







VIOLENCE AGAINST THE OLDER ADULT: PERCEPTIONS OF THE BASIC HEALTH CARE TEAMS

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ABSTRACT

Objective: to understand how the professionals working in primary care teams perceive violence against the older adult.

Method: a qualitative study, carried out from the conduction of four focus groups with a total of 30 basic care professionals, in the municipality of Marília, São Paulo. Data collection was carried out from November to December 2018. For data analysis, Hermeneutics-Dialectics was adopted.

Results: it was revealed that the professionals suspect and identify cases of physical and financial violence and mainly negligence, with the main perpetrator of the aggression being a family member. They recognize that older adults are in complex life contexts and that many situations are beyond their capacity for intervention. They expressed fear and insecurity in reporting the cases and are unaware of the role of the other services, making the approach even more complex.

Conclusion: the professionals experience situations of violence against the older adult in their daily lives; however, barriers such as fear of reporting the cases, ignorance of the roles of different professionals, and the inefficiency of the care network hinder the necessary interventions.

DESCRIPTORS: Aged. Aging. Violence. Primary Health Care. Family health.

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VIOLÊNCIA CONTRA A PESSOA IDOSA: PERCEPÇÕES DAS EQUIPES DA ATENÇÃO BÁSICA À SAÚDE

RESUMO

Objetivo: compreender como os profissionais das equipes de atenção primária percebem a violência contra a pessoa idosa.

Método: estudo qualitativo, realizado a partir da realização de quatro grupos focais com um total de 30 profissionais da atenção básica, no município de Marília-SP. A coleta de dados foi realizada de novembro a dezembro de 2018. Para a análise dos dados, adotou-se a Hermenêutica-Dialética.

Resultados: revelou que os profissionais suspeitam e identificam casos de violência física, financeira e principalmente a negligência, sendo o principal autor da agressão um membro da família. Reconhecem que os idosos se encontram em contextos de vida complexos e muitas situações estão além de suas capacidades de intervenção. Expressaram medo e insegurança na realização da denúncia e desconhecem o papel dos demais serviços, tornando a abordagem ainda mais complexa.

Conclusão: os profissionais vivenciam situações de violência contra o idoso no seu cotidiano; no entanto, barreiras como o medo de realizar a denúncia, o desconhecimento dos papéis de diferentes profissionais e a falta de efetividade da rede de atenção dificultam as intervenções necessárias.

DESCRITORES: Idoso. Envelhecimento. Violência. Atenção Primária à Saúde. Saúde da família.

VIOLENCIA CONTRA ADULTOS MAYORES: PERCEPCIONES DE LOS EQUIPOS DE ATENCIÓN BÁSICA DE LA SALUD

RESUMEN

Objetivo: comprender cómo los profesionales de los equipos de atención básica de la salud perciben la violencia contra adultos mayores.

Método: estudio cualitativo, realizado a partir de la creación de cuatro grupos focales, con un total de 30 profesionales de la atención primaria de la salud, en el municipio de Marília-SP. La recolección de datos se realizó entre noviembre y diciembre de 2018. Para el análisis, se adoptó la Hermenêutica-Dialéctica.

Resultados: se revela que los profesionales sospechan y corroboran casos de violencia física, financiera y, principalmente, casos de negligencia, advirtiéndose que el principal autor de la agresión es un miembro de la familia. Se reconoce que los adultos mayores se hallan en contextos de vida complejos y que muchas situaciones van más allá de su capacidad de intervención. Los profesionales expresan miedo e inseguridad en la realización de denuncias y desconocen el rol de otras instituciones, hecho que torna el abordaje aún más complejo.

Conclusión: los profesionales atraviesan situaciones de violencia contra el adulto mayor en su cotidianidad, sin embargo, barreras como el miedo a realizar la denuncia, o el desconocimiento sobre el rol de otros profesionales, y la ineficacia de la red de atención dificultan las intervenciones necesarias.

DESCRITORES: Adulto Mayor. Envejecimiento. Violencia. Atención básica de salud. Salud de la familia.

