



Sociodemographic and health characteristics associated with elder abuse in the community: cross-sectional study

Características sociodemográficas e de saúde associadas à violência contra pessoa idosa na comunidade: estudo transversal

Características sociodemográficas y de salud asociadas a violencia contra personas mayores en la comunidad: estudio transversal

ABSTRACT

Objective: To analyze the association between sociodemographic and health characteristics and the risk of violence against elderly people in the community. **Method:** This was a cross-sectional, quantitative study of elderly people. The translated and validated Hwalek-Sengstock Elder Abuse Screening Test was used to screen for the risk of violence. The data was analyzed using the Statistical Package for the Social Sciences and Chi-square, Chance Ratio and 95% Confidence Interval were used, adopting a p-value < 0.05 for all variables. **Results:** Elderly people who were white, literate, lived with someone, had no or two illnesses and took medication were significantly associated with the group not at risk of violence. **Final remarks:** The multifactorial influence of violence was reinforced, requiring a broad, intersectoral approach.

Descriptors: Aged; Aging; Elder abuse; Social determinants of health.

RESUMO

Objetivo: Analisar a associação entre as características sociodemográficas e de saúde com risco de violência contra a pessoa idosa na comunidade.

Método: Estudo de corte transversal, de abordagem quantitativa, realizado com pessoas idosas. Para o rastreio do risco de violência, foi utilizado o instrumento traduzido e validado Hwalek-Sengstock Elder Abuse Screening Test. Os dados foram analisados com auxílio do Statistical Package for the Social Sciences, sendo utilizado Qui-quadrado, Razão de Chance e Intervalo de Confiança de 95%, adotando p-valor < 0,05 para todas as variáveis. **Resultados:** Pessoas idosas da raça/cor branca, alfabetizada, que moram com alguém, que apresentam nenhuma a duas doenças e que fazem o uso de medicação, foram associadas significativamente ao grupo sem risco de violência. **Considerações finais:** Foi reforçada a influência multifatorial da violência, exigindo uma abordagem ampliada e intersectorial.

Descritores: Pessoa idosa; Envelhecimento; Violência contra pessoa idosa; Determinantes sociais da saúde.

RESUMEN

Objetivo: Analizar la asociación entre las características sociodemográficas y de salud y el riesgo de violencia contra las personas mayores en la comunidad. **Método:** Estudio cuantitativo transversal de personas mayores. Se utilizó la prueba traducida y validada Hwalek-Sengstock Elder Abuse Screening Test para detectar el riesgo de violencia. Los datos se analizaron con el paquete estadístico Statistical Package for the Social Sciences y se utilizaron Chi-cuadrado, cociente de probabilidades e intervalo de confianza del 95%, adoptando un valor p < 0,05 para todas las variables. **Resultados:** Los ancianos de raza blanca, alfabetizados, que vivían con alguien, que no tenían ninguna o dos enfermedades y que tomaban medicación se asociaron significativamente con el grupo sin riesgo de violencia. **Consideraciones finales:** Se reforzó la influencia multifactorial de la violencia, que requiere un abordaje amplio e intersectorial.

Descriptores: Persona Mayor; Envejecimiento; Abuso de ancianos; Determinantes sociales de la salud.

Bruna Caroline Cassiano da Silva¹

ID 0000-0002-3192-8448

Nathaly da Luz Andrade¹

ID 0000-0002-5990-5766

Kalyne Patrícia de Macêdo Rocha¹

ID 0000-0002-8557-1616

Maria Laurência Grou Parreirinha Gemito²

ID 0000-0001-9254-6083

Sheila Cristina Rocha-Brischiliari³

ID 0000-0002-0591-7307

Gilson de Vasconcelos Torres¹

ID 0000-0003-2265-5078

¹Federal University of Rio Grande do Norte. Rio Grande do Norte, Brazil.

²University of Évora. Évora, Portugal.

³State University of Western Paraná. Paraná, Brazil.

Corresponding author's:

Bruna Caroline Cassiano da Silva
brunacassiano1@gmail.com

INTRODUCTION

Elder abuse (EA) entails political, social, economic, and cultural repercussions and is defined by the World Health Organization (WHO)⁽¹⁾ as any behavior or omission, intentional or unintentional, that results in or has the potential to cause physical, psychological, or social harm. In this context, attention is drawn to the vulnerabilities and biopsychosocial changes inherent to the aging process, which, when combined with insufficient social protection, contribute to the perpetuation and worsening of violence cases^(2,3).

The phenomenon affects the long-lived population regardless of socioeconomic status, ethnicity, or religion. Studies indicate a 250.9% increase in reported violence cases between 2013 and 2023, with 28,704 cases recorded in 2023^(4,5). In Brazil, EA manifests as physical, psychological, institutional, patrimonial, sexual, and financial abuse, as well as neglect, abandonment, and discrimination⁽⁶⁾, with the simultaneous occurrence of several types being common. Thus, exposure to the risk of violence, combined with health complexities and isolation, may negatively impact the quality of life of older adults, intensifying the process of frailty⁽³⁻⁷⁾.

