, without the possibility of individual identification, are not registered and passed on to the Research Ethics Committee/National Research Ethics Committee (CEP/CONEP).

RESULTS

A total of 2,290 SINAN notifications of self-inflicted violence by older people in the South of Brazil between 2009 and 2016 were analyzed. The average age of older people was 68.9 years, with 43.9% female and 56.1% male. 90.9% declared themselves as white and 5.9% as brown, of which 6.3% had zero to four years of education, followed by 28.6% who had five to eight years of education; these characteristics prevail in the three age stratifications. 54.0% declared themselves married or in a stable relationship and 23.0% widowed, it is noted that married people predominate in the three stratified age groups. These information are found in table 1.

Table 2 describes the characteristics of the places where self-inflicted violence among older people occurred in the southern region of Brazil. The state of Rio Grande do Sul registered 50.7% of notifications, followed by Santa Catarina 27.1% and finally Paraná with 22.2%, showing that the state of Rio Grande do Sul has the highest percentage of records of self-inflicted violence in the three stratified age groups. Self-inflicted violence occurred predominantly in urban or peri-urban areas, with 81.8% of registered cases. The place with the highest occurrence of self-inflicted violence recorded was residence/collective housing with 90.2%. The time of occurrence was 33.3% in the morning and in the afternoon with 33.1%.

Table 1. Sociodemographic characteristics of older people who committed self-inflicted violence, notified in SINAN. (N=2,290). Southern Region. Brazil. 2009-2016.

Characteristics	Total	60-69 years		70-79 years		80 years or more		*p* value
	N (%)	n (%)	95% CI	n (%)	95% CI	n (%)	95% CI	
Sex (n=2,290)								<0.001
Female	1,005 (43.9)	666 (66.3)	63.2-69.1	237(23.6)	21.0-26.3	102 (10.1)	8.4-12.1	
Male	1,285 (56.1)	738 (57.4)	54.7-60.1	382 (29.7)	27.2-32.2	165 (12.9)	11.1-14.7	
Skin color (n=2,229)								0.252
White	2.026 (90.9)	1.231(60.8)	58.6-62.8	561(27.7)	25.7-29.6	234 (11.5)	10.2-13.0	
Black	58 (2.6)	33 (56.9)	43.5-69.2	17(29.3)	18.8-42.6	8 (13.8)	06.9-25.6	
Yellow/Indigenous	13 (0.6)	8 (61.5)	30.5-85.3	3 (23.1)	6.3-57.1	9 (15.4)	3.0-50.9	
Brown	132 (5.9)	94 (71.2)	62.8-78.3	23 (17.4)	11.7-24.9	15 (11.4)	6.9-18.1	
Education (years) (n=1,519)								<0.001
0-4	855 (56.3)	493 (57.7)	54.3-60.9	253 (29.6)	26.6-32.7	109 (12.7)	10.6-15.1	
5-8	434 (28.6)	304 (70.1)	65.5-74.1	99 (22.8)	19.0-27.0	31 (7.1)	5.0-9.9	
9-11	171 (11.2)	128 (74.9)	67.7-80.8	30 (17.5)	12.5-24.0	13 (7.6)	4.4-12.7	
12 or more	59 (3.9)	508 (4.7)	72.7-92.0	8 (13.6)	6.7-25.2	1 (1.7)	0.2-11.6	
Marital Status (n=1,970)								<0.001
Single	241 (12.2)	158 (65.6)	59.2-71.3	57 (23.6)	18.6-29.4	26 (10.8)	7.4-15.4	
Married/Stable union	1.063 (54.0)	703 (66.1)	63.2-68.9	273 (25.7)	23.1-28.3	87 (8.2)	6.6-9.9	
Widow	453 (23.0)	177 (39.1)	34.6-43.6	160 (35.3)	31.0-39.8	116 (25.6)	27.1-29.8	
Separated	213 (10.8)	163 (76.5)	70.3-81.7	41 (19.3)	14.4-25.1	9 (4.2)	2.2-7.9	

Source: VIVA/SINAN, 2009-2016.

Table 2. Characteristics of places where self-inflicted violence was committed by older people notified to SINAN. (N=2,290). Southern Region. Brazil. 2009-2016.

Characteristics	Total	60-69 years		70-79 years		80 years or more		*p* value
	N (%)	n (%)	95% CI	n (%)	95% CI	n (%)	95% CI	
State (n=2,290)								<0,001
Paraná	509 (22.2)	323 (63.5)	59.1 -67.5	144 (28.3)	24.5-32.3	42 (8.2)	6.1-10.9	
Santa Catarina	620 (27.1)	417 (67.3)	63.4-70.8	146 (23.5)	20.3-27.0	57 (9.2)	7.1-11.7	
Rio Grande do Sul	1,161(50.7)	664 (57.2)	54.3-60.0	329 (28.3)	25.8-31.0	267 (14.5)	12.5-16.6	
Occurrence zone (n=2,163)								0.023
urban/periurban	1,769 (81.8)	1,105 (62.5)	60.1-64.6	470 (26.6)	24.5-28.6	194 (10.9)	9.5-12.5	
Rural	394 (18.2)	217 (55.1)	50.1-59.9	123 (31.2)	26.8-35.9	54 (13.7)	10.6-17.4	
Location of occurrence (n=2,234)								0.064
Residence/collective housing	2,016 (90.2)	1,226 (60.8)	58.6-62.9	545 (27.0)	25.1-29.0	245 (12.2)	10.7-13.6	
Public road	106 (4.8)	74 (69.8)	60.2-77.8	25 (23.6)	16.3-32.7	7 (6.6)	3.1-13.3	
Others	112 (5.0)	74 (66.0)	56.6-74.3	32 (28.6)	20.8-37.7	6 (5.4)	2.3-11.5	

to be continued

Continuation of Table 2

Characteristics	Total	60-69 years		70-79 years		80 years or more		*p* value
	N (%)	n (%)	95% CI	n (%)	95% CI	n (%)	95% CI	
Time of occurrence (n=1,490)								0.086
Morning	491 (33.0)	276 (56.2)	51.7-60.5	149 (30.4)	26.4-34.5	66 (13.4)	10.6-16.7	
Afternoon	493 (33.1)	299 (60.6)	56.2-64.8	138 (28.0)	24.1-32.1	56 (11.4)	8.8-14.4	
Night	361 (24.2)	236 (65.4)	60.2-70.1	85 (23.5)	19.4-28.2	40 (11.1)	8.2-14.7	
Late night	145 (9.7)	98 (67.6)	59.4-74.7	35 (24.1)	17.7-31.8	12 (8.3)	4.7-14.0	

Source: VIVA/SINAN, 2009-2016.

Table 3 refers to the characteristics of the means of violence used by older people in self-inflicted violence, with hanging with 29.9%, poisoning 24.9%, piercing object 11.5%, body strength/beating 6.4% and firearm 6.2%. It was recorded that 31.5% of cases of self-inflicted violence were repeated. 397 older people (43.8%) died as a result of self-inflicted violence, 203 (51.3%) aged 60 to 69 years, 126 (31.7%) aged 70 to 79 years and 68 (17.1%) of 80 years or more.

Table 3. Characteristics of the means of violence of self-inflicted violence committed by older people notified in SINAN. (N=2,290). Southern Region. Brazil. 2009-2016.

Characteristics	Total	60-69 years		70-79 years		80 years or more		*p* value
	N (%)	n (%)	95% CI	n (%)	95% CI	n (%)	95% CI	
Means of self-harm								
Body strength/beating (n=2,220)								0.860
Yes	143 (6.4)	91 (63.6)	55.3-71.1	36 (25.2)	18.6-33.0	16 (11.2)	6.9-17.5	
No	2,077 (93.6)	1,274 (61.3)	59.2-63.4	559 (26.9)	25.0-28.8	244 (11.8)	10.4-13.2	
Hanging (n=2,236)								0.014
Yes	669 (29.9)	383 (57.2)	53.4-60.9	191(28.6)	25.2-32.1	95 (14.2)	11.7-17.0	
No	1,567 (70.1)	990 (63.2)	60.7-65.5	409 (26.1)	23.9-28.3	168 (10.7)	9.2-12.3	
Blunt object (n=2,224)								0.328
Yes	36 (1.6)	21 (58.3)	41.1-73.7	8 (22.2)	11.1-39.4	7 (19.5)	9.2-36.4	
No	2,188 (98.4)	1,347 (61.6)	59.5-63.5	588 (26.9)	25.0-28.7	253 (11.6)	10.2-12.9	
Sharp piercing object (n=2,229)								0.089
Yes	257 (11.5)	145 (56.4)	50.2-62.3	84 (32.7)	27.1-38.6	28 (10.9)	7.6-15.3	
No	1,972 (88.5)	1,223 (62.0)	59.8-64.1	517 (26.2)	24.3-28.2	232 (11.8)	10.4-13.2	
Hot substance/object (n=2,222)								0.691
Yes	31 (1.4)	19 (61.3)	42.4-77.2	7 (22.6)	10.6-41.5	5 (16.1)	6.5-34.6	
No	2,191 (98.6)	1,347 (61.5)	59.4-63.4	589 (26.9)	25.0-28.7	255 (11.6)	10.3-13.0	
Poisoning (n=2,222)								<0.001
Yes	553 (24.9)	406 (73.4)	69.5-76.9	118 (21.3)	18.1-24.9	29 (5.3)	3.6-7.4	
No	1,669 (75.1)	960 (57.5)	55.1-59.8	478 (28.7)	26.5-30.8	231 (13.8)	12.2-15.5	

to be continued

Continuation of Table 3

Characteristics	Total	60-69 years		70-79 years		80 years or more		*p* value
	N (%)	n (%)	95% CI	n (%)	95% CI	n (%)	95% CI	
Firearm (n=2,230)								
Yes	138 (6.2)	61 (44.2)	36.0-52.6	57 (41.3)	33.3-49.7	20 (14.5)	9.4-21.5	<0.001
No	2,092 (93.8)	1,309 (62.6)	60.4-64.6	543 (25.9)	24.1-27.8	240 (11.5)	10.1-12.9	
Repetition (n=1,812)								
Yes	571 (31.5)	376 (65.9)	61.8-69.6	136 (23.8)	20.4-27.4	59 (10.3)	8.0-13.1	0.081
No	1,241 (68.5)	749 (60.4)	57.5-63.0	345 (27.8)	25.3-30.3	147 (11.8)	10.1-13.7	
Evolution*								
Death (n=906)								
Yes	397 (43.8)	203 (51.3)	46.2-56.0	126 (31.7)	27.3-36.5	68 (17.1)	13.7-21.1	<0.001
No	509 (56.2)	325 (63.8)	59.5-67.9	130 (25.5)	21.9-29.5	54 (10.6)	8.2-13.6	

* present in notifications until June 2015; Source: VIVA/SINAN, 2009-2016.