INTRODUCTION

Population aging demands studies that aim to contribute to a healthier and quality old age, essentially through changes in the sociocultural view in relation to this segment of the population. In view of the accelerated growth of the older adult population in the contemporary Western scenario, it is verified that this public has been suffering violence of different types, since society is not prepared to deal with the issues demanded by these individuals¹.

Violence against the older adult can be defined as any action, single or repeated, or even the omission of appropriate action, which occurs within a relationship in which there is an expectation of trust, which causes harm or distress to an older adult².

The International Network for the Prevention of Elder Abuse and the World Health Organization (WHO) listed seven types of violence: physical abuse, in which physical force is used causing injuries, pain, disability or death; psychological abuse or mistreatment, which corresponds to verbal or gestural aggressions; negligence, in which the person responsible for the care of the older adult refuses or omits their responsibility; self-neglect, when there is denial or failure to provide adequate self-care; abandonment, which consists of absence of assistance from the person in charge; financial abuse, in which unauthorized or illegal exploitation of older adult's resources occurs; and sexual abuse³.

Violent situations result in harms to the functional capacity of the older adult, suicide attempts, violation of human rights, decreased quality of life and high mortality rates^{2,4}. Despite being a serious public health problem, violence against the older adult is still a condition camouflaged by society and little valued in the health care context⁴.

Older adults are a population group with high vulnerability to abuse, especially when they are women, single, aged, with low schooling, have some physical or psychological dependence and live with children, daughters-in-law and grandchildren⁵. For reasons such as shame, intimidation, guilt and fear of retaliation or institutionalization, older adults do not report the abuse they have suffered⁶⁻⁷. In a study carried out in the state of Minas Gerais, which analyzed reported cases of violence against women, it was observed that lethality was higher among women over 80 years of age⁸.

The difficulties that older adults face when confronting the situation of violence essentially result from not knowing their rights or from lack of access to a police station to make the report. In addition, most of the older adults have difficulties in making the decision to denounce the aggression or abuse suffered, as the aggressor is often a member of their own family and/or the only caregiver and, in other cases, they do not recognize themselves as victim of violence⁹.

In Brazil, given the importance of the theme, when the Statute of the Older Adult was promulgated, it became mandatory to report suspicion or confirmation of all forms of violence by health professionals, in addition to proposing the Plan to Fight Violence Against the Older Adult¹⁰.

With regard to health, Basic Care (BC) stands out in assisting the aged population. Inserted in the first level of the care network, it assumes the primary role in the implementation of health actions for this population and in the coordination of the flow of aged users in the health system, with emphasis on situations of violence, as it develops activities in a territory attached, in the logic of health surveillance¹¹.

The professionals who work close to the population, with emphasis on Nursing in this case, have an important role in the dissemination and discussion of this problem in the community. It is worth remembering that every visit by the older adult to a health service is an opportunity to detect such situations¹⁰. Therefore, it is recommended to carefully observe the behavior, gestures and facial expressions of the older adult, which will allow identifying risk situations and the development of appropriate coping strategies.

However, they often do not want to get involved in the case, claiming that they prefer to wait for the older adult to take the initiative to report, conduct home visits or take action from a professional colleague¹¹. Thus, preparing the health professionals to welcome the older adult victimized by aggression is a challenge that must be realized, as it is essential that the health professional knows how to identify what happened, seeking solutions to the problem of maltreatment and neglect¹⁰.

In view of the relevance of violence against the older adult, as a public health problem and of the primary care team in coping with it, the present study aims to understand how the professionals of the primary care teams perceive violence against the older adult.

METHOD

A study with a qualitative approach, through a focus group with professionals from the primary care network of a medium-sized municipality in the inland of the state of São Paulo. For data analysis, it was decided to adopt the methodological stance of hermeneutic-dialectical (HD) thinking. This article is part of a larger project entitled Older adult victim of violence: the interface of Health, Legal and Social assistance for the development of interventions.

The basic health network in the municipality consists of 12 Basic Health Units (BHUs) and 36 Family Health Units (FHUs). For urgency and emergency care, the municipality has two emergency rooms, an ECU, a Clinical Hospital and a Maternal-Child hospital¹².