EA is a global phenomenon, and its prevalence varies according to sociocultural and economic contexts. A review study showed widely variable rates, including 81% in Saudi Arabia, 28.5% in Peru, 10% to 27.3% in the United States, and 2.6% in the United Kingdom⁽⁸⁾. Another study reported a variation between 1.6% and 20.2%, with similar types of violence observed in developed and developing countries⁽⁹⁾.

In Brazil, from 2018 to 2022, there was an increase of nearly 40% in EA notifications. In 2022 alone, approximately 267

complaints were recorded per day, more than 40 of which corresponded to physical violence⁽¹⁰⁾. Furthermore, the Human Rights Hotline (Dial 100) registered more than 960,000 violations of older adults' rights in 2024⁽¹¹⁾. Despite this heterogeneity, factors such as gender, race, education, income, frailty, and dependency appear to significantly influence violence outcomes^(4,9,12,13). Thus, identifying factors that influence this exposure is essential, given the impact of violence on physical and mental health^(2,8,14).

It is evident that EA represents a major public health issue requiring broad and intersectoral action. Additionally, reports in Brazil have risen sharply. Therefore, this study is justified by the need to investigate possible profiles that more vulnerable to violence, in order to guide prevention strategies and strengthen protective policies for older people.

This study has the objective of analyzing the association between sociodemographic and health characteristics and the risk of elder abuse among older adults in the community of Foz do Iguaçu, Paraná, Brazil. The study hypothesis is that the risk of violence is directly influenced by sociodemographic and health aspects.

METHODS

This was an observational, analytical, cross-sectional study with a quantitative approach, guided by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool. It was carried out with older adults registered in Primary Health Care (PHC) residing in the municipality of Foz do Iguaçu, Paraná (PR), a tri-border region, between April and July 2022. This study is part of a multicenter national and international project

conducted by the “International Research Network on Vulnerability, Health, Safety, and Quality of Life of Older People: Brazil, Portugal, Spain, France, Chile, Mexico, and the United States.”

Participants included users aged 60 years or older⁽¹⁵⁾ who were permanent residents for at least six months, registered in one of the 29 PHC units in the municipality, and who completed the Mini-Mental State Examination (MMSE). Older adults with clinical characteristics or a medical diagnosis that actively impaired motor testing were excluded.

To determine the sample size, the equation for calculating a sample for a proportion study in a finite population was used. With an estimated population of 34,172 older adults⁽¹⁶⁾, a confidence level of 95% ($Z = 1.96$), a sampling error ($e = 0.08$), an estimated proportion of correct answers (P) of 50%, and an expected error (Q) of 50%, the estimated sample resulted in 149 participants assisted by Primary Health Care. A 10% increase was added to account for possible losses, totaling a final estimated sample of 164 participants. Thus, non-probabilistic convenience sampling was used.

Data collection was carried out by the research team, composed of undergraduate and graduate nursing students who were previously trained. Participants were approached while they were at the Primary Health Care Unit (PHCU) for an appointment (consultation, exams, or vaccination). Eligible individuals who agreed to participate were informed about the study and data confidentiality and signed the Free and Informed Consent Form (FICF). Interviews were conducted in a private room within the PHCU facilities, before or after the appointment, ensuring no

interference with consultation flow or unit dynamics. The interviews were conducted face-to-face (researcher and participant), lasting an average of 40 minutes, with all questions read aloud by the interviewer. Data were recorded using the Google Forms platform or a printed questionnaire when internet access was restricted.

The study included variables related to sociodemographic and health aspects. To characterize these variables, the research coordinators developed a structured questionnaire with information on gender, age in years, race, marital status, living arrangement, education, employment, income, diseases, and medications. To screen for the risk of EA, the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) was used.

Adapted, translated, and validated for the Brazilian context, the H-S/EAST⁽¹⁷⁾ seeks to identify related circumstances, as well as the direct or indirect presence, or even suspicion of elder abuse through the Elder Abuse Suspicion Index (EASI). The instrument consists of 15 dichotomous items and three dimensions: direct abuse, vulnerability to abuse, and potential abuse. These dimensions allow the assessment of risk for physical, psychological, and financial violence, as well as isolation and neglect. One point is assigned to each affirmative response, except for items 1, 6, 12, and 14, where the point is assigned to negative responses. A score of three or higher indicates a risk of violence. In the present study, the risk of violence variable was categorized as “at risk” and “not at risk,” and the dimensions as “vulnerability,” “indirect violence,” and “direct violence.”

The risk of violence was defined as the dependent variable, while the independent variables were gender (female/

male), age group (60–69 years / 70 years or older), self-reported race/color (white/non-white), literacy (literate/illiterate), retired (yes/no), income (zero to two minimum wages / more than two minimum wages), living arrangement (alone / with someone), self-reported diseases (zero to two / three or more), medication use (yes/no), and number of medications (zero to two / three or more).