DISCUSSION

In this study, the sociodemographic profile of older people who committed self-inflicted violence reported on SINAN in southern Brazil was characterized. The main results show that the predominant age group was 60-69 years old, male, white-skinned people, low education level and married.

In this context, the age group with the highest occurrence of self-inflicted violence among older people proved to be at the beginning of the aging cycle. The literature[17] emphasizes that as age advances, the lethality of suicide attempts increases, as the aging process is multifactorial, promoting anatomical and functional changes in the body[18], naturally, as age advances, the body is more fragile and susceptible to external actions.

Regarding gender, in the southern region of Brazil, the male individual was the main author of self-inflicted violence, a study carried out in São Paulo, Capital, found similar data[19], however, other researches showed that women in the studied age group present greater attempts to take their own lives than men[17-22].

The hierarchies of social power between the sexes follow the demands of patriarchy, that is, a model that highlights the authority of men over women and children[23]. Older women were referred in a process not to realize their basic needs, however their obligations were in favor of taking care of the other, whether husband, children or family members. Masculinity and virility are terrifying conflicts for older men, when they step away from work, from the familiar social position of providers that is imposed by the social hierarchical power. In this line of thought, older males are victims of this social model, which does not allow and does not forgive showing vulnerability[24].

In the last IBGE Census[25], 78.3% of the population in the southern region of Brazil declared themselves white, followed by 16.7% brown. This information may be related to the result of this study, as the number of notifications was predominantly in white (91.0%) and brown (5.9%) people. Other Brazilian studies that address the theme of self-inflicted violence in older people reported that the victims were of mixed race/color, followed by whites[18,26,27]. It is known that the processes of skin color identification are subjective, complex, multifaceted, involving historical and sociocultural factors[28]. In addition to these factors, the greater concentration of whites in the southern region is explained by the colonization process in that region. Colonized mainly by German, Italian and Polish immigrants, in the southern region, the phenotypic characteristics and cultural preferences of the inhabitants are very close to European standards, including with regard to the predominantly white skin color[29].

As for the aspect of schooling, this is an important factor to measure the characteristics of a society. The educational level of the studied population predominated with low educational level, information that corroborates the national and international literature[19,26,27,30]. The low educational level of older people increases the probability of a low socioeconomic level, which can harm individual, family and social life, and may be a triggering factor for self-inflicted violence, as it hinders aging with dignity[31].

Surveys conducted in Turkey and Colombia with older people corroborate the epidemiological data of this study, which pointed out that most self-inflicted, non-fatal violence occurred with people who were married or who lived in a stable relationship[22,32]. Understanding the cultural aspect of the southern region of Brazil, it is necessary to point out that when older people got married they assumed an indissoluble commitment, a decision made for life[30].

Regarding the characteristics of violence, the state of Rio Grande de Sul was the one with the highest number of records of notifications for self-inflicted violence. A study carried out in that state showed an annual and gradual increase in cases of self-inflicted violence in the population studied, from 85/100,000 in 2005 to 149/100,000 in 2013[33]. When self-inflicted violence results in death in older people, the South of Brazil is the region with the highest rates, especially Rio Grande do Sul[14,34].

Regarding the location, the highest incidence of occurrences occurred in the urban area, other researchers found equivalent findings[26]. This data is understood when observing the Brazilian population concentration, since the largest number of people reside in urban areas[25]. Added to this fact, it is known that in urban centers there is a concentration of health services[35]. Another relevant information, regarding the location, is that self-inflicted violence occurred predominantly in the residence/collective housing, corroborating other studies[18,22,27].

As for the means of violence used for self-inflicted violence, hanging was chosen by the majority of the sample in question, there are also studies on suicide among older people reporting that this is the most used method[21,27]. From this perspective, it is observed that the most used means of violence produces different outcomes.

It was possible to find important outcomes in this study through the notifications: the high percentage of repetition of cases of self-inflicted violence in older people and the 397 deaths. This last information was included in the notification form until 2015, if the field was kept, in the current form, the value could be higher.

A limitation found in this study stems from the probable underreporting of cases of self-inflicted violence, as many cases do not reach the health services for adequate care, as self-inflicted violence is a taboo for society, the victim's family and the victims themselves[34].

This is a descriptive work, which does not propose to demonstrate associations between the variables of older people who committed self-inflicted violence in southern Brazil. The ability to determine possible causal interferences and to extrapolate the results to other populations is limited.

CONCLUSION

The study presented data that, for the most part, corroborate international and national research on self-inflicted violence with older people, therefore, it is noted that there is similarity in the profile of victims, places and means of violence used. With a delineated epidemiological profile, it becomes possible to identify the risk factors at an early stage and, in this way, prevent attempts at self-inflicted violence from occurring.

The data presented here encourage public policies for the prevention and promotion of self-inflicted violence to be carried out within the Unified Health System and the network responsible for the care of older people. Further research on the subject is suggested so that further studies can occur on self-inflicted, non-fatal violence committed by older people, as this subject still lacks studies.

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Profile of older people victims of domestic violence in an integrated center for protection and defense of rights in times of pandemic

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Abstract

Objective: to compare the profile of older people victim of intra-family violence attended at an Integrated Center for the Protection and Defense of Rights, in Manaus, Amazonas, Brazil, in 2019 and in the context of a pandemic. *Method:* Cross-sectional analytical study of care for older people victims of intra-family violence carried out from January 2019 to December 2020. Descriptive and comparative analysis was applied with the χ^2 test, at a significance level of 5%, in the distribution of characteristics of victims, occurrences and care provided. *Results:* There was an increase of almost 25% in the care provided to victims of intra-family violence in 2020 compared to 2019. The profile points to most of the female sex (58.9%), aged between 60 and 80 years (78.9%), widowed/married/stable union (60.0%), brown (71.0%), Catholic (56.0%), with elementary education (37.7%), retired/pensioners (55.6%) and residents in the northern (23.3%) and southern (19.9%) zones of Manaus. The violence that most affected the older people assisted was intimidation/disruption (34.5% in 2019 and 33.2% in 2020), perpetrated by their children (66.4% in 2019 and 69.0% in 2020) with about 7.0% of situations under alcohol and/or drug use. There was a reduction of almost 9.0% in face-to-face care provided in 2020 ($p<0.01$). The occurrences demanded referral mainly to the specialized police station (40%). *Conclusion:* Significant differences were found in the characteristics of occurrences and care between years, which reinforces the influence of the pandemic and the importance of the performance of the system of guarantees of rights for older people.

Keywords: Aged. Violence. Elder Abuse. Public Policy.

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INTRODUCTION

The demographic transition is one of the most important structural phenomena that has marked the Brazilian economy and society since the second half of the last century[1]. According to population estimates, there was an increase of almost 5.0% of the older people population in Amazonas in 2020, compared to the previous year. Manaus concentrates about 57.0% of the total older people residents in the state[2].

With the increase in the proportion of older people in the population, it is understood that a set of public policies are conditioned[3] on the growth of social awareness, chronological age and its different stages, and these start to be used as guiding principles for new rights and duties, especially in the case of more vulnerable groups[4].

According to Minayo and Souza[5], social and age vulnerability makes older people more exposed to the occurrence of violence, and this can manifest itself in a: (a) structural way, that which occurs due to social inequality and is naturalized in the manifestations of poverty, of misery and discrimination; (b) interpersonal in forms of communication and daily interaction and (c) institutional, in the application or omission in the management of social policies by the State and by care institutions, a privileged way of reproducing asymmetrical relations of power, domination, contempt and discrimination.

For the World Health Organization (WHO)[6], violence constitutes the intentional use of physical force or power, real or threatening, against oneself or against another person, group or community, resulting in or in the possibility of injury, death, psychological damage, developmental disability or deprivation, or all of these. As for its classification, violence can be classified as: physical, psychological, sexual, financial abuse, negligence, abandonment and self-neglect.

Intra-family violence is an issue of great breadth and complexity that involves professionals from different fields of activity, requiring, therefore, an effective mobilization of various sectors of government and civil society. Such mobilization aims, in particular, to strengthen and enhance actions and services from the perspective of a new attitude, commitment and collaboration in relation to the problem[7].

Social isolation resulting from the COVID-19 pandemic had an impact on the occurrence of domestic and family violence. Although information is still incipient, news in the media and reports from international organizations point to an increase in this type of violence. In China, police records of domestic violence tripled during the epidemic. In Italy, France and Spain, an increase in the occurrence of domestic violence was also observed after the implementation of mandatory home quarantine[8]. However, Moraes et al.[9] state that this social isolation generates several negative repercussions, including the increase in intra-family violence against children, adolescents, women and older people.

To ensure access to the system for guaranteeing the rights of older people and to prevent the occurrence of such violence, it is essential to implement public policies that respond to the needs generated by rapid demographic changes. Unlike societies that have aged at a slower pace and have gradually adapted to this situation, Brazil is faced with the requirement to broaden its understanding of the demographic, economic and social implications of the aging process and organize policies to address them[10].

Thus, given the above, and understanding the importance of paying attention to intrafamily violence against older people in times of pandemic, in order to understand how public institutions for the protection and guarantees of the rights of older people have acted in this context , the aim of this article is to compare the profile of older people victim of intrafamily violence assisted at an Integrated Center for the Protection and Defense of Rights, in Manaus, Amazonas, Brazil, in 2019 and in the context of the COVID-19 pandemic, in the year 2020.

METHOD

This is an analytical cross-sectional study of care provided to older people aged 60 years or over, victims of intra-family violence at the Integrated

Center for the Protection and Defense of the Rights of the Older Person (CIPDI) located in the city of Manaus, Amazonas, Brazil. The data used in the study refer to care provided between January 2019 and December 2020, generated by the Official Monthly Service Reports requested in October 2020.

CIPDI was implemented in 2007 to offer qualified and multi-sector care to older people who are victims of discrimination or violence, coordinated by the Human Development Council (CDH) and implemented by the State Secretariat for Public Security (SSP), in partnership with the Social Assistance Secretariat (SEAS). The assistance provided relies on the availability of security professionals, social workers and psychologists, in order to provide psychosocial support to older people victims of intra-family violence.

In order to trace the profile of care, the following variables were studied: characterization of victims (gender, age, marital status, race/color, religion, education, economic status and area of residence); characterization of the occurrence (type of violence, bond with the victim and whether at the time of the occurrence the aggressor was using psychoactive drugs); as well as the referrals and assistance provided to the older person in the highlighted institution.

In the comparative statistical analysis, the differences in the characteristics of victims, occurrences and care between the years of analysis 2019 (pre-pandemic) and 2020 (pandemic context) were tested by the chi-square test (χ^2), at the 5% level of significance.