Collection in the units was carried out from November to December 2018 in three teams from the FHU and a BHU, which were selected from the geoprocessing data, considering those located in regions with a higher proportion of records of older adults who suffered violence. To carry out the focus group, initially, a face-to-face visit was conducted with the head of each health unit; she explained the study to the team and verified the interest in participating in the activity.

Four focus groups were carried out, two of which had nine participants and the others with six, totaling 30 participants. The times for their conduction were previously defined according to the availability of each team, and all the focus groups were held during the time of a team meeting, which is held weekly in all units of the Family Health Strategy of the municipality.

Among the study participants, four are nursing assistants, 13 community health workers, two nursing technicians, a general services assistant, two dentists, three nurses, two physicians, an agent to fight endemic diseases and two office assistants. The participation of the professionals was voluntary and, therefore, it was not possible to guarantee the participation of all professional categories in all units.

The inclusion criterion involved professionals who were working on the day of the focus group. The exclusion criterion was being away from the service for any reason during the period established with the team.

It is worth noting that, although the assistants in general and office services do not fit the staff of health professionals, they make up the primary care teams and also participate in team meetings, contributing with information and reflections from their daily experiences.

The development of the focus groups took place in rooms of the health unit itself and had the participation of a moderator and two observers, who are the researchers themselves. It was the moderator's responsibility to mediate the discussion and use strategies that favored debate. The observers were responsible for taking down note of the dynamics of the group and assisting the moderator.

Seeking to promote reflection among the professionals, at the beginning of the focus group, images of older adults who were victims of violence were presented. Then, a script was used with the following questions: how did you feel looking at these images? Have you faced similar situations

in your work? If so, how was it? What was done? What is the best way to assist an aged patient who is a victim of violence?

At the end of all groups, one of the observers read the summary of the discussion in order to validate the data collected from the participants. Subsequently, the data collected were validated by three experienced researchers.

For data analysis, it was decided to adopt the methodological posture of Hermeneutic-Dialectical (HD) thinking, which analyzes the data provided by the subjects' narratives in search of the meanings underlying them, by understanding the meaning of the facts that composed the dynamics of the experienced process. It allows for an approximation of reality with the belief that reaching total reality is not possible, since it is the points of view and certain social factors that define reality, with no consensus¹³.

For data interpretation from the perspective of hermeneutics-dialectics, a way is presented for the researchers to seek understanding of the text in themselves, considering the testimony as a result of a social and knowledge process, resulting from multiple determinations, but with specific meaning¹³.

Data analysis followed the stages of organization, classification and interpretation of data¹⁴. This analysis must respect the temporality and maturity existing in the statements, and use Hermeneutics and Dialectics to understand the data¹⁴.

The research took into account the ethical precepts proposed in Resolution 466/2012 and was approved by the Ethics Committee in Research with Human Beings. Everyone consented to their participation after signing the Free and Informed Consent Form. To preserve anonymity the codes G1, G2, G3 and G4 and P1 to P9 were used.

RESULTS

The participants are in the age range between 27 and 60 years old, 26 of whom are female and four are male, with professional experience ranging from three months to 17 years. The meanings underlying the professionals' statements revealed four analytical axes: experiencing different types of violence; complexity of the life context; threat and insecurity in reporting the case of violence; and inter-sectoral disarticulation.

Experience of different types of violence

The professionals are able to identify or suspect different types of violence, such as physical, negligence and financial, with the family member as the main aggressor. They understand that older adults feel abandoned and lonely and, even so, they do not want to report it. The professionals, in turn, experience feelings of indignation and sadness.

Yes, there was a day when I went to visit [...]. The woman, she was always in an armchair in the room in front of the door, there was a table with a glass of water, some loose tablets on the table, a plate of food uncapped with a fly, a cup of coffee. I kept changing the diaper all the time and there was a lot of green flies surrounding it. That doesn't leave my memory! It's a situation of contempt, of abandonment, of little case (G2, P4).

[...] I found out that they needed to keep the father there, in which case it would be the son and daughter-in-law, to keep the father there because the father received the benefit. They used the benefit to pay the rent, for things like that (G1, P5).

The agent who goes to the home visit realizes that sometimes they are in a different place, further back in the house, a place that is inaccessible to the family members' rooms, but the older adult also doesn't want to report anything, so it's a case so difficult, of the types of violence we are less able to clearly identify [...]. (G3, P4).