After completion of the data collection instrument, the data were entered and organized in Microsoft Excel® 2010, exported, and analyzed using the Statistical Package for the Social Sciences program (SPSS), version 21.0. The Kolmogorov-Smirnov test was used to assess normality. Simple and double-entry frequency tables and descriptive analyses of categorical variables were performed using absolute

(n) and relative (%) frequencies. To assess possible statistical significance between sociodemographic and health variables and the risk of violence, Pearson's Chi-square non-parametric test was applied. The odds ratio (OR) was calculated for all analyses, with a 5% margin of error, confidence intervals (CI) of 95%, and $p < 0.05$ as the significance threshold.

This study was submitted to and approved by the Research Ethics Committee for Human Beings of the State University of Western Paraná (Unioeste, as per its Portuguese acronym), Opinion n. ° 4.662.293/2021. All recommendations and ethical principles for research involving human subjects were followed, in accordance with Resolution n. ° 466/2012 of the Brazilian National Health Council (CNS, as per its Portuguese acronym).

Table 1 – Association between sociodemographic and health characteristics of older adults in the community and the risk of violence, Foz do Iguaçu, Paraná, Brazil, 2022

Sociodemographic and health characteristics	Violence (H-S/EAST*) (n = 200)		
	No risk (n = 113)	At risk (n = 87)	p-value†
	n (%)	n (%)	OR* (95% CI§)
Gender			
Female	75 (36,5)	58 (29,0)	0,965
Male	38 (20,0)	29 (14,5)	
Age group			
60 to 69 years	67 (33,5)	55 (27,5)	0,572
70 years or older	46 (23,0)	32 (16,0)	
Self-reported race/skin color			
White	76 (38,0)	41 (20,5)	0,004 1,5 (1,1-1,9)
Non-white	37 (18,5)	46 (23,0)	
Educational level			
Literate	107 (53,5)	72 (36,0)	0,006 2,1 (1,1-4,2)
Illiterate	6 (3,0)	15 (7,5)	
Retired			
No	38 (19,0)	31 (15,5)	0,768
Yes	75 (37,5)	56 (28,0)	
Income			
Zero to two minimum wages	53 (26,5)	45 (22,5)	0,499
More than two minimum wages	60 (30,0)	42 (21,0)	

Continue

Sociodemographic and health characteristics	Violence (H-S/EAST*) (n = 200)		p-value† OR‡ (95% CI§)
	No risk (n = 113)	At risk (n = 87)	
	n (%)	n (%)	
Living arrangement			
Living alone	20 (10,0)	7 (3,5)	0,048 1,4 (1,1-1,8)
Living with someone	93 (46,5)	80 (40,0)	
Self-reported diseases			
Zero to two diseases	87 (43,5)	56 (28,0)	0,050 1,3 (1,0-1,8)
Three or more diseases	26 (13,0)	31 (15,5)	
Medication use			
No	29 (14,5)	11 (5,5)	0,022 1,4 (1,1 - 1,8)
Yes	84 (42,0)	76 (38,0)	
Number of medications			
Zero to two	67 (33,5)	41 (20,5)	0,087
Three or more	46 (23,0)	46 (23,0)	

Source: research data

Note: H-S/EAST – Hwalek-Sengstock Elder Abuse Screening Test*; p-value† = statistical significance; OR‡ = odds ratio‡; CI§ = confidence interval

It is possible to infer that older adults of the white race/skin color were 1.5 times more likely not to be at risk of violence, as were literate participants, who were 2.1 times more likely, and those who lived with someone, who were 1.4 times more likely. Participants with zero to two self-reported diseases were 1.3 times more likely not to be at risk of violence, and those who used medication were 1.4 times more likely (Table 1).

Table 2 shows the association between sociodemographic and health characteristics and the H-S/EAST dimensions. A significant association was observed between white race/skin color and all three dimensions: vulnerability (p = 0.034), indi-

rect violence (p = 0.006), and direct violence (p = 0.022). Being literate was associated with the indirect violence (p = 0.010) and direct violence (p < 0.001) dimensions, while living with someone was associated only with the indirect violence dimension (p = 0.038)—all for the group not at risk of violence.

For the same group (those not at risk), among health variables, there was a significant association between having zero to two self-reported diseases and the vulnerability (p = 0.018) and indirect violence (p = 0.027) dimensions; using medication and the direct violence dimension (p = 0.015); and using zero to two medications and the vulnerability dimension (p = 0.032).