The study was not submitted to the Research Ethics Committee for using secondary data, in the public domain, available on the Amazonas Government Information System (e-SIGA) website. As well as, access to the Official Service Reports was requested from the State Secretariat for Justice, Human Rights and Citizenship (SEJUSC) for scientific production purposes. It is added that the data do not present any information regarding the identification of the assisted cases, in line with the norms and guidelines of Resolution 510/2016 of the National Health Council.

RESULTS

During the period from January 2019 to December 2020, 5,365 cases of intra-family violence involving older people attended at the CIPDI were reported, being 2,385 in 2019 and 2,980 in 2020. There was an increase of 24.9% in cases in 2020, first year of pandemic compared to the previous year. The months with the highest frequency of occurrences in the year 2019 were January (9.5%) and July (11.7%), respectively. However, in 2020, the month of April presented a drop of almost 97% in occurrences compared to the same period of the previous year. Still in 2020, it was found that the care provided to older people victims of intra-family violence doubled between the months of October and December when compared to the same months in 2019 (Figure 1).

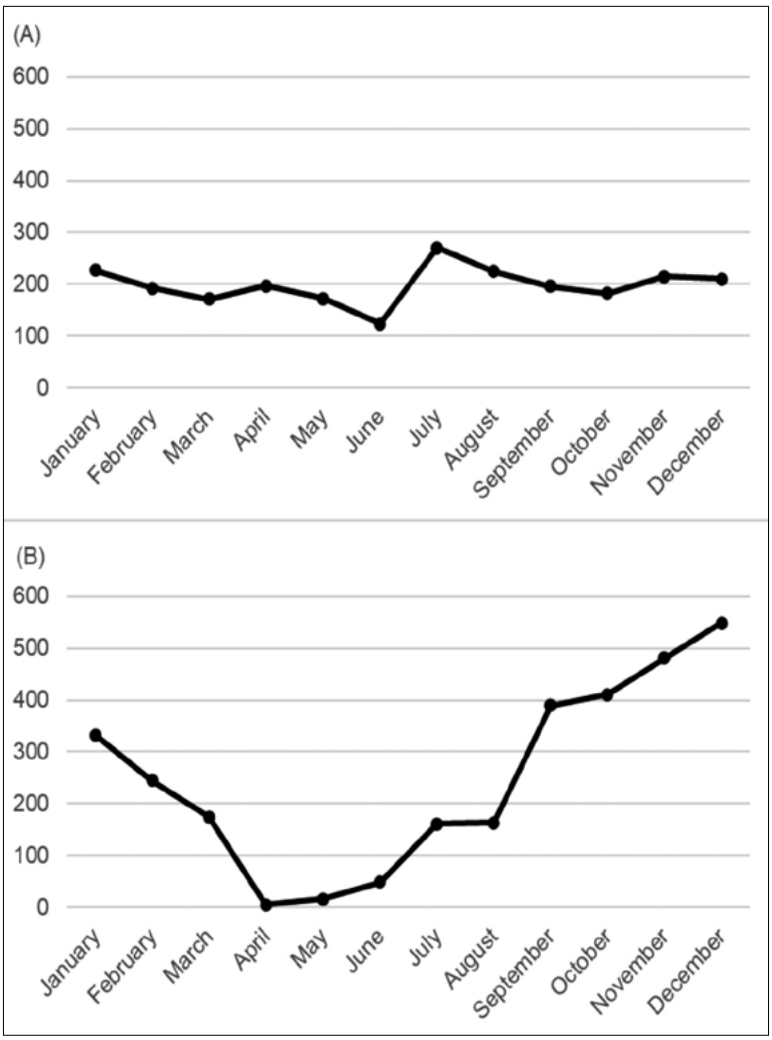
The description of the sociodemographic characteristics of cases of intra-family violence involving older people assisted by the CIPDI, according to the year of care, is presented in Table 1. Considering the set of occurrences, almost 60% of the cases were female. It was observed that in more than 80% of older people affected were under 80 years of age.

Also in Table 1, of the total number of cases of intra-family violence treated, 60% were widowed, married or in a stable relationship, with more than 70% of the cases of mixed race/color. Most older people declared themselves Catholics and in both years of analysis, elementary education (incomplete or complete) predominated among the victims' educational level. Among the assistance provided, more than 50.0% referred to retirees or pensioners. The area of residence of these victims was concentrated between the northern and southern regions of the capital of the state of Amazonas. Regarding the comparative analysis, there was a difference in the characteristics related to marital status, education, economic status and area of residence between the years of (p<0.05).

The characteristics of the occurrences of intra-family violence are presented in Table 2. The main types of violence perpetrated against older people in both years of analysis were intimidation/disruption

and negligence, affecting more than 50% of the cases. However, there was a reduction in registered cases of abuse, financial abuse and verbal threats in the pandemic year. The occurrence of some unidentified violence in 2019, such as verbal and physical aggression, self-neglect, threat of death, abandonment and discrimination, were also identified and confirmed by the statistically significant difference between the years of analysis (p<0.05). In more than 2/3 of the situations of intra-family violence monitored by the center, children were the main aggressors and the use of alcohol and other drugs by the perpetrators during the occurrence showed a slight increase in the year of the pandemic.

Table 3 presents the description of referrals and assistance provided to older people victims of intra-family violence by CIPDI. In the years 2019 and 2020, more than 50% of the consultations required some kind of referral, especially to the Specialized Police Office for Crime Against Older People. In 2020, the first year of the COVID-19 pandemic, there was a 54.2% increase in demand for other external assistance provided by CIPDI, with emphasis on home visits, mediation of conflicts and technical visits. However, it was found that services aimed at psychological assessment had their offer reduced to less than half in 2020, compared to the previous year.



Source: Amazonas Government Information System (e-SIGA).

Figure 1. Cases of intra-family violence against older people assisted by the Integrated Center for the Protection and Defense of the Rights of the Older Person. Manaus, AM, Brazil (A) 2019 – (B) 2020.

Table 1. Description of the sociodemographic characteristics of older people victims of intra-family violence assisted by an Integrated Center for the Protection and Defense of the Rights of the Older Person (N=5,365). Manaus, AM, Brazil, 2019 – 2020.

Variables	Total n (%)	2019 n (%)	2020 n (%)	*p*-value
Sex				
Female	3,159 (58.9)	1,431 (60.0)	1,728 (58.0)	*0.136*
Male	2,206 (41.1)	954 (40.0)	1,252 (42.0)	
Age group (years)				
60 – 70	2,555 (47.6)	1,184 (49.6)	1,371 (46.0)	
71 – 80	1,679 (31.3)	725 (30.4)	954 (32.0)	*0.060*
81- 90	924 (17.2)	388 (16.3)	536 (18.0)	
91 and over	207 (3.9)	88 (3.7)	119 (4.0)	
Marital status				
Widower	1,609 (30.0)	781 (32.7)	828 (27.8)	
Married/stable union	1,610 (30.0)	543 (22.8)	1,067 (35.8)	*<0.01**
Single	966 (18.0)	495 (20.8)	471 (15.8)	
Divorced/separated	1,180 (22.0)	566 (23.7)	614 (20.6)	
Race/color				
Brown	3,809 (71.0)	1,694 (71.0)	2,115 (71.0)	
Not brown	1,551 (28.9)	689 (28.9)	862 (28.9)	*0.980*
No information	5 (0.1)	2 (0.1)	3 (0.1)	
Religion				
Catholic	3,004 (56.0)	1,336 (56.0)	1,668 (56.0)	
Evangelical	1,717 (32.0)	763 (32.0)	954 (32.0)	*1.000*
Others	54 (1.0)	24 (1.0)	30 (1.0)	
No information	590 (11.0)	262 (11.0)	328 (11.0)	
Education				
Illiterate	1,019 (19.0)	453 (19.0)	566 (19.0)	
Literate	898 (16.7)	451 (18.9)	447 (15.0)	*<0.01**
Elementary school incomplete/complete	2,019 (37.7)	887 (37.1)	1,132 (38.0)	
High school incomplete/complete	1,020 (19.0)	453 (19.0)	567 (19.0)	
College incomplete/complete	357 (6.6)	119 (6.9)	238 (8.0)	
Others/ no information	52 (1.0)	22 (0.9)	30 (1.0)	
Economic situation				
Retired	2,447 (45.6)	1,076 (45.1)	1,371 (46.0)	
Pensioners	538 (10.0)	240 (10.1)	298 (10.0)	
BPC	1,166 (21.7)	510 (21.4)	656 (22.0)	
Autonomous	230 (4.3)	111 (4.6)	119 (4.0)	*<0.01**
No income	452 (8.4)	243 (10.2)	209 (7.0)	
Others	474 (8.8)	177 (7.4)	297 (10.0)	
No information	58 (1.1)	28 (1.2)	30 (1.0)	

to be continued

Continuation of Table 1

Variables	Total n (%)	2019 n (%)	2020 n (%)	*p*-value
Residence area				
North	1,253 (23.3)	538 (22.6)	715 (24.0)	
South	1,068 (19.9)	472 (19.8)	596 (20.0)	
East	1,001 (18.7)	465 (19.5)	536 (18.0)	
West	729 (13.6)	342 (14.3)	387 (13.0)	*0.02**
South-Central	614 (11.4)	287 (12.0)	327 (11.0)	
West-Central	470 (8.8)	202 (8.5)	268 (9.0)	
Rural	141 (2.6)	52 (2.2)	89 (3.0)	
Other municipalities	89 (1.7)	27 (1.1)	62 (2.1)	

Pearson's chi-square test; *p-value<0.05; BPC: Continuous Cash Benefit. **Source:** Amazonas Government Information System (e-SIGA).

Table 2. Description of the characteristics of the occurrence of intra-family violence against older people assisted by an Integrated Center for the Protection and Defense of the Rights of the Older Person (N=5,365). Manaus, AM, Brazil, 2019 – 2020.

Variables	2019 n (%)	2020 n (%)	*p*-value
Type of intrafamily violence			
Abandonment	0 (0.0)	15 (0.5)	
Financial abuse	190 (8.0)	117 (3.9)	
Psychological aggression	218 (9.1)	268 (9.0)	
Verbal aggression	0 (0.0)	185 (6.2)	
Physical aggression	0 (0.0)	157 (5.3)	
Death threat	0 (0.0)	142 (4.8)	*<0.01**
Verbal threat	331 (13.9)	200 (6.7)	
Self-neglect	0 (0.0)	77 (2.6)	
Discrimination	0 (0.0)	10 (0.3)	
Intimidation/disturbance	823 (34.5)	989 (33.2)	
Mistreatment	107 (4.5)	74 (2.5)	
Negligence	716 (30.0)	746 (25.0)	
Bond with the victim			
Child	1,584 (66.4)	2,055 (69.0)	*<0.01**
Self	343 (14.4)	341 (11.4)	
Other family members	458 (19.2)	584 (19.6)	
Use of psychoactive substances during the occurrence			
Alcohol	45 (1.9)	62 (2.1)	
Other drugs	23 (0.9)	50 (1.7)	*0.118*
Alcohol and other drugs	76 (3.2)	105 (3.5)	
Not applicable	2,241 (94.0)	2,763 (92.7)	

Pearson's chi-square test; *p-value<0.05. **Source:** Amazonas Government Information System (e-SIGA).