Normally, what we have more like this, that I already saw here or in other units, is children who are already 40 years old, they don't leave the house, they are drug users, and then they end up attacking the parents, because of the money for drugs, so we have a lot (G1, P6).

Complexity of the life context

Many older adults live in complex situations, both social and family-related. In this context, some professionals came across older adults who are cared for by people who are also fragile, such as sons and daughters who use drugs. In addition, this care represents a burden on the family members, especially those with less purchasing power and who need to work. Overwork can also generate a situation of violence.

I think that an older adult could not live under the care of a person like that as he is in a situation that is also fragile, like this drug user son [...]. Does it have to be a family member like that, at least with a healthy head? So, even if they have some difficulty, but a healthy person (G1, P2);

Today the families see the older adults as a burden, who can afford it, resolve easily. But how good is paying? Of course, it solves, it helps, but what about that family, personal, love thing, doesn't it matter anymore? I mean, my parents were useful to me until a certain point in life, now I don't need them anymore, I have my life, my family, my job, which is much more important than them [...]. (G3, P8).

The difficulty is mainly in the lower class, because the rich man can pay a nurse, someone to stay there all day. Those with less purchasing power can't do it, so it's that person who gets really harmed, stays there all day in bed, if someone comes to give food, it's fine, if they don't come [...] because the person has to work too, they can't stop working [...]. (G1, P6).

The daughter attacked her father and mother. She's a user and she attacked her father and mother, both verbally and physically [...]. (G4, P4).

Threat and insecurity in reporting the case of violence

Referring to the insecurity in reporting, the health professionals state that they are constantly threatened in the coverage area, as they have worked for a long time in the unit and many of them also live in the same coverage area. In addition, the professionals reported insecurity in reporting cases to other services, as they end up informing the families who made the reports. Thus, they believe that the aggressors will always blame and revolt against the professional, leaving them at risk, especially when carrying out home visits. For this reason, many choose to make the report only by dialing 100, which remains anonymous. Some statements deal with this concept:

[...] The only thing we learned is that they came here "Oh, they went over to my house and said that you denounced! That the doctor made the report!" "I'm going to wreck his car!", "Let him just make a visit near my house." So like that, we stayed a month, is something going to happen? Will it not? [...] and we didn't get a response from the Council [...]. (G4, P4).

[...] The problem is that the unit is in that place, the employees are fixed, they know where the employees live. Depending on the family, it takes one way, but sometimes we deal with some areas, not only here, but in the whole city, some areas of risk, so depending, you create an absurd problem with the professional who leaves from the professional sphere and enters into personal issues, and then it's complicated (G2, P3).

There are some who even curse us, use bad words, still say that we have nothing to do. 'Come here and take care of our lives, they don't have anything to do?', they still curse us! (G1, P8).

With Dial 100 we already feel safe, there will be no problem in reporting [...]. (G4, P3).

Inter-sectoral disarticulation

The disjointed relationships in inter-sectoriality, the lack of communication and the resolution of cases are perceived by the team, limiting the quality of the service. They manifest that the team's professionals do not receive counter-referrals of the cases that have already been reported and, thus, the users and the health team are left with no answers, making it difficult to solve the health needs.

But I think that there is also a little lack of inter-sectoral support, that we are not fully supported; there is, but we don't have that close, you know? So, health does that, social assistance, CREAS and CRAS, CRAS not so much, that we already get more depending on the unit that you, plus CREAS, do something else and these two don't talk, don't get together (G2, P6).

[...] Because today we don't even receive any referral, so we really don't know what happened and, many times, I think that even in this case that you reported, the patient himself doesn't know what he solved, they are waiting for an answer from us [...] (G4, P3).

Lack of knowledge about the possible actions in the face of the situation of violence and the role of other services that are also responsible for the care of older adults victims of violence are difficulties faced by the professionals, since they do not know how to act. In addition, there is an understanding that many situations are not within their competence, they do not feel sufficiently supported for the approach because it is a complex situation, they feel discouraged in the face of those situations and suggest a support network.