Table 2 – Association between sociodemographic and health characteristics of older adults in the community and the H-S/EAST dimensions, Foz do Iguaçu, Paraná, Brazil, 2022

Sociodemographic and health characteristics	Violence (H-S/EAST*) (n = 200)								
	Vulnerability			Indirect violence			Direct violence		
	No (n = 137) n (%)	Yes (n = 63) n (%)	p-value† OR‡ (95% IC§)	No (n = 119) n (%)	Yes (n = 81) n (%)	p-value† OR‡ (95% IC§)	No (n = 119) n (%)	Yes (n = 81) n (%)	p-value† OR‡ (95% IC§)
Gender									
Female	90 (45,0)	43 (21,5)	0,722	79 (39,5)	54 (27,0)	0,967	84 (42,0)	49 (24,5)	0,887
Male	47 (23,5)	20 (10,0)		40 (20,0)	27 (13,5)		43 (21,5)	24 (12,0)	
Age group									
60 to 69 years	83 (41,5)	39 (19,5)	0,859	70 (35,0)	52 (26,0)	0,444	76 (38,0)	46 (23,0)	0,658
70 years or older	54 (27,0)	24 (12,0)		49 (24,5)	29 (14,5)		51 (25,5)	27 (13,5)	
Self-reported race/skin color			0,034*			0,006*			0,022
White	87 (43,5)	30 (15,0)	1,2	79 (39,5)	38 (19,0)	1,4	82 (41,0)	35 (17,5)	1,3
Non-white	50 (25,0)	33 (16,5)	(1,0 - 1,5)	40 (20,0)	43 (21,5)	(1,1-1,8)	45 (22,5)	38 (19,0)	(1,0-1,6)
Educational level						0,010*			< 0,001
Literate	126 (63,0)	53 (26,5)	0,093	112 (56,0)	67 (33,5)	1,9	121 (60,5)	58 (29,0)	2,4
Illiterate	11 (5,5)	10 (5,0)		7 (3,5)	17 (7,0)	(1,0-3,5)	6 (3,0)	15 (7,5)	(1,2-4,7)
Retired									
No	50 (25,0)	19 (9,5)	0,381	40 (20,0)	29 (14,5)	0,749	44 (22,0)	25 (12,5)	0,954
Yes	87 (43,5)	44 (22,0)		79 (39,5)	52 (26,0)		83 (41,5)	48 (24,0)	
Income									
Zero to two minimum wages	64 (34,0)	34 (17,0)	0,341	55 (27,5)	43 (21,5)	0,340	62 (31,0)	36 (18,0)	0,946
More than two minimum wages	73 (36,5)	29 (14,5)		64 (32,0)	38 (19,0)		65 (32,5)	37 (18,5)	
Living arrangement						0,038*			0,0,98
Living alone	21 (10,5)	6 (3,0)	0,264	21 (10,5)	6 (3,0)	1,4	21 (10,5)	6 (3,0)	
Living with someone	116 (58,0)	57 (28,5)		98 (49,0)	75 (37,5)	(1,1-1,7)	106 (53,0)	67 (33,5)	
Self-reported diseases			0,018*			0,027*			0,658
Zero to two diseases	105 (52,5)	38 (19,0)	1,3	92 (46,0)	51 (25,5)	1,4	96 (48,0)	47 (23,5)	
Three or more diseases	32 (16,0)	25 (12,5)	(1,0-1,7)	27 (13,5)	30 (15,0)	(1,0-1,8)	31 (15,5)	26 (13,0)	
Medication use									0,015
No	32 (16,0)	8 (4,0)	0,080	29 (14,5)	11 (5,5)	0,061	32 (16,0)	8 (4,0)	1,3
Yes	105 (52,5)	55 (27,5)		90 (45,0)	70 (35,0)		95 (47,5)	65 (32,5)	(1,1-1,6)
Number of medications			0,032*						0,11
Zero to two	81 (40,5)	27 (13,5)	1,2	67 (33,5)	41 (20,5)	0,428	74 (37,0)	34 (17,0)	
Three or more	56 (28,0)	36 (18,0)	(1,0-1,5)	52 (26,0)	40 (20,0)		53 (26,5)	39 (19,5)	

Source: research data

Note: H-S/EAST – Hwalek-Sengstock Elder Abuse Screening Test*; p-value† = statistical significance; OR‡ = odds ratio‡; CI§ = confidence interval

For the final model, as shown in Table 2, it can be inferred that older adults of the white race/skin color were, respectively, 1.2, 1.4, and 1.3 times more likely not to present a risk of violence across the three dimensions. Literate older adults were 1.9

times more likely in the indirect violence dimension and 2.4 times more likely in the direct violence dimension. Those who lived with someone were 1.4 times more likely not to present a risk of indirect violence.

Regarding health variables, having

zero to two self-reported diseases and using zero to two medications conferred 1.3 and 1.2 times, respectively, greater chances of not being in a situation of vulnerability. Older adults reporting zero to two diseases were also 1.4 times more likely not to be exposed to indirect violence. In addition, those who used medication had a 1.3 times greater likelihood of not presenting direct violence (Table 2).

DISCUSSION

Given the increasing longevity observed in Brazil and other countries, discussing elder abuse (EA) requires close attention to the vulnerabilities inherent to the aging process. Identifying the factors that contribute to this phenomenon is essential to preventing violence from becoming established. The results of this study indicated that factors such as race/skin color, education, living arrangements, and health conditions may have a stronger influence on exposure to violence at the community level.