Table 3. Description of care provided to older people victims of intra-family violence attended by an Integrated Center for the Protection and Defense of the Rights of the Older Person (N=5.365). Manaus, AM, Brazil, 2019 – 2020.

Variables	2019 n (%)	2020 n (%)	*p*-value
Referrals			
Casa da Cidadania/DPE	484 (20.3)	387 (13.0)	
Specialized Center/DPE	487 (20.4)	566 (19.0)	*<0.01**
Specialized Police/DECCI	486 (20.4)	596 (20.0)	
Other services	928 (38.9)	1,431 (48.0)	
Other services			
Home visits	155 (16.7)	464 (32.4)	
Conflict Mediation	127 (13.7)	252 (17.6)	
Psychological assessment	59 (6.4)	30 (2.1)	*<0.01**
Technical visits	18 (1.9)	58 (4.1)	
No information	569 (61.3)	627 (43.8)	

Pearson's chi-square test; **p*-value<0.05. DPE: State Public Defender; DECCI: Specialized Precinct for Crime against the Older Person; Source: Amazonas Government Information System (e-SIGA).

DISCUSSION

The present study showed an increase in the number of cases of intrafamily violence against older people in the first year of the COVID-19 pandemic in Manaus compared to 2019. The number of cases decreased dramatically in April and May of 2020, demonstrating the impact of government social isolation decrees on the records and care of these victims. In addition, it was found that the number of CIPDI consultations doubled in the last three months of the year 2020 when compared to the previous year, when the pandemic context had not yet been declared.

Moraes et al.[9] state that in the context of the pandemic, or even outside of it, older people are one of the groups most vulnerable to the problem due to a set of reasons, among which stands out the usual social discrimination regarding aging and insufficiency of public policies to guarantee rights or due to the loss of purchasing power of families in the context of the economic crisis triggered by the pandemic. In addition, many victims of family violence may be currently facing the "worst case scenario", as being stuck at home with a violent aggressor during a period of severely limited contact with the outside world is likely to trigger these actions[11].

The underreporting of cases of violence against older people in this context is a reality, considering the limitation of care given by government decrees on social distancing and the fact that many older people may never have been able to get care for the violence suffered. According to Ricca and Oliveira[12] despite the existence of legal protection for the older person victim of abuse, due to the fact that the aggressors are generally family members, it provides conflicts related to affection, dependence on the older person to report them to human rights and police agencies, directly contributing to the non-reporting of cases of violence against the older person within the family.

In general, the variables that characterized the victims, the occurrences and the assistance analyzed showed significant differences when comparing the pandemic context and the year 2019. The analyzed assistance shows that most violence against older people was perpetrated against women. This data corroborates most of the findings of other national studies, which indicate that older women are doubly fragile, due to the circumstances of aging, as they are generally sicker than men and even have more functional incapacities[13]. With regard to the age group of the older people assisted, it appears that the largest number of records of complaints occurred between 60 and 80 years old, reinforcing the findings of Pampolim et al.[14].

Another highlighted point is the widowed older person, with greater predominance in the CIPDI care. The absence of a partner is identified as a factor potentially associated with situations of neglect in older people[15]. This characteristic corroborates the findings regarding one of the main types of violence perpetrated against older people in this study. Mainly due to dependence on other family members and how these losses can make them fragile to the point of feeling incapable of performing their own self-care.

There was also a low level of education among the older people assisted by the CIPDI. Nóbrega et al.16 reinforce that the fact that the older person is not educated is associated with an increase in the probability of suffering violence and the implications due to low education make it difficult to access information on ways to prevent violence or solve problems. There was a predominance of retired older people or those receiving some type of benefit. A study by Freitas et al.[15] identified that the fixed income of older people was the main motivating factor for abuse. As for the majority of the older people self-declared brown, Souza et al.[17] show that the black and brown older people are the most vulnerable to violence, as there is a social construction of domination-exploitation in relation to blacks, as a result of the slavery heritage, which brings with it prejudice and discrimination.

The place of origin predominates among the older people attended at the center point to the emphasis of the North and South zones, respectively. This finding is due to the fact that the North region is the region with the largest number of inhabitants in the Amazonian capital, and the South region corresponds to the location area of the CIPDI itself.

In Manaus, during 2019 and in the first year of the COVID-19 pandemic, both intimidation/disturbance and negligence were the most frequently recorded among the assistance provided by the defense and protection center. The predominance of neglect/abandonment and intimidation/disturbance as psychological violence reaffirms the findings of Lopes and D'Elboux[18] in a study based on notifications of violence against older people in Campinas, São Paulo, in the last 11 years.

Still in the context of pandemic, the occurrence of more serious domestic violence such as physical aggression and threat of death and not identified in 2019, corroborates with Carmo et al.[19] on the growing trend of mortality from external causes in older people in Brazil and in different Brazilian regions, mainly in the North, Northeast and Midwest regions. According to the Manual for Combating Violence against the Older Person[20], the nature of violence against older people can manifest itself in various ways and all these types of actions or omissions can cause serious physical and emotional injuries and death. The Older People Statute[4] highlights that no older person will be subject to any type of negligence, discrimination, violence, cruelty or oppression, and any violation of their rights, by action or omission, will be punished in accordance with the law.

Regarding the characteristics of the aggressor and kinship with the older person, the results of this study are similar to those of other research[21-23], in revealing that the main aggressor is a family member, highlighting the children of the older person who were the main denounced and were under the influence of alcohol or other drugs at the time of the assault. It is noteworthy that older people often find it difficult to report the aggressor for different reasons, one of which is because they are a family member, the victim constantly insists on defending and justifying the aggressor's attitudes out of fear of harm or that the situation between them may be aggravated by the complaint. Minayo and Souza[5] clarify that the aggressors usually live in the house with the victim, they are children dependent on the older person and the older person dependent on family members. Children or older people who abuse alcohol and drugs belong to families with little affection throughout their lives and are socially isolated.

The assistance directed to older people victims of intra-family violence carried out by the CIPDI showed that in more than 60% of the registered cases they required referrals to other points of the older people protection network, in particular the specialized police for crime against older people, denoting the need for a service network that is articulated and of prompt assistance to the victim. Wanderbroocke[24] states that a safety network cannot be considered

good or bad based only on its size, but that other characteristics must always be taken into account, such as density, composition, dispersion and types of functions performed by its members. It is at the confluence of their characteristics that their capacity to be a source of well-being can be established.

Some external face-to-face care provided by the center showed an increase in 2020, demonstrating the possible impact of the new coronavirus and the need to decree the temporary cancellation of services offered to this population in various sectors and the need to take the care to the homes of older people. Grilo and Lombardi Junior[25] emphasize that prevention and intervention must be carried out together with the older person who have suffered abuse, as in addition to developing strategies to encourage victims to talk about the episodes they have experienced, the assistance provided by these professionals makes it possible to raise their awareness about violence and how this can interfere with aging, which must be safe and dignified.

Despite the limitations found, those inherent in a research with secondary data are pointed out, in which researchers have little control over the data used to prepare the reports that served as the source of information, in addition to the absence of some information that would make it possible to describe in detail the profile of victims, aggressors and the care provided by the center.

CONCLUSION

The results found in this study show that, in the city of Manaus, intra-family violence against older people showed a significant increase after the declaration by the World Health Organization of a pandemic caused by the new coronavirus. The differences identified in the profile of the older people assisted reinforce the extent to which the state decrees to guarantee social distance and control the spread of the disease had an impact on the record of occurrences of this type of violence, demanding the intensification of home and technical visits. In addition, the number of occurrences of these types of violence may have been much higher than officially recorded, resulting in underreporting of cases due to the difficulty in accessing the services offered by the integrated center during this period.

Knowing the profile of older people victims of intra-family violence assisted by the CIPDI, the occurrences and possible aggressors can contribute to future studies in this area, in addition to supporting the planning of actions at the center itself and other public policies for the protection of older people in the capital of Amazonas given the observation of the demographic transition that occurs in all states of Brazil and the importance of offering these services as the main way to intervene in the cycle of violence.

Thus, it is concluded that it is essential to provide older people with a comprehensive service network capable of ensuring the entire population, the basic rights, such as: health, transport, leisure, absence of violence both in the family space and in the public space. The pandemic scenario made older people population more vulnerable and exposed to intra-family violence and limited them in terms of constitutional rights. In this context, the Integrated Center for the Protection and Defense of the Rights of the Older Person through the services offered is characterized as a public policy necessary for access to the system of guarantees of rights that aim at more than preventing, confronting and enforcing the rights of the Older Person. It is hoped that this work will encourage the realization of new studies, dedicated to exploring other possibilities for analyzing the theme.

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The challenges of the protection network and coping with violence against older people in Manaus, Amazonas, Brazil

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Abstract

Objective: To know the protection network, its challenges and elements that interfere in the protection, coping and care of the older person, victim of violence in the city of Manaus, AM, Brazil. *Method:* This is a descriptive study structured from a qualitative research using field research. Sixteen professionals were interviewed who are in charge of the main institutions that are part of the Protection Network in Confronting Violence against Older People in the city of Manaus from 07/29 to 11/21/2020. *Results:* despite being extensive and active, the network does not have the necessary articulation to meet and monitor the demands of older people in a satisfactory way. There is also no established service flow, nor is there any monitoring of cases of violence against older people in the city. *Conclusion:* Integration and articulation between the different institutions is necessary, since the multidisciplinary approach and work from an intersectoral and articulated perspective can result in potentiality in confronting violence against older people in the city of Manaus.

Keywords: Health Policy. Elderly abuse. Social Protection in Health.

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INTRODUCTION

In 2005, the National Council for the Rights of the Older Person convened the 1st National Conference on the Rights of the Older Person, with the theme Building the National Network for the Protection and Defense of the Older Person (RENADI). This Conference had as its central objective to define the strategies for the implementation of RENADI[1]. Thus the Network for the Protection and Confrontation of Violence against the Older Person was born, which, little by little, was consolidated and strengthened in all Brazilian states and municipalities. In the city of Manaus it was no different and the city has numerous institutions dedicated to the protection and promotion of the rights of the older person, and that seek to put into practice the legal statutes and implement public policies in this segment.

In 2011, the network took on another important role: according to Law No. 12.461/11, which reformulated Article No. 19 of the Statute of the Older Person - EI (Law No. 10.741/03)[2], it became mandatory that the protection network was notified in cases of suspected or confirmed violence against older people. However, despite the performance of this network, the numbers of reports of violations against older people continue at high levels.