Yes, or suddenly to know how far each one can go. What can CREAS really do, how far can they go? Do they know what we can do? How far can we go? What is the responsibility of the health area, of social assistance? (G4, P2).

I don't know, if I had another type of support network, [...] only the center would intervene? You have to have a support network, you have to have a structure, change that (G3, P8).

Just like this report that came to me yesterday from this father, then I even read it, I said it came to me, now I don't know, do they want me to refer the boy to the CAPES? [...] How are you going to make him go? No way! The father is already under medical follow-up, so what am I going to do there? It's not a part that will be the responsibility of nursing anymore (G1, P6).

Because at the beginning too, it seems that everything we encounter as a problem we want to bring and have a solution, everything will be solved, so we get discouraged (G1, P5).

DISCUSSION

In view of the intense dynamism and constant transformation in the context of public health, there is a need for a thorough understanding of the reality in which these actions are developed. Therefore, it is based on reflection and inquiry, with a view to essentially understanding the contradiction existing in this process, as the current context is one of uncertainties regarding the appearance of the facts and the ways of acting and interacting with them. The present study, therefore, was guided by dialectical hermeneutics in order to understand the perception of the professionals of the primary care team involving cases of violence against older adults.

In this context, it emerged that primary care professionals perceive the existence of different types of violence, with abandonment within the residence itself being quite common, where the older adult is placed in a room apart from the house, and remains in precarious conditions of survival, even lacking hygiene and food.

Associated with different types of violence, there is psychological, still being considered as one of the most difficult types to identify, since it was not recognized in the statements of the study participants.

Older adults who are victims of psychological violence suffer from emotional pain, anguish and distress. The aggressor uses actions that involve controlling, denigrating, depriving, intimidating, threatening, manipulating, blaming, harassing, infuriating, infantilizing and showing indifference¹⁵.

Many professionals claim that they are able to identify cases of violence, with abandonment and negligence being the most common; however, they prefer that the reports be made by the family or by the older adult, as the team is afraid of the aggressors' reaction.¹¹ It is added that the professionals believe that the lack of support and communication across the sectors responsible for the care of older adults who are victims of violence directly impairs the course of the entire care process for these individuals¹⁶.

Violence against the older adult is a contradictory human practice, present in the construction of interpersonal relationships, which is mainly revealed when the older adults do not realize that they are being neglected by the family member or caregiver. Thus, the present rule is modified and new orders and social representations are imposed, which make older adults even more vulnerable,¹³ through power relationships that influence behaviors and permeate interactions between the groups and the classes¹⁷.

However, although there are policies aimed at this segment of the population, more and more older adults are found abandoned by their own families and with precarious access to health, especially when they have unfavorable socioeconomic conditions.

As a positive aspect, it is acknowledged that, in view of the institutional devices, the older adult receives *status* as a citizen, which contemplates the principle of human dignity and full protection. Sequentially, other laws such as the Brazilian Civil Code - Law 10,406/2002, and specific laws - Law 10,741/2003 (Statute of the Older Adult), Law 8,842/1994 (National Policy for the Older Adult) and the Organic Law on Social Assistance (Law 8,742/1993), were elaborated with the purpose of clarifying and directing the attention that the older adult needs in the social, family and issues related to health care¹⁸.

In addition, due to affection or care dependence, older adults subject themselves to deplorable situations that can even lead to death. It is also worth mentioning that the situation of violence is also aggravated when the older adult is cared for by another aged person or by people who have mental disorders¹⁹.

In the speeches of the professionals, it is emphasized that they feel afraid, threatened and frightened when they seek to identify and communicate the cases of violence against the older adult, especially because they experience those situations that occur within the home and with family members themselves as aggressors. Faced with such a situation, they often do not know how to act and avoid continuing the case.

As it is related to a context in which the aggressor belongs to the victim's family, in addition to being linked to the trafficking or use of illicit drugs, both the older adult and the health professionals feel afraid and coerced not to report or interfere in the case of violence, making the matter even more complex.