In a society marked by structural racism, violence may be related to racial disparities. In this study, the white race/skin color was associated with a lower likelihood of risk of violence, as well as a lower likelihood across all three dimensions. This finding contrasts with national epidemiological studies that analyzed violence notification in this age group and found prevalence rates of the white race/skin color of 47.32% from 2011 to 2019⁽¹⁸⁾, 44.17% from 2018 to 2023⁽¹⁹⁾, and 52% in 2022⁽¹⁰⁾. Furthermore, a study conducted in the Southeast region identified that older adults who self-identified as white more frequently experienced physical violence, followed by neglect and abandonment⁽²⁰⁾.

However, older adults of the bla-

ck race are the most affected by various types of violence, presenting a mortality rate of 16.6 deaths from aggression per 100,000 inhabitants in 2021⁽³⁾. In 2023, hospitalization rates due to aggression once again highlighted the reality of racial inequality⁽⁵⁾, corroborating studies that also describe a more susceptible profile among older adults of the non-white race/skin color^(7,9). These results may be related to marginalization, poorer social indicators, and worse living conditions, which predominantly affect the non-white population^(9,21). Despite controversies surrounding racial issues, race/skin color remains a potential element of vulnerability to violence, and racial markers cannot be disregarded when analyzing violence against older adults.

Regarding educational level, in this study, literate older adults were significantly associated with the group not at risk of violence, as well as with the dimensions related to absence of direct or indirect violence. This result aligns with Brazilian studies and research from countries such as the United States and China^(2,12,13,22), which identify low educational level as an important determinant of risk of violence and show a 1.03 times increase in the likelihood of violence among illiterate older adults⁽¹³⁾.

Education can influence the ability to recognize rights, identify ways to report cases, and access strategies for conflict prevention or mediation. However, a Brazilian study highlights that higher educational levels are not necessarily protective^(2,7), as literate older adults show a higher risk for psychological violence⁽¹⁴⁾. This may be related to the tendency of individuals with higher education to avoid reporting in order to preserve privacy and autonomy,

or due to feelings of shame or fear of experiencing additional abusive situations. Thus, while educational level plays a role in the outcome of violence, higher education alone is not a definitive protective factor.

Although intrafamilial violence is often present in aging contexts and may appear subtly, in this study, living with someone was associated with a lower likelihood of risk of violence, showing a 1.4 times higher likelihood of not experiencing indirect violence compared with those living alone. The absence of a spouse and lack of social relationships contribute to the risk of violence, as they create a sense of isolation^(12,23), increasing vulnerability to intrafamilial and intergenerational conflict. Additionally, older adults who have experienced psychological or physical violence reported living alone⁽¹⁴⁾.

On the other hand, due to the aging process and progressive loss of autonomy, older adults tend to spend more time at home, increasing vulnerability to violence. This hypothesis is confirmed by studies in the Northeast region, which identified a higher risk of violence among those living with someone^(14,24). Other studies reinforce this finding, indicating that mistreatment occurs most frequently in the home environment, with financial violence being the most common type^(13,24). It is important to underscore that the presence of family members at home does not guarantee protection: research shows that physical, financial, and property-related violence is often perpetrated by close relatives, especially children, spouses, and grandchildren, often repeatedly^(14,18,24,20,21).

Violence and health conditions are directly related, especially in cases involving functional dependence, cognitive decline, frailty, or the need for intensive

care⁽¹²⁾. Such vulnerabilities can influence interpersonal, family, and social relationships, increasing susceptibility to neglect or mistreatment. However, studies indicate that violence also occurs against older adults with good cognitive and functional status⁽²⁾.

In this study, older adults reporting zero to two diseases had a greater chance of being classified as not at risk of violence, without vulnerability and without indirect violence. This contrasts with another Brazilian multicenter cross-sectional study, which found a significant association between risk of violence and the presence of four or more comorbidities, as well as a positive correlation between psychological and physical violence, with a 7.03 times higher risk⁽¹⁴⁾.

Nonetheless, unlike the previous study, another multicenter Brazilian study found an 85.5% prevalence of risk of EA among older adults without a history of diseases⁽⁷⁾. Still, research in Brazil, India, Saudi Arabia, and Iran indicates that chronic diseases contribute to the risk of violence^(8,20), reinforcing a pattern in the profile of victims. Multiple comorbidities may increase vulnerability to violence, as they may lead to increased biopsychosocial consequences, hospitalization, and premature death. It is also important to note that long-lived older adults with chronic diseases and physical limitations may have difficulty defending themselves or reporting aggressors due to fear of abandonment or neglect.

Comorbidity notification also implies the use of continuous medication to prevent disease progression. Additionally, medication use among older adults may negatively affect mental and physical health, increasing vulnerability to violence⁽²³⁾.

However, an important observation in our study is that older adults who used medication were significantly associated with the group not at risk of violence and without direct violence, and those using zero to two medications were associated with the group without vulnerability. This contrasts with the idea that medication use increases the risk of violence among older adults.