According to the reports of the Department of Intelligence of the State Secretariat for Public Security of Amazonas, in the historical series from 2012 to 2019, there was a substantial increase in the number of reports of violations against older people made in police stations in the city of Manaus. In 2012, this amount was 6,840 occurrences, increasing in 2019 to 16,697, which corresponded to an increase of more than 140% for the period[3]. When comparing the number of complaints made on the Human Rights Hotline - Dial 100 - with the number of older people in each Brazilian state, it appears that Amazonas and the Federal District took turns, over the last eight years between the first and second in the *ranking* of the most violent states against older people in the country. While the national average is 166.09 complaints per 100,000 inhabitants for the period, the Federal District has an average of 418.87 and the state of Amazonas of 418.48[3,4].

Given these findings, it is questioned whether there is a link between the network so that the demands of older people in situations of violence receive adequate treatment and prompt responses; if there is a flow of care for the older person in case of violence to be followed by the network and how is the monitoring of these demands in the city of Manaus.

The objective of the article is to know the protection network in coping with violence, its challenges and elements that interfere in the protection, coping and care of older people, victims of violence in the city of Manaus, AM, Brazil.

METHOD

It is a descriptive study structured from a qualitative research, according to the guidelines of Richardson[5] and Minayo[6]. It started with the guiding question: *what are the challenges and elements that interfere in the protection, confrontation and care of the older person, victim of violence in the city of Manaus/Am, in the view of the protection network managers?* The method used was a field research, with the use of semi-structured interviews with sixteen managers of the main institutions that are part of the protection network in combating violence against older people in the city of Manaus. Such institutions were mapped and indicated by the State Council for the Older Person (CEI), based on their roles and purposes established in the institutional discourse. All managers or immediate substitutes who had been working for at least two years in front of the institutions took part in the study.

Data collection took place through semi-structured interviews, with open and closed questions about the investigated topic. Such interviews were conducted in face-to-face meetings and remotely, using the tools "Google Meet" and "Zoom", in the period from July 29 to November 21, 2020. For data analysis, the technique called content analysis was used, following the guidelines of Bardin[7].

As this research involves human beings, the project was submitted to the Research Ethics Council of the State University of Amazonas (CEP/UEA), and

approved according to CAAE 29766320.0.0000.5016 and Opinion 4.016.698/2020.

RESULTS AND DISCUSSION

Initially, 25 institutions were selected, of which 16 agreed to participate in the interviews. Respondents were between 31 and 59 years of age; nine of them were female and seven were male, working in institutions for periods ranging from two to nine years. In the following sections, results of interviews with 16 network managers are presented, in an attempt to understand the challenges and elements that interfere in the protection, coping and care of older people, victims of violence.

Characterization of the main institutions that make up the formal protection network in the city of Manaus, Amazonas

The managing institution of the Older Person Policy in the state of Amazonas is the State Secretariat for Justice, Human Rights and Citizenship (SEJUSC), which has a reference center called the Integrated Center for the Protection and Defense of the Rights of the Older Person (CIPDI), whose proposal is to work prevention and awareness policies on the different types of violence against older people. Psychosocial assistance is provided, as well as the reception of complaints, home visits and referrals for measures to protect and guarantee rights.

The municipal older people policy manager is the Dr. Thomas Older People Support Foundation (FDT). With over 100 years of existence, the FDT has the mission of coordinating and evaluating the implementation of the Municipal Policy for the Older Person through various programs. The *Longa Permanência* Program provides assistance on an asylum basis to older people at social risk, noting that the FDT is the only long-stay institution for older people in the three levels of dependency in the state of Amazonas. The *Conviver* Program, which runs on the premises of Parque Municipal do Idoso (PMI), and benefits older people with physical, labor, recreational, cultural and education activities for citizenship. The Foundation also conducts home visits through the Home Care Program for the Older Person (PADI) when requested through *Disque Idoso* 165.

The Open University for the Older Person Foundation (FUNATI) is also part of the protection network for the older person, in Manaus. It has legal personality under public law, management autonomy and, as axes of action, teaching, research, extension and assistance activities. Among its attributions are those of producing and socializing knowledge and technologies through its axes of action.

Another institution with extremely relevant services for the older person in Manaus, especially when dealing with cases of violence, is the State Secretariat for Public Security (SSP/AM). The population has 30 Integrated Civil Police Districts (DIPs), located in various neighborhoods, to register police reports, file complaints or even receive guidance on specific cases and violence. In addition to the DIPs, the older person can count on the Specialized Police in Crimes against Older People (DECCI), located in the Parque Dez de Novembro neighborhood, in the central-south zone of Manaus.

The state and municipal health secretariats are also part of the protection network, through their entire service network: hospitals, Basic Health Units (UBS), Emergency Care Unit (UPA) and Centers for Comprehensive Care for the Older Person (CAIMI), located in the north, west and south zones and which function as medium-complexity polyclinics, with multi-professional teams. In Manaus, there are currently three centers that are located in the north, west and central-south zone.

The Social Assistance Reference Centers (CRAS), the Specialized Reference Centers for Social Assistance (CREAS), the State Older People Coexistence Center (CECI) and the State Family Coexistence Centers (CECF) are also part of the network and are under the management of the Municipal and State Secretariats for Social Assistance. CRAS and CREAS are the main units of the National Social Assistance Policy (PNAS), but each has its own competencies and specificities. The CRAS are intended for Basic Social Protection, aimed at preventing the occurrence of situations of social

vulnerability and risk, while the CREAS are intended for Special Social Protection of Medium Complexity and aim at social work with families and individuals at personal and social risk for violation of rights.

The State Family Coexistence Centers (CECF) and the Older People Coexistence Center (CECI) are also part of the protection network in combating violence against older people. There are seven spaces that offer basic social protection for families, with a range of activities aimed at promoting health, well-being, as well as contact with various artistic and cultural manifestations.

The Older People Rights Councils (CDIs) are also part of the protection network in combating violence against the segment. They are formed by a collegiate of representatives of the public power and civil society. It is a space created especially to deliberate and define guidelines for social policies aimed at the older people segment, overseeing services and assistance provided by public and private entities. The Municipal Council for Older People (CMI) acts within the city of Manaus, and the State Council for Older People of Amazonas (CEI/AM) in the State.

The older person's awareness of their role as citizens makes them fight for their rights and seek effective access to justice. In this sense, two more institutions for the protection of the older person come into play: the Public Defender's Office and the Public Ministry. For Ribeiro[8], Brazil has a justice system for the defense of the older person that is still deficient. There are few or even non-existent courts, prosecutors, defenders and police stations specializing in older people in the various Federation Units. The city of Manaus has DECCI, in addition to the State Public Defender (DPE/AM) and the Public Ministry of Amazonas (MPAM).

Within the scope of the DPE, there is the Specialized Nucleus for the Defense of the Older Person, with a team of professionals focused on legal assistance to needy people in matters related to the condition of the older person, especially the rights guaranteed in the Older People Statute (EI)[2]. In a complaint for abuse or abandonment, the hearing is held, the legal status of the older person is explained to the aggressor, that is, about the rights provided for in the Older People Statute, and, finally, an agreement is sought between the parties involved.

The MPAM, on the other hand, is an independent institution equipped with constitutional guarantees, essential to the jurisdictional function of the State, responsible for defending the legal order, the democratic regime and social, individual and collective interests. When any entity commits an infraction that jeopardizes the rights guaranteed by the National Policy for the Older Person - PNI (Law 8.842/94)[9], It is responsible for taking the appropriate measures as well as promoting, without the need for legal proceedings, the suspension of activities or the dissolution of the entity, with the prohibition of serving older people in the public interest. Another important intervention available to the PM, but still little used, according to Couto[10], is the civil liability of the State for non-compliance with the law. In the state of Amazonas, we currently have two Public Prosecutors for older people, the 42nd and 56th Public Prosecutors for the Defense of Human Rights of the Older Person.

Both the DPE and the MPAM are instruments of citizenship available to the older population in the state of Amazonas, considering that access to justice involves much more than the mere judicialization of demands. It involves, above all, the empowerment of older people about their rights and their co-responsibility for the peaceful search for the solution of their private, public and social disputes.

To summarize the main institutions in combating and confronting violence against older people in the city of Manaus, they are listed in the chart below.

Chart 1. Main institutions that are part of the Protection Network against Violence against Older People in Manaus and Amazonas.

Seq	Institution Name	Qty	Participant of this study
1	State Department of Justice, Human Rights and Citizenship	1	
2	Integrated Center for the Protection and Defense of the Rights of the Older Person	1	X
3	Dr. Thomas Older People Support Foundation	1	X
4	Home Care Program for the Older Person	1	X
5	Municipal Park for the Older Person - (PMI)	1	X
6	Open University for the Older Person Foundation	1	
7	State Secretariat for Public Security	1	X
8	Special Police of Crimes against Older People	1	X
9	Hospitals	7	X*
10	Basic Health Units	12	X*
11	Emergency Care Units	6	X*
12	Centers for Comprehensive Care for Older People	1	
13	Social Assistance Reference Center	11	
14	Specialized Social Assistance Reference Centers	1	
15	State Coexistence Centers for Older People	2	
16	State Family Coexistence Centers	5	
17	State Council for the Older Person	1	X
18	Municipal Council for the Older Person	1	X
19	State Public Defender's Office	1	X
20	State Public Ministry	1	X

*Two managers from different institutions participated; Source: Prepared by the author based on research carried out.

Although there is no consolidated information on the quantity of the network in other Brazilian capitals, it is noted that in Manaus, there are several institutions that make up the protection network, not only in the fight against violence, but that seek in various ways to protect the rights of the older person in the most diverse areas. In this research we characterize only the deemed as main, selected by the CEI, based on their roles and purposes established in the institutional discourse.

The lack of articulation in the protection network

All 16 managers interviewed were unanimous in stating that the protection network in combating violence against olde people in Manaus does not have the necessary articulation so that the demands of the older person receive adequate treatment and prompt responses. For them, the demands are streamlined through personal contacts and that the articulation needs to be strengthened, as we see below:

> "[...] this interaction, that is, I know my mission and the role of the other. So I need the other's function to complement mine. This is not happening". (Public Ministry).

> "I believe that there is no articulation in the network. We need interconnection to be able to function. There is no interconnection even in the sectors of a single network. In health, I don't see interconnection between BHU/CAIMI/Social Centers, for example". (State Health Network).

> "We have a network with several bodies, to fight violence, but it does need an articulation in which the role of each body within this protection network is actually established". (Municipal Health Network).

> "When you establish personal contact, then the situation of that older person, it flows faster [...] but the articulation needs to be strengthened because violence can require different types of service". (State Council for the Older Person).