In this perspective, violence is conceived by the professionals as a problem inherent to the family and notification is perceived as a possibility of disruption, both in the family order and in the bonding relationships between the health team and users²⁰. When reflecting on the violence against the older adult experienced by the professionals in the basic health care network, there is an inversion in the values of life, which can be opposed to the humanization of practices, since it evokes, in human action, moral values such as respect, compassion, solidarity, empathy and kindness. It is thus consistent with the fact that, even though they are aware of the relevance of the subjectivity field for the improvement of health care, the thought remains among the professionals that it is not possible to do it the way it should be²¹.

Thus, the professional role and the exercise of citizenship are disregarded, especially considering that primary care works on the logic of health surveillance of people, families and the community. In the objective appearance of reality, this condition can manifest itself as contradictory; however, in the dialectical logic, the contradiction manifests itself as a condition to be overcome, with a view to the continuous process of development²².

It is understood that violence is a difficult situation for the primary care team, as these professionals do not feel safe for such a confrontation, since their training was centered on the biomedical model and, in most of the events, they cannot deal with the uniqueness of the older adult and of the aggressor²³. In addition, even if they manage to identify what happened, there is lack of support and protection services for the older adult, which hinders the consolidation of the formal report¹¹.

In this perspective, the aim is to access a care network to address the issue in a multidisciplinary and inter-sectoral manner¹¹. In order to solve cases of violence in a forceful way, inter-sectorality is necessary, as support occurs both for the family and the victim as well as for the professionals, who are able to perform their function properly and supported because it is an integrated operation²⁴.

However, in the present study, the professionals report the difficulty in not having an effective counter-referral of the notified cases, in addition to witnessing the users' request for the resolution of problems that were referred to other sectors or care levels.

As much as there is a proposal in Brazil to bring health services closer to the community through bonding and longitudinality, failures in the referral and counter-referral process interrupt trust and continuity of care²⁵.

There is an understanding that, at the federal, state and municipal levels, actions to fight violence encounter obstacles in the operationalization of the health care network, which lacks assistance services in quantity and organization, financial resources and people trained to deal with situations of violence. Advances in this direction require a broader understanding of the phenomenon, a management involved with the establishment of flows, and the definition of diversified recognition and coping strategies²⁶.

In the inter-sectoral field, the difficulties run through even more complex issues, since professionals working in primary health care are even unaware of the role of other sectors in relation to violence against the older adult.

In order to fill the gap in the promotion of the assistance provided to the older adult, in 2002, the National Council for the Rights of the Older Adult was created, with the purpose of strengthening the inter-sectoral articulation and the social participation of the relevant actors for the social protection of the older adults. However, in an analysis of the performance of this council, in the period from 2002 to 2016 and in relation to the proposal of implementing and monitoring strategies of the National Policy for the Older adult (*Política Nacional do Idoso*, PNI) and the Statute of the Older Adult in the country, difficulties were found in the relationship between the social actors and little involvement of some governmental agencies²⁷⁻²⁸.

Therefore, this study is limited to the view of the health professionals working in primary care, for being carried out in four health units in a single municipality. Even so, it is believed that the data herein presented has the potential to produce reflections in face of the reality that proves to be multi-determined, contradictory and complex.

Furthermore, it is suggested that new studies be carried out with a more comprehensive focus on the perceptions and experiences of professionals from different areas, in addition to deepening the concepts of the family members related to cases of violence, in order to obtain data for a broader understanding of the theme, aiming at redefining the roles of the different services and the effectiveness of the service flow.

CONCLUSION

Referring to the perception of primary care professionals about violence against the older adult, the present study revealed that they suspect and identify cases of physical and financial violence and mainly negligence, with the main perpetrator of the aggression being a family member. They recognize that the victims do not report the cases of violence and show feelings of abandonment and loneliness. As they have lived in the same area of coverage or work in the unit for a long time, they feel threatened by the aggressors, leading to insecurity, which makes it difficult to report the cases and conduct other necessary interventions. Such facts lead to feelings of indignation and sadness among the professionals and for them to report the cases through Dial 100, which allows anonymity.

Disarticulation, lack of communication and counter-referral between the services responsible for the care of older adults who are victims of violence, as well as ignoring the role of the other services, limit the resolution of cases and, consequently, the quality of the service.