The lack of studies addressing the relationship between the risk of violence and the use of medications, or the used quantity, makes theoretical comparison difficult. However, literature indicates that the use of multiple medications increases the risk of mistreatment⁽⁷⁾. Although not significant, another study found a 60.8% prevalence of violence risk among older adults not using polypharmacy⁽²³⁾. Conversely, a national study⁽⁴⁾ found a 63.9% prevalence of no violence risk among older adults using up to two medications.

Older adults who are victims of violence experience significant impacts on well-being, including mental health problems, decreased life expectancy, reduced quality of life, and loss of autonomy and independence⁽⁸⁾. Understanding the victim profile can support health care professionals, facilitating intervention, notification, and appropriate referral. Primary Health Care services play a key role in addressing this issue, as they serve as the main entry point to the health care system. For this reason, it is essential that professionals in this area receive training and provide qualified listening.

However, during undergraduate studies, violence-related content—when present—is addressed indirectly in courses⁽²⁵⁾, leaving health care professionals unprepared to deal with the complexity of this

phenomenon. Given the rising life expectancy, it is critical to include EA-related content in academic curricula and promote continuous training by public agencies to strengthen the protection network and ensure safe, humane, and effective care for victims.

In addition to gaps in academic training, challenges also exist in identifying this phenomenon, such as difficulty recognizing abusive situations, the scarcity of validated instruments adapted to the Brazilian context, and limited field research directly examining factors influencing EA. Although often concealed, EA is an unacceptable phenomenon demanding special attention.

It is underlined that this study presents limitations. The first concerns the cross-sectional design, which does not allow for establishing causal relationships between the analyzed variables, reinforcing the need for longitudinal, multiregional studies with larger samples to produce more robust evidence. Another limitation concerns the use of self-report instruments, which may be influenced by participants' subjective perceptions and biases, leading to underreporting or omission of experiences of violence. Additionally, although the findings contribute to understanding the phenomenon and encourage future investigations in other population contexts, results cannot be generalized, as they reflect the reality of a single municipality in a tri-border region with specific socioeconomic, cultural, and ethnic characteristics influencing the quality of life of older adults.

FINAL CONSIDERATIONS

Confirming the multicausal nature of this phenomenon, this study identified

a greater likelihood of not being at risk of violence among older adults who were white, literate, lived with someone, had zero to two diseases, and used medication. Furthermore, race/skin color (white) was the only factor that influenced all three dimensions, showing a higher likelihood of not being vulnerable, nor experiencing indirect or direct violence.

Therefore, by understanding that elder abuse is a public health issue, it is essential to recognize the role of health care professionals in developing actions to prevent this phenomenon, aiming for comprehensive care. Furthermore, it is evident that health care professionals must be trained to address EA cases starting from undergraduate education, with additional training throughout their professional careers—along with the implementation of municipal protocols focused on identifying and managing violence cases.

RESULTS

The sample consisted of 200 participants, of whom 43.5% ($n = 87$) were at risk of violence. Participants' ages ranged from 60 to 96 years, with a mean of 68.7 years and a mode of 60 years.

Regarding sociodemographic characteristics, the sample was predominantly composed of older adults who were female (66.5%, $n = 133$), white (58.5%, $n = 117$), literate (89.5%, $n = 179$), retired (65.5%, $n = 131$), had an income above one minimum wage (55.5%, $n = 111$), and lived with someone (86.5%, $n = 173$). Concerning health characteristics, most participants reported zero to two diseases (71.5%, $n = 143$), used medication (80.0%, $n = 160$), and used zero to two medications (54.0%, $n = 108$).

Table 1 shows the association between sociodemographic and health charac-

teristics of older adults in the community and the risk of violence. Statistically significant associations were observed for the variables white race/skin color ($p = 0.004$), being literate ($p = 0.006$), living with someone ($p = 0.048$), having zero to two self-reported diseases ($p = 0.050$), and using medication ($p = 0.022$).

REFERENCES

1. World Health Organization (WHO); International Network for the Prevention of Elder Abuse (INPEA). Missing Voices: views of older persons on elder abuse [Internet]. Geneva: WHO; 2002. Available from: https://iris.who.int/bitstream/handle/10665/67371/WHO_NMH_VIP_02.1.pdf?sequence=1
2. Silva SPC, Lima MJL, Vasconcelos ECFR, Silva MMC, Matos KKC. Violência na velhice: representações sociais elaboradas por pessoas idosas. Esc Anna Nery [Internet]. 2023 [citado em 10 abr. 2025];27(2):1-8. Disponível em: <https://doi.org/10.1590/2177-9465-EAN-2022-0169pt>
3. Instituto de Pesquisa Econômica Aplicada (BR); Fórum Brasileiro de Segurança Pública (FBSP). Atlas da violência 2023: violência contra idosos [Internet]. Rio de Janeiro: Ipea; 2023. Disponível em: <https://www.ipea.gov.br/atlasviolencia/arquivos/artigos/9350-223443riatlasda-violencia2023-final.pdf>
4. Silva BCC, Dantas BAS, Maculan AA, Andrade NL, Torres SMSGO, Martínez CSG, et al. Sociodemographic profile, functionality, depression, and frailty as determinants for the risk of abuse and violence against older people in the community: an observational study conducted in Brazil. PLoS One. 2025 Jun [citado em 10 jun. 2025];20(6):e0317855. DOI: 10.1371/journal.pone.0317855. In: PubMed; PMID

40523016.