The National Policy for the Older Person (PNI) establishes as a competence of the public power to develop forms of cooperation between institutions, since, despite the personal and primary network of the older person being fundamental for care, it needs to be articulated with the secondary services network, which, incidentally, need to function as a shared network of responsibilities. In this sense, the efficient articulation of the protection network and its actors is imperative. Isolated, disconnected and discontinuous actions get lost in the universe of bureaucracies of public bodies, most of the time[11].

Ribeiro and Silva[12] argue that violence, as a multifactorial phenomenon, requires multidisciplinary and interdisciplinary approaches, "one or two professional categories are not expected to deal with such complex situations". For Vasconcelos[13], hardly a single professional would handle all the aspects of such a complex reality. Cezar and Arpini14 point out that technical manuals, ordinances and laws are necessary for the care, protection and prevention of violence. However, for them to be really effective, they need to be operationalized in the daily action of the protection network services, where everyone has the duty to care for and protect the older person, especially in a context of violence.

The flow of care for older people in situations of violence, carried out by the protection network

For the 16 managers interviewed, there is no service flow outlined and followed by the network in Manaus. Their knowledge is restricted to the service flow of the institution to which they are linked.

> "There is no defined flow, and worse: there is not much information for the older person and for the family where they can look in case they are a victim of violence [...] we have already tried to work the flow of care, this is a struggle, we've already tried to put it into law, but so far we haven't. " (State Council for the Older Person).

> "We don't have [a flow] and it's absurdly confusing [...] absolutely confusing, it doesn't make sense and this I've noticed since I came here [...] so it's from scratch. We have to start from scratch [...]". (Public Ministry).

> "[...] There is no delimited flow. First they go to a health unit. Then another... and another.... There is no such design [...] I am not aware if there is any flow [...] none of the institutions I work in have this flow. In the last five years I was the coordinator of the ICU at Platão Araújo [...] I'm completely unaware of it; I was never informed about it [...]". (State Health Network).

> "I can only talk about FDT's own flow". (Doctor Thomas Foundation).

It is clear to the network that there is no flow of care for older people in the city of Manaus. The flowchart is one of the tools used in organizational analysis that graphically represents the sequence of an activity. Its importance is noticed, especially when used to analyze organizational processes with a view to their improvement. Through it, the processes that involve a service are mapped, allowing a precise and clear description of the sequencing of the entire service. For Peinado and Graemil[15], the tool can make an impactful contribution to the management of any process and/or project, involving any area of expertise. According to Baltzan[16], the flowchart is a fundamental tool for both planning and improving any process, enabling critical analysis and pointing to possible changes and adjustments. A well-designed flow can help identify unnecessary steps, bottlenecks and other inefficiencies[17].

Therefore, it is relevant that the protection network in the fight against violence against older people in Manaus has well-defined activity flows, free from shadowing, rework and attribution conflicts. Whenever possible, it should also be simplified and absolutely clear for everyone involved, but especially for the older people in situations of violence, who, in many circumstances, do not know who to turn to. It should be noted, however, the challenges that the network has in the development of this flowchart of care, since there are several institutions that make it up, from various spheres of government, with

different structures, with disparate organizational cultures and often opposing interests.

However, coping with violence is an extremely complex task and requires fruitful designed and elaborated actions, with the need for managers to use the most diverse management tools available and thus adopt appropriate protocols and care flows[18]. Isolated and disjointed actions, even if very well intentioned, are unfortunately not able to mitigate such an enigmatic and sometimes abstruse problem, which is violence against older people.

Monitoring cases of violence involving older people in Manaus

The survey showed that the network managers were also unanimous in stating that they do not know or that there is no follow-up of cases of violence against older people in the city, as shown in the fragments below:

> "I couldn't tell. I think not. I've never heard of follow-up". (State Council for Older People).

> "The Public Defender Assistant to Older People would not be able to say about this follow-up. He believes there is none". (Public Defender's Office).

> "I can't tell you." (Public Ministry)

> "Honey, it doesn't exist. For example, psychological intervention. In Platão Araújo, we don't have a psychologist [...] so, there isn't. In relation to abusers, these things, there's not, either, do you understand? I don't know of any follow-up". (State Health Network).

> "[...] after that [the service] I think there is no more follow-up. Also in relation to the abusers, only the police station can tell you". (Municipal Health Network).

Carrying out follow-up on cases of violence against older people is a necessary and complex mission at the same time, especially due to the place where they usually occur and the actors involved. However, in Manaus, according to the results of the present study, this does not occur. In addition to high demand, there are not enough professionals or a unified information system that can gather data, generate reports with information that has visibility to network managers.

According to Brito[19], the family is the *locus* in which the largest number of violence against older people is concentrated and this is practiced by the older person's own family. This is an extremely delicate situation, requiring even more in-depth studies.

For Abath et al.[20], it is the weakened relationships and previous family history of violence that favored the emergence of aggression. The authors conclude that "families unprepared to understand, manage and tolerate their own conflicts tend to be violent", and add "the quality of the relationship between them and the older person depends on beliefs, values and conceptions about old age and care".

On the other hand, Brazilian culture, supported by the Older People Statute, imposes an obligation on the family to be responsible for the care of older members[2]. Thus, it is predictable that neglect and abandonment are attributed to relatives. In most families with problems of violence, members do not have a pro-social interpersonal repertoire to deal with difficulties and even the reduced physical space of the houses can generate strain and conflicts. As a result of the lack of skills to live with these difficulties, situations of neglect, abandonment or physical and psychological aggression occur[6].

Studies show that many of the abusers, in addition to having a history of violence in the family, have loose affective family ties, were victims of abandonment, neglect and sexual abuse in childhood. Sometimes the aggressor can unload feelings of ambivalence, hurt and anger on the older person, placing the older person in a situation where he once was and perhaps still is[21-23]. Allied to this fact, Neri[24] points out that the older person can also contribute to the occurrence of violence, due to the demands they make, impatience and even a possible process of dementia or mental illness that is not understood by family members. In this sense, what is sought is to draw attention to the complex sphere and nuances of family relationships, its multifaceted character, its dynamics and, therefore, its possible consequences in cases of intrafamily violence. Such questions lead us to a reflection on the need to change the way

society fosters the aggressor. There must be a broader vision, devoid of prejudices and stereotypes, a more empathetic and welcoming society.

Hence the rapid demand for follow-up and interventions, both in relation to the older person and possible aggressors. Its effects could certainly result in a reduction in the number of recurrences of violence against older people in the city of Manaus.

It should be noted that the COVID-19 pandemic was considered an obstacle to conducting the interviews, which constituted a research limitation. Some institutions were not active due to social isolation and others claimed to be primarily focused on care related to the pandemic. Another limitation was having encountered resistance from managers, since some of them held commissioned public positions and did not feel comfortable addressing issues that could denote some gap or weakness in their professional practice.

FINAL CONSIDERATIONS

Despite not having the necessary articulation to meet and monitor the demands of older people, with no follow-up, nor defined service flows, the protection network in combating violence against the older person in the city of Manaus is extensive and active. It is up to the public authorities to develop forms of cooperation between institutions, since the older person's personal and primary network is fundamental for care, but it needs to be articulated with the secondary network of services and function as a shared network of responsibilities.

Therefore, there is a need for integration and articulation between the different institutions: an active, intersectoral, welcoming network that dialogues, supports and knows the importance of both its work and the other components of the protection network. The multidisciplinary approach and work from an intersectorial and articulated perspective can result in potentiality in confronting violence against older people in the city of Manaus. Therefore, professionals, institutions and managers need to understand the importance of this networking based on their performance as a multidisciplinary and interdisciplinary team, that is, different areas dialoguing with their common knowledge and objectives.

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Epidemiological profile of reports of violence against older adults in Rio Grande do Norte, Brazil (2018-2019)

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Abstract

Objective: to characterize the reports of violence against older people made via the Dial 100 service in the state of Rio Grande do Norte (RN), Brazil, between December 2018 and November 2019. *Methods*: a cross-sectional study involving a descriptive analysis of data contained in excerpts from reports of violence made via the Dial 100 service was conducted and an exploratory spatial analysis carried out. The cities of residence of the victims, types of violence, place of occurrence and referrals to the Network for Securing Rights were analyzed, along with age, sex and race/color of both victims and suspected perpetrators, besides the relationship between them. *Results*: In total, 878 reports of violence against 1,014 older people were registered, the majority in the city of Natal-RN (46.9%). The most prevalent complaints were neglect (77%), psychological violence (44.9%) and financial abuse (19%). Acts of violence were perpetrated predominantly in victims' homes (95.3%) and affected mainly women (66.9%). Most suspected perpetrators were children of the victim (62.1%) and female (49.3%). *Conclusion*: The results suggest a weakness in the family support/nucleus and the need for state assistance to deliver care in this context. In addition, the fact that the main forms of violence do not always leave physical evidence highlights the role of the population in helping to identify violence against the older population. Finally, the results suggest a lack of awareness about the Dial 100 service among residents in the interior of the state, pointing to the need for greater dissemination of the channels for denouncing violence against this group, allowing a more accurate analysis of the problem in the state and more effective actions to tackle the issue.

Keywords: Aged. Violence. Elder Abuse.

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INTRODUCTION

Ageing is part of the human life course and varies from person to person according to associated biological and social contexts. Typically, this phase is characterized by a decline in social relationships and a great role in the life of older adults by the family. Although protected by law, the elderly are more vulnerable in terms of health care needs and due to limitations imposed by the aging process, often becoming the victims of violence[1]. According to the Statute for the Elderly, article 19, §1, Chapter IV, "violence against the elderly constitutes any action or omission practiced in a public or private place which may cause death, harm, physical or psychologic suffering"[2]. This is a problem found in all societies that affects different cultures, irrespective of socioeconomic status, race or religion[3].

Violence against older adults can manifest in different forms, namely: (1) physical, involving the use of physical force with intent to hurt, cause pain, disability or death; (2) psychological, including verbal or gestural aggression and humiliation; (3) sexual, including sexual arousal of the suspected perpetrator, sexual intercourse or erotic practices without the victim´s consent; (4) abandonment, which involves omission of governmental, institutional entities or family members responsible for the provision of the necessary services of care or protection; (5) neglect, defined as refusal or omission in the provision of the necessary care by institutions or family members responsible; (6) financial, involving the improper exploitation of older individuals or use of their financial resources and assets; (7) self-neglect, characterized as the behavior of older individuals which threatens their own personal health or safety, due to a refusal to care for oneself [4].

In this respect, it is often difficult to identify acts of violence perpetrated against older people, given that not all acts of aggression targeting these individuals leave physical evidence[5]. Besides physical injuries, older adults subjected to violent acts may experience moral and psychoemotional trauma. Violence against older adults can result in dependence and disability, and in some cases, death[6]. According to a meta-analysis of 52 studies published between 2002 and 2015, an estimated 1 in 6 older individuals are victims of aggression worldwide[7].