REFERENCES

1. Bittencourt P, Silva MA. Violência verbal contra idosos: palavras e silêncio marcados pela dominação. *Rev Pretextos* [Internet]. 2018 [cited 2020 Jan 31];3(6):622-40. Available from: <http://periodicos.pucminas.br/index.php/pretextos/article/view/15938>
2. World Health Organization. Missing voices: views of older persons on elder abuse. Geneva (CH): WHO; 2002.
3. Oliveira KSM, Carvalho FPB, Oliveira LC Simpson CA, Silva FTL, Martins AGC. Violence against the elderly: the conceptions of nursing professionals regarding detection and prevention. *Rev Gaúcha Enferm* [Internet]. 2018 [cited 2020 May 15];39:e57462. Available from: <https://doi.org/10.1590/1983-1447.2018.57462>
4. Cavalcante FG, Minayo MCS. Estudo qualitativo sobre tentativas e ideias suicidas com 60 pessoas idosas brasileiras. *Ciênc Saúde Coletiva* [Internet]. 2015 [cited 2020 May 15];20(6):1655-66. Available from: <https://doi.org/10.1590/1413-81232015206.06462015>
5. Castro VC, Rissardo LK, Carreira L. Violência contra os idosos brasileiros: uma análise das internações hospitalares. *Rev Bras Enferm* [Internet]. 2018 [cited 2020 May 27];71(Suppl 2):777-85. Available from: <https://doi.org/10.1590/0034-7167-2017-0139>
6. Castle N, Ferguson-Rome JC, Teresi JA. Elder abuse in residential long-term care: an update to the 2003 National Research Council report. *J Appl Gerontol* [Internet]. 2015 [cited 2020 Feb 3];34(4):407-43. Available from: <https://doi.org/10.1177/0733464813492583>
7. Câmara dos Deputados (BR). Brasil 2050: desafios de uma nação que envelhece [Internet]. Brasília, DF(BR); 2017 [cited 2017 Feb 23]. Available from: <http://www2.camara.leg.br/atividade-legislativa/comissoes/comissoes-permanentes/ce/noticias/brasil-2050-desafios-de-uma-nacao-que-envelhece>
8. Andrade JO, Castro SS, Heitor SFD, Andrade WP, Atihe CC. Indicadores da violência contra a mulher provenientes das notificações dos serviços de saúde de Minas Gerais-Brasil. *Texto Contexto Enferm* [Internet]. 2016 [cited 2020 June 02];25(3):e2880015. Available from: <https://doi.org/10.1590/0104-07072016002880015>.
9. Silva CFS, Dias CMSB. Violência contra idosos na família: motivações, sentimentos e necessidades do agressor. *Psicol Cienc Prof* [internet]. 2016 [cited 2020 Feb 5];36(3):637-52. Available from: <https://doi.org/10.1590/1982-3703001462014>
10. Camacho ACLF, Alves RR. Mistreatment against the elderly in the nursing perspective: an integrative review. *J Nurs UFPE online* [Internet]. 2015 [cited 2020 Feb 5];9(Suppl 2):927-35. Available from: <https://doi.org/10.5205/reuol.6391-62431-2-ed.0902supl201520>