5. Instituto de Pesquisa Econômica Aplicada (BR); Fórum Brasileiro de Segurança Pública (FBSP). Atlas da violência 2025: violência contra idosos [Internet]. Rio de Janeiro: Ipea; 2023. Disponível em: <https://www.ipea.gov.br/atlasviolencia/arquivos/artigos/5999-atlasdaviolencia2025.pdf>

6. Ministério da Mulher, da Família e dos Direitos Humanos (BR). Violência contra a pessoa idosa: vamos falar sobre isso? [Internet]. Brasília (DF): Ministério da Mulher, da Família e dos Direitos Humanos; 2020. Disponível em: <https://www.gov.br/mdh/pt-br/assuntos/noticias/2020-2/junho/cartilhacombateviolenciapessoaidosa.pdf>

7. Andrade N, Batista F, Silva B, Maia E, Dantas B, Torres G. Caracterização sociodemográfica e de saúde da pessoa idosa institucionalizada em risco de violência. Rev Ibero-Am Saude Envelhec [Internet]. 2025 [citado em 7 abr. 2025];10(2):11-26. DOI: 10.60468/r.riase.2024.10(2).701.11-26

8. Alias AN, Mokti K, Ibrahim MY, Saupin S, Madrim MF. Elderly abuse and neglect on population health: literature review and interventions from selected countries. Korean J Fam Med. 2023 [citado em 7 abr. 2025];44(6):311-8. DOI: 10.4082/kjfm.23.0046. In: PubMed; PMID 37641174.

9. Santos RVS, Monteiro EA, Silva SPC, Oliveira ABC. Violência contra idosos: um problema que precisa ser evidenciado. Revista Recien [Internet]. 2022 [citado em 7 abr. 2025];12(40):210-2. Disponível em: <https://www.recien.com.br/index.php/Recien/article/view/667>

10. Ministério dos Direitos Humanos e Cidadania (BR). Observatório Nacional dos Direitos Humanos [Internet]. Brasília: Ministério dos Direitos Humanos e Cida-

dania; 2024. Disponível em: <https://observadh.mdh.gov.br/>

11. Ministério dos Direitos Humanos e Cidadania (BR). Disque Direitos Humanos (Disque 100) [Internet]. Brasília: Ministério dos Direitos Humanos e Cidadania; 2024. Disponível em: <https://www.gov.br/mdh/pt-br/aceso-a-informacao/dados-abertos/disque100>

12. Du P, Chen Y. Prevalence of elder abuse and victim-related risk factors during the COVID-19 pandemic in China. BMC Public Health. 2021 [cited 2025 Abr 10];21(1):1-9. DOI: 10.1186/s12889-021-11175-z. In: PubMed; PMID 34103014.

13. Ranzani CM, Silva SC, Hino P, Taminato M, Okuno MFP, Fernandes H. Profile and characteristics of violence against older adults during the COVID-19 pandemic. Rev Latino-Am Enfermagem. 2023 [cited 2025 Abr 10];31:e3825. DOI: 10.1590/1518-8345.6220.3825. In: PubMed; PMID 36722639.

14. Monteiro GKA, Santos RC, Brandão WFM, Costa GMC, Almeida AM, Souto RQ. Factors associated with elder abuse according to the levels of social determinants in Brazil. J Forensic Nurs. 2025 [cited 2025 Abr 9];21(1):19-28. DOI: 10.1097/JFN.0000000000000501. In: PubMed; PMID 39235315.

15. BRASIL. Lei federal n. 10.741, de 01 de outubro de 2003. Dispõe sobre o Estatuto da Pessoa Idosa e dá outras providências [Internet]. Brasília (DF): Secretaria Especial dos Direitos Humanos; 2004. Disponível em: https://www.planalto.gov.br/ccivil_03/leis/2003/l10.741.htm

16. Instituto Brasileiro de Geografia e Estatística (BR). Censo Demográfico 2021 [Internet]. Rio de Janeiro: Instituto Brasileiro de Geografia e Estatística; 2022. Disponível em: <https://www.ibge.gov.br/>