In view of the magnitude of this problem posing society, in 2010, the Secretariat of Human Rights of the Presidency of the Republic of Brazil, the body overseeing the National Policy on the Elderly, set up the Dial 100 service with a specific module for reporting acts of violence acts against older individuals, the "Elderly Module of Dial Human Rights".

A nationwide study in Brazil identified a total of 233,383 reports of violence against older persons via the Dial 100 service between 2011 and 2018[9]. In addition, the Northeast region of Brazil ranked the 2nd highest in number of cases of violence reported against older individuals[8]. Also according to data from the Dial 100 service, Rio Grande do Norte was ranked the 3rd highest state, between 2011 and 2015, in number of acts of violence reported against older individuals per 100,000 population[10].

A significant amount of information characterizing the victims and suspected perpetrators of violence is lost, highlighting the need for future studies to elucidate the dynamic of the problem of violence against older adults. This information can help inform political strategies for promoting health, early identification of infractions, tackle violence against this group and provide victims and family members with follow-up support. Although nationwide studies have quantified reports of violence against older people in Rio Grande do Norte state, no investigations characterizing the most common types of violence or mapping the profile of victims and perpetrators of violence have been carried out in the state. Thus, the objective of the present study was to characterize reports of violence against older people made via the Dial 100 service in cities of Rio Grande do Norte state, Brazil.

METHODS

A cross-sectional descriptive epidemiological study involving analysis of excerpts of reported acts of violence against older people was performed. These reports of violence were collected via the Dial 100 service, having been received by the Ministry of

Women, Family and Human Rights and submitted to the State Board of Rights for Older Persons (CEDEPI/RN). The study period spanned from December 2018 to November 2019, corresponding to the time interval for which data was available from the CEDEPI-RN. All reports of violence against individuals aged ≥60 years received during the study period were included in the analysis. The project was approved by the Research Ethics Committee for Human Research (CEP) of the University Teaching Hospital Onofre Lopes, part of the Federal University of Rio Grande do Norte (permit nº 3.898.143). Given the study was based solely on secondary data, the need for a Free and Informed Consent Form was waived. However, a Granting of Permission Form was signed by the CEDEPI/RN authorizing the use of the data from the reports for analysis and disclosure.

The Dial 100 service is for use by the public to communicate with the Government National Human Rights Ombudsman – which seeks to provide conflict resolution in cases of suspected rights violations and operates a 24/7 free-phone service, with reports screened and referred to the relevant bodies[11].

The geographic area of interest of the study was Rio Grande do Norte (RN), a Brazilian state which has a total of 167 cities and an elderly population of 342,890, representing 9.7% of the total population of the state. Of this group, 55.9% were female and 44.1% male, according the latest census[12]. The state has a HDI of 0.684, ranking 16th among Brazil´s states[13].

Observational investigations were conducted in spectator fashion with no interference on the part of the researchers. After data collection from excerpts of reports of violence made to the Dial 100 service, referred to the CEDEPI/RN via a report, the authors produced a database containing all the variables analyzed according to the sociodemographic profile of the victims and characterization of the violence suffered. For this phase of the study, 2 researchers were trained to standardize the reports recording the type of violence reported, in an effort to minimize observer bias.

The variables covered in the study encompass those related to the acts of violence reported: the cities where acts of violence occurred, the referrals to the Network for Securing Rights, types of violence perpetrated (physical, psychological, sexual, financial, abandonment, neglect and self-neglect), in addition to the location where the violent acts took place. The description of the profile of the victims of violence included the number of victims per report, victim age, gender and race. The description of the suspected perpetrators included number of suspects, age, gender, race/color and relationship between victim and perpetrator.

Regarding the data gathered, the reports of violence against the older individual often involved concomitant types of aggression where, in some cases, the same individual may have been subjected to several acts of violence registered in a single report of violence. Similarly, a large proportion of the reports were referred to more than one body of the Network for Securing Rights.

A descriptive analysis of the data collected was performed. Results were expressed as absolute frequency (n) and relative frequency (%), with a 95% confidence interval (95%CI) for categorical variables, and as mean and standard deviation for quantitative variables. The data lost due to failure to complete the report excerpt were also described, in order to keep the same sample number of reports for all the variables analyzed. Subsequently, an exploratory spatial analysis was carried out to identify the distribution of the reports of violence against older people in the state of Rio Grande do Norte.

RESULTS

In the state of Rio Grande do Norte, between December 2018 and November 2019, a total of 878 acts of violence were reported on the Dial 100 service against 1,014 individuals aged ≥60 years, where Natal was the city registering the highest number of victims (n=411; 46.9%; 95%CI: 43.8–50.0), followed by Mossoró (n=69; 8.0%; 6.3–9.7) and Parnamirim (n=64.7.3%; 5.7–8.9). The distribution of reports by city in the state is depicted in Figure 1.

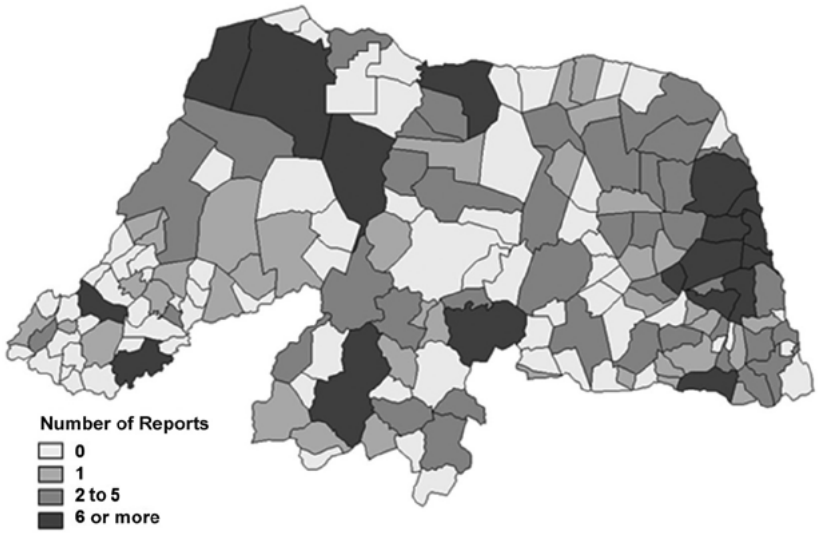

Figure 1. Spatial distribution of number of reports of violence against older persons made via the Dial 100 service in the state of Rio Grande do Norte, between December 2018 and November 2019.

Regarding types of violence reported, neglect situations predominated (n=781; 77%; 95%CI=74.4–79.6), followed by psychological violence (n=506; 49.9%; 95%CI=46.8–53.0), financial abuse (n=455; 44.9%; 95%CI=41.8–48.0) and physical violence (n=193; 19%; 95%CI= 16.6–21.4), respectively, where these occurred alone or concomitantly (see Table 1). Abandonment (n=17; 1.7%; 95%CI=0.9–2.5) and/or self-neglect (n=11; 1.1%; 95%CI=0.5–1.7) accounted for only a small proportion of cases. There were no cases of sexual violence reported during the period studied. In addition, some of the reports showed that victims were socially vulnerable (n=46; 4.3%; 95%CI: 3.1–5.5).

Table 1. Characteristics of type of violence against older persons made via the Dial 100 service between December 2018 and November 2019 in the state of Rio Grande do Norte.

Variable	Category	n (%)	CI (95%)
Neglect	Yes	781 (77)	74.4 – 79.6
	No	233 (23)	20.4 – 25.6
Psychological violence	Yes	506 (49.9)	46.8 – 53.0
	No	508 (50.1)	47 – 53.2
Financial violence	Yes	455 (44.9)	41.8 – 48.0
	No	558 (55.1)	52.0 – 58.2
Physical violence	Yes	193 (19)	16.6 – 21.4
	No	823 (81)	78.6 – 83.4
Abandonment	Yes	17 (1.7)	0.9 – 2.5
	No	983 (98.3)	97.5 – 99.1
Self-neglect	Yes	11 (1.1)	0.5 – 1.7
	No	989 (98.9)	98.3 – 99.5
Sexual violence	Yes	0 (0)	0.0 – 0.0
	No	(0) 100	100.0 – 100.0
Social vulnerability	Yes	46 (4.3)	3.1 – 5.5
	No	1024 (95.7)	94.5 – 96.9

Information on the profile of victims and suspected perpetrators, together with the place where acts of violence occurred, are given in Table 2. Regarding profile of victims, mean age was 76.9±9.3 years (range 60 -105 years), and most victims were women (n=79; 66.9%; 95%CI: 28.8–34.5). For race of the individuals subjected to violence, most were declared white by those lodging the complaint (n= 384; 37.9%; 95%CI: 34.9–40.9), followed by brown (n=345; 34%; 95%CI: 31.1-36.9) and black. The main place where violence occurred was at the victims´ home (n=837; 95.3%; 95%CI=94.0–96.6).

With regard to the characteristics of the suspected perpetrators, there was a prevalence of females (n=707; 49.3%; 95%CI: 46.2–52.4). For race/color of suspected perpetrators, most were reported as brown (n=435; 30.3%; 27.5-33.1) and white (n=403; 28.1%; 95%CI: 25.3–30.9), followed by black (n=96; 6.7%; 95%CI: 5.1–8.3). Moreover, the victims´ children were the suspected perpetrators in most cases (n=891; 62.1%; 95%CI: 59.1–65.1), followed by grandchildren (n=128; 8.9%; 95%CI: 7.2–10.6) and sons- or daughters-in-law (n=72; 5%; 95%CI: 3,7–6,3).

Table 2. Characteristics of place, victim and suspected perpetrator of violence against older persons made via the Dial 100 service between December 2018 and November 2019 in the state of Rio Grande do Norte.