11. Coelho LP, Motta LB, Caldas CP. Rede de atenção ao idoso: fatores facilitadores e barreiras para implementação. *Physis* [Internet]. 2018 [cited 2020 May 18];8(4):e280404. <https://doi.org/10.1590/s0103-73312018280404>
12. Oliveira KSM, Carvalho FPB, Oliveira LC, Simpson CA, Silva FTL, Martins AGC. Violence against the elderly: the conceptions of nursing professionals regarding detection and prevention. *Rev Gaúcha Enferm* [Internet]. 2018 [cited 2020 Feb 5];39:e57462. Available from: <https://doi.org/10.1590/1983-1447.2018.57462>
13. Instituto Brasileiro de Geografia e Estatística [Internet]. Cidades. Marília (SP). Panorama [cited 2020 Feb 7]. Available from: <https://cidades.ibge.gov.br/v4/brasil/sp/marilia/panorama>
14. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13th ed. São Paulo, Sp(BR): Hucitec; 2013.
15. Oliveira MM. Metodologia Interativa: um processo hermenêutico dialético. *Interfaces* [Internet]. 2001 [cited 2020 Feb 7];1(1):67-78. Available from: <https://periodicos.ufpel.edu.br/ojs2/index.php/interfaces/article/viewFile/6284/4372>
16. Brownell P. A reflection on gender issues in elder abuse research: Brazil and Portugal. *Ciênc Saúde Coletiva* [Internet]. 2016 [cited 2020 Feb 15];21(11):323-30. Available from: <https://doi.org/10.1590/1413-812320152111.23142016>
17. Alcântara MCM, Souza RR, Caetano LGA, Louzada CF, Silveira RP, Lima JO, et al. Subnotificação e invisibilidade da violência contra a mulher. *Rev Med Minas Gerais* [Internet]. 2016 [cited 2020 Feb 15];26(Suppl 8):S313-17. Available from: <http://rmmg.org/artigo/detalhes/2170>
18. Foucault M. *Microfísica do poder*. 13th ed. Rio de Janeiro, RJ(BR): Graal; 1998.
19. Viegas CMAR, Barros MF. Abandono afetivo inverso: o abandono do idoso e a violação do dever de cuidado por parte da prole. *Cadernos do Programa de Pós-Graduação em Direito/UFRGS* [Internet]. 2016 [cited 2020 Feb 16];11(3):168-201. Available from: <https://doi.org/10.22456/2317-8558.66610>
20. Hohendorff JV, Paz AP, Freitas CPPde, Lawrenz P, Habigzang LF. Caracterização da violência contra idosos a partir de casos notificados por profissionais da saúde. *Rev SPAGESP* [Internet]. 2018 [cited 2020 May 27];19(2):64-80. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=s1677-29702018000200006&lng=en
21. Eгры EY, Apostolico MR, Morais TCP. Reporting child violence, health care flows and work process of primary health care professionals. *Ciênc Saúde Coletiva* [Internet]. 2018 [cited 2020 Feb 16];23(1):83-92. Available from: <https://doi.org/10.1590/1413-81232018231.22062017>
22. Rios IC. Humanização: a essência da ação técnica e ética nas práticas de saúde. *Rev Bras Educ Med* [Internet]. 2009 [cited 2020 Feb 12];33(2):253-61. Available from: <https://doi.org/10.1590/S0100-55022009000200013>
23. Hegel GWF. *Fenomenologia do espírito*. 2nd ed. Petrópolis, RJ(BR): Vozes; 1992.
24. Schenker M, Costa DH. Advances and challenges of health care of the elderly population with chronic diseases in Primary Health care. *Ciênc Saúde Coletiva* [Internet]. 2019 [cited 2020 Feb 16];24(4):1369-80. Available from: <https://doi.org/10.1590/1413-81232018244.01222019>
25. Carmo ME, Guizardi FL. O conceito de vulnerabilidade e seus sentidos para as políticas públicas de saúde e assistência social. *Cad Saúde Pública* [Internet]. 2018 [cited 2020 Jan 31];34(3):e00101417. Available from: <https://doi.org/10.1590/0102-311x00101417>
26. Neto FJ, Bracciali DAL, Correa EM. Comunicação entre médicos a partir da referência e contra referência: potencialidade e fragilidade. *Atas – Investigação Qualitativa em Saúde* [Internet]. 2018 [cited 2020 Feb 18];2:101-10. Available from: <https://proceedings.ciaiq.org/index.php/ciaiq2018/article/view/1769>

27. Egry EY, Apostólico MR, Albuquerque LM, Gessner R, Fonseca RMGS. Understanding child neglect in a gender context: a study performed in a Brazilian city. *Rev Esc Enferm USP* [Internet]. 2015 [cited 2020 Feb 18];49(4):556-63. Available from: <https://doi.org/10.1590/S0080-623420150000400004>
28. Brasil. Decreto nº 9.893, de 27 de junho de 2019. Dispõe sobre o Conselho Nacional dos Direitos da Pessoa Idosa [Internet]. *Diário Oficial da União*. 2019 Jun 27 [cited 2020 Feb 20]. Available from: http://www.planalto.gov.br/ccivil_03/_ato2019-2022/2019/decreto/d9893.htm#art9

NOTES

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There is no conflict of interest.

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