17. Reichenheim ME, Paixão CM Jr, Moraes CL. Adaptação transcultural para o português (Brasil) do Hwalek-Sengstock Elder Abuse Screening Test (HS/EAST) utilizado para identificar risco de violência contra idosos. *Cad Saúde Pública*. 2008 [citado em 7 abr. 2025];24:1801-13. DOI: 10.1590/S0102-311X2008000800009. In: PubMed; PMID 18709221.
18. Cipriano Bovolenta L, Lima Mantonvani J, Menegatti Frisanco F, Ribeiro Dalla Vechia AD. Perfil de la violencia contra las personas mayores en Brasil según las capitales brasileñas. *Rev Cuid*. 2024 [citado em 7 abr. 2025];15(1):e3233. DOI: 10.15649/cuidarte.3233. In: PubMed; PMID 40115903
19. Dias AV, Macedo HD, Cardoso LGS, Ruas SX, Maia LC. Análise epidemiológica da violência contra idosos no Brasil. *Braz J Hea Rev [Internet]*. 2024 [citado em 7 abr. 2025];7(5):e74116. Disponível em: <https://ojs.brazilianjournals.com.br/ojs/index.php/BJHR/article/view/74116>
20. Lima VMDF, Stochero L, Azeredo CM, Moraes CL, Hasselmann MH, Marques ES. Characterization and completeness of notification sheet of violence against the older adults in Niterói-RJ, 2011-2020. *Epidemiol Serv Saúde*. 2023 [cited 2025 Abr 7];32(1):e2022451. DOI: 10.1590/S2237-96222023000100024. In: PubMed; PMID 36946831
21. Ribeiro ECSAR, Ghiggino LT, Valentim AAF, Meira KC, Castro PCP Júnior, Ferreira AA. Fatores sociodemográficos associados à não longevidade e longevidade em idosos no Brasil. *Estud Interdiscip Envelhec [Internet]*. 2024 [citado em 7 abr. 2025];29(1). Disponível em: <https://seer.ufrgs.br/index.php/RevEnvelhecer/article/view/134979>
22. Elman A, Breckman R, Clark S, Gottesman E, Rachmuth L, Reiff M, et al. Effects of the COVID-19 outbreak on elder mistreatment and response in New York City: initial lessons. *J Appl Gerontol*. 2020 [cited 2025 Abr 10];39(7):690-9. DOI: 10.1177/0733464820924853. In: PubMed; PMID 32380891
23. Soares JS, Santos AC, Santos-Rodrigues RC, Araújo-Monteiro GKN, Brandão BMLS, Souto RQ. Risk of violence and frailty syndrome among older adults treated at a hospital service. *Rev Bras Enferm*. 2023 [cited 2025 Abr 1];76(Suppl 2):1-8. DOI: 10.1590/0034-7167-2022-0278pt. In: PubMed; PMID 37255185.
24. Brandão BM, Santos RC, Araújo-Monteiro GK, Carneiro AD, Medeiros FD, Souto RQ. Risk of violence and functional capacity of hospitalized elderly: a cross-sectional study. *Rev Esc Enferm USP [Internet]*. 2021 [cited 2025 Abr 1];55:e20200528. DOI: 10.1590/1980-220x-reeusp-2020-0528. In: PubMed; PMID 34448805.
25. Souza JSR, Calheiros CAP, Terra FDS, Costa ACB, Vilela SC. A enfermagem forense e seus conteúdos curriculares nos cursos de graduação em Enfermagem. *Rev Enferm Cent-Oeste Min [Internet]*. 2021 [citado em 1 abr. 2025];10. Disponível em: <http://www.seer.ufsj.edu.br/recom/article/view/3635>

Authors' contribution:

Research concept and design: RBCCS, SCR-B, GVT

Data collection: RBCCS, SCR-B

Data analysis and interpretation: R: BCCS, NLA, KPMR, GVT

Funding acquisition: GVT

Manuscript writing: BCCS, NLA, KPMR, MLGPG, SCR-B, GVT

Critical review of the manuscript for the intellectual content: BCCS, MLGPG, SCR-B, GVT

Responsible editors:

Patrícia Pinto Braga – Editor – in Chief

Kellen Rosa Coelho Sbampato – Scientific editor

Note:

National Council for Scientific and Technological Development (CNPq), Brazil. Funding was obtained through Call CNPq/MCTI/FNDCT No. 18/2021 – Category B – Consolidated Groups, Process No. 0257801662000850; Coordination for the Improvement of Higher Education Personnel (Capes), Process No. PRINT-INTERNATIONALIZATION PROGRAM – 88887.831236/2023-00 – Call No. 41/2017; North-Riograndense Research and Culture Foundation, Process No. 139/2021/PROPESQ/REITORIA/CONSUNI/UFRN.

Received on: 15/08/2025

Approved on: 08/10/2025

How to cite this article:

Silva BCC, Andrade NL, Rocha KPM, et al. Sociodemographic and health characteristics associated with violence against older people in the community: cross-sectional study.

Revista de Enfermagem do Centro-Oeste Mineiro. 2026;16:e5806. [Access_____]; Available in:_____. DOI: <http://doi.org/10.19175/recom.v16i0.5806>



This is an open-access article distributed under the terms of the Creative Commons Attribution License.