Variables	N (%)	CI (95%)
Place of occurrence		
Home	837 (95.3)	94.0 – 96.6
Street	19 (2.2)	1.3 – 3.1
Others	18 (2.0)	1.1 – 2.9
Not informed	4 (0.5)	0.1 – 0.9
Gender of victim		
Male	321 (31.7)	28.8 – 34.5
Female	679 (66.9)	64.0 – 69.8
Not informed	14(1.4)	0.7 – 2.1
Race of victim		
White	384 (37.9)	34.9 – 40.9
Brown	345 (34.0)	31.1 – 36.9
Black	81 (8.0)	6.3 – 9.7
Others	11 (1.1)	0.46 – 1.74
Not informed	193 (19.0)	16.6 – 21.4
Gender of suspect		
Male	609 (42.4)	39.4 – 45.4
Female	707 (49.3)	46.2 – 52.4
Not informed	119 (8.3)	6.6 - 10.0
Race of suspect		
White	403 (28.1)	25.3 – 30.9
Brown	435 (30.3)	27.5 – 33.1
Black	96 (6.7)	5.2 – 8.2
Yellow	6 (0.4)	0 – 0.7
Not informed	495 (34.5)	31.6 – 37.4
Relationship		
Son	891 (62.1)	59.1 – 65.1
Grandchild	128 (8.9)	7.2 – 10.6
Son/Daughter-in-law	72 (5.0)	3.7 – 6.3
Others	274 (19.1)	16.7 – 21.5
Not informed	70 (4.9)	3.6 – 6.2

Of the reports registered via the Dial 100 service, 1,640 were referred to the entities of the Network for Securing Rights, predominantly to the Marcos Dionísio Referral Center for Human Rights of the Federal University of Rio Grande do Norte (CRDH/UFRN) (n=394; 44.9%; 95%CI: 41.6–48.2), overseen by the Department of Women´s Rights and Minorities (CODIMM) of the Department of Public Security and Social Defense of Rio Grande do Norte (SESED) (n=221; 25.2%; 95%CI: 22.3-28.1) and of the State Prosecutor for Defense of Disabled and Older persons of the city of Natal, RN state (26th PmJ) (n=21; 2.1%; 95%CI: 1.2–3.0).

In 14.7% (n=129; 95%CI: 12.4-17.0) of cases reported, the individual reporting the incident had contacted the Dial 100 service on more than 1 occasion, where 97 (75.2%; 95%CI: 72.9–78.5) had called twice, and the greatest number of calls made by the same individual was 52. A large number of incidents involved more than one suspected perpetrator (37.2%; n=327; 95%CI: 34.0–40.3), with one case involving up to 9 suspects. Also, a relatively large proportion of reports involved more than one victim (13.8%; n=120; 95%CI: 11.5–16.1).

Table 3. Characteristics of reports of violence against older persons made via the Dial 100 service between December 2018 and November 2019 in the state of Rio Grande do Norte.

Variables	n (%)	CI (95%)
Referrals		
CRDH/UFRN*	394 (44.9%)	41.6 – 48.2
CODIMM**	221 (25.2%)	22.3 – 28.1
26th PmJ***	21 (2.1%)	1.2 – 3.0
Others	317 (31.3%)	28.3 – 34.3
Number of repeat contacts		
1	759 (14.7%)	12.4 - 17.0
2	97 (11.0%)	(8.9 - 13.1)
≥3	32 (3.6%)	(2.3 – 4.9)
Number of suspects		
1	561 (62.7%)	(49.5 – 65.9)
≥2	327 (37.3%)	34.0 – 40.3
Number of victims per case reported		
1	758 (16.2%)	13.8 – 18.6
≥2	120 (13.8%)	11.5 – 16.1

*Marcos Dionísio Referral Center for Human Rights; **Department of Women´s Rights and of Minorities; ***State Prosecutor for Defense of Disabled and Elderly persons of Natal, RN state.

DISCUSSION

In the present study, the cities associated with most reports of violence were Natal, Mossoró and Parnamirim, representing the 3 most populous cities in Rio Grande do Norte state. The higher frequency of reports of violence against older adults in these cities and the low incidence in others may be explained by several factors, including aspects related to the size of the local populations. The cities associated with the highest number of reported incidents were also the most populous[14]. Also, in more sparsely populated towns, fewer cases of violence against older people might be reported because the public may be unaware of the Dial 100 service. Thus, the data collected from the incidents reported may not represent the full number of cases of violence against older people in the state.

In a previous study of reported cases of violence against older adults via the Dial 100 service between 2011 and 2018, a higher rate of notifications was found for the states of Paraná, Rio Grande do Norte and São Paulo[14]. With the exception of Rio Grande do Norte, the higher rate of reports in more developed areas supports the notion that the present study data is strongly influenced by the recognition among the cities of the importance of reporting incidents and awareness of the Dial 100 service.

Violence against older adults is a complex phenomenon with individual, social and political implications that has a multi-causal nature[3]. In the present investigation, neglect, psychological violence and financial abuse were the most commonly reported acts of aggression and occurred concomitantly with other types of violence in most cases reported. Corroborated by the current findings, the most prevalent types of violence against older individuals in Brazil as a whole are neglect, followed by psychological, financial and physical abuse[7,15].

These acts of violence may stem from lack of respect and appreciation for the elderly and the social stigma attached to the aging process pervading society. This group bears the brunt of a society which places an emphasis on maximum productivity and youth, with the older population not given due recognition. This phenomenon is especially evident when examining the way society intrinsically fuels prejudice and stereotypes related to aging, where the older population is seen to display socially undesirable characteristics[16].

Neglect is a type of violence found at a domestic and institutional level in Brazil, and often leads to other types of violence[17]. According to previous studies, the burden of caring for an older person represents a relevant risk factor for neglect [18].

Psychological violence is more commonly reported than physical aggression, a finding possibly explained by the cycle of violence, where the victim is often first threatened with, or is subject to, psychological violence before physical aggression ensues[19]. It is also noteworthy that psychological abuse often goes unrecognized as such, leading to under-reporting of this kind of violence. Financial abuse, another prevalent type of violence in this study, is widely described in the literature. Financial dependence of the aggressor on the older individual is a factor contributing to the occurrence of financial violence, where lower incomes tend to be associated with neglect, and higher incomes with psychological violence[20].

The data collected via the Dial 100 service on acts of violence against older people reported in RN revealed that over 95% (n= 837) of cases occurred in the homes of victims. The results of two studies in the city of Recife, Pernambuco state, Brazil, contrast with the findings of the present study, showing the lower rates of 47.52%[21] and 59.3%[22] of incidents of violence in the home. This disparity, however, can be explained by the source of the data employed. The first comparative study was based on data from the national Institute of Forensic Medicine[21], while the second drew on data from the Brazilian Disease Notification System (Sinan)[22], both comprising notifications made by health professionals.

However, results of another study, also based on analysis of incidents reported via the Dial 100 service, between 2011 and 2015 in Brazil, showed the higher percentage of cases at victims´ homes of 72.47%)[10], a rate similar to the present study. Given that the Dial 100 service is an open system for public use, and thus more readily accessible for reporting incidents with commensurately more calls[23], there is a greater likelihood of recording incidents of violence at the home.

In this respect, the intrafamily environment is the main setting in which older individuals are subject to acts of aggression. Consequently, older victims are often reluctant to report cases and denounce the perpetrators, perhaps to avoid negatively impacting the family with whom they have ties, or for fear of exacerbating the situation within their home[24].

In parallel, it is important to devise strategies for tackling domestic violence against older adults which are underpinned by public policies safeguarding the rights of these individuals. To this end, a concerted collaborative effort is needed between primary healthcare, family members, friends and individuals from the community. In this context, the role of the primary healthcare system is important, comprising the Basic Health Units (UBS) and the Family Health

Care Strategy (ESF). This support network can, through closer contact between professionals and users, detect and deal with situations of family violence, particularly among the more vulnerable members of society, thanks to the ready access to care delivered under this healthcare model [25].

Besides the domestic environment, 3 private and 12 public institutions were cited as being suspected of ill-treating older adults, one of which was a Long-Term Care Facility (LTCF). In Brazil, studies point to the need for continued training of LTCF staff, for addressing the existence of institutional neglect and other forms of violence, accessibility problems, access to medications, difficulties receiving treatment by the national health system (SUS), barriers to social interaction with the community and the need for improvements in devising and implementing Brazilian public policies[26].

In the analysis of violence against older people, it is important to consider the relationship problems often emerging during the care process. The caregiver is typically a family member not well prepared for the role who, when not receiving help in the act of caring, can suffer high levels of stress, leading to abusive behavior and acts of violence[27]. Consistent with this notion, most of the suspected perpetrators identified in the study were next-of-kin, most commonly son or daughter. This finding is similar to results found in a previous study in the state of Pará, Brazil, in which the main aggressors of older people were also the children of victims.

In the present study, the suspected perpetrators of violence were mostly women, explained by the fact that the role of caregiver is invariably performed by women. In this scenario, the State support of family is important, providing long-term care facilities, especially amid the current sociodemographic scenario of families were fewer children and greater participation of women in the job market[28].

Most of the victims were female, echoing findings of other studies in the scientific literature showing that women are more often victims of domestic violence than men[11,27]. This fact might be attributed to the social construction concerning women´s role in society, still strongly associated with subordination and lack of recognition[29]. Moreover, in Brazil the higher mortality rate of males over females, from birth through into adult life [30], together with the lower propensity of males to seek medical services[31], may have some bearing on this scenario, given there are more older women than men in the population.

With regard to color/race, victims of violent acts were more commonly white or brown, a pattern likely related to the composition of the Brazilian population, comprising 45.2% white, 45.1% brown and 8.9% black[12]. Furthermore, the socially vulnerable status of some of the individuals in this study, whether associated with additional infringements or otherwise, may be associated with the structural violence in Brazil, particularly in the Northeast. This is characterized by inequalities in the organized and institutionalized structures of the family and in economic, cultural and political systems, leading to oppression of these individuals, rendering them more vulnerable [32,33]. As a consequence, individuals from this group are often exposed to greater risk of developing illness or of worsening of pre-existing conditions, while also facing more limited access to health services, lack of social support and low education, potentially exacerbating health or contributing to a poor health[34]. Besides structural violence, social determinants are also key factors associated with interpersonal violence[35].

This study has several limitations. First, the data analyzed were collected from a single reporting channel, precluding the building of a broader picture of the profile of violence against older people in RN. In addition, it is important to mention the low representativeness of the cases of violence with respect to a significant contingent of smaller towns in the state, for which few or no reports are available, a situation attributable to a lack of awareness of the Dial 100 service in these places. Lastly, missing data on race/color in the Dial 100 records also proved a factor limiting the mapping of a clearer profile of both victims and perpetrators.

CONCLUSION

The study results showed that most cases of violence against older people in RN state took place at the home of victims and were perpetrated

predominantly by their children. The most commonly reported types of violence were neglect, psychological violence and financial abuse. Given their more prominent role as caregivers of older people, women were more frequently the suspects of perpetrating violence, while at the same time main victims of it. Regarding race/ethnicity, most victims were white and brown, according to those reporting the violence. The number of reports of violence was proportional to the population density of the cities, where higher rates of violent incidents were observed in the 3 most populous cities in RN state (Natal, Mossoró and Parnamirim).

Therefore, greater investment in expanding and disseminating the services for reporting violence against older persons is paramount, particularly in less populous cities where a large contingent are unaware of these channels. Investment should also be made in apparatus dedicated to the investigation and resolution cases of violence. In addition, public policies in support of older people and their caregivers should be devised to engage the government, society and families in the delivery of quality care, thereby securing the rights of the older population.

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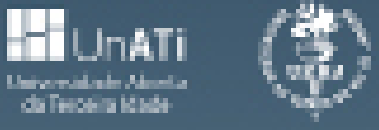
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