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Violence against elderly people screening: association with perceived stress and depressive symptoms in hospitalized elderly

Rastreamento de violência contra pessoas idosas: associação com estresse percebido e sintomas depressivos em idosos hospitalizados

Detección de violencia contra personas mayores: asociación con estrés percibido y síntomas depresivos en ancianos hospitalizados

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Abstract

Objective: To assess the prevalence and factors associated with violence in hospitalized elderly. **Method:** Cross-sectional study conducted with 100 hospitalized elderly. The following instruments were applied: H-S / EAST, Perceived Stress Scale and Geriatric Depression Scale. Descriptive analysis was used for the sociodemographic and clinic characteristics. To associate age with H-S / EAST, the Mann-Whitney test was used; perceived stress with H-S / EAST the T test was used; and depressive symptoms with H-S / EAST the Likelihood Ratio test was used. **Results:** The average age of the elderly was 70.39 and 56.0%, there was an increased risk for violation of personal rights, characteristics of vulnerability and potentially abusive situations. The factors associated with increased risk for violation of personal rights or direct abuse in the elderly were older age, perceived stress and symptoms of mild to severe depression. **Conclusion and implication for practice:** These results show, the importance of careful observation of the elderly by the nurse to allow the identification of risk for violence or violation of rights. This allows establishing preventive actions, coordinated with the participation of other professionals as well as the correct referral of each situation, compliance with the legal duty of the profession and the citizen role.

Keywords: Aged; Violence; Depression; Hospitalization; Nursing.

Resumo

Objetivo: Avaliar a prevalência e fatores associados à violência em idosos hospitalizados. **Método:** Estudo transversal realizado com 100 idosos internados. Aplicaram-se os instrumentos: H-S/EAST, Escala de Estresse Percebido e Escala de Depressão Geriátrica. Utilizou-se análise descritiva para a caracterização sociodemográfica e clínica. Para associar a idade ao H-S/EAST foi utilizado o teste de Mann-Whitney; estresse percebido com o H-S/EAST foi utilizado o teste T, e sintomas depressivos com o H-S/EAST foi utilizado o teste da Razão Verossimilhança. **Resultados:** A média de idade dos idosos foi 70,39 e 56,0%, houve risco aumentado para violação de direitos pessoais, características de vulnerabilidade e situações potencialmente abusivas. Os fatores associados ao risco aumentado para violação de direitos pessoais ou abuso direto nos idosos foram maior idade, apresentar estresse percebido e ter sintomas de depressão leve a severa. **Conclusão e implicação para a prática:** Esses resultados mostram, portanto, a importância da observação atenta do idoso por parte do enfermeiro para permitir a identificação do risco para violência ou violação de direitos. O que possibilita estabelecer ações preventivas, coordenadas com a participação dos demais profissionais bem como o encaminhamento correto de cada situação, cumprimento do dever legal da profissão e do papel cidadão.

Palavras-chave: Idoso; Violência; Depressão; Hospitalização; Enfermagem.

Resumen

Objetivo: Evaluar la prevalencia y los factores asociados a la violencia en los ancianos hospitalizados. **Método:** estudio transversal con 100 ancianos hospitalizados. Se aplicaron los instrumentos: H-S / EAST, Escala de estrés percibido y Escala de depresión geriátrica. Se utilizó el análisis descriptivo para la caracterización sociodemográfica y clínica. Para asociar la edad con el H-S / EAST, se utilizó la prueba de Mann-Whitney; estrés percibido con el H-S / EAST se utilizó la prueba T; y los síntomas depresivos con el H-S / EAST se utilizó la prueba de relación de probabilidad. **Resultados:** La edad promedio de los ancianos era de 70,39 y el 56,0%, había un mayor riesgo de violación de los derechos personales, características de vulnerabilidad y situaciones potencialmente abusivas. Los factores asociados con un mayor riesgo de violación de los derechos personales en los ancianos fueron la edad más avanzada, el estrés percibido y los síntomas de depresión de leve a severa. **Conclusión e implicación para la práctica:** Estos resultados muestran, por lo tanto, la importancia de la observación cuidadosa de los ancianos por parte de la enfermera para permitir la identificación del riesgo de violencia o violación de los derechos. Esto permite establecer acciones preventivas, coordinadas con la participación de los demás profesionales, así como la derivación correcta de cada situación, el cumplimiento del deber legal de la profesión y el rol ciudadano.

Palabras clave: Anciano; Violencia; Depresión; Hospitalización; Enfermería.

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INTRODUCTION

In Brazil, since 1940, the elderly population has had high population growth rates, and it is estimated that by 2040 there will be 153 elderly for every 100 people under the age of 15.[1] Unlike in many developed countries, the increase in the Brazilian elderly population is progressive and rapid, which points to new challenges for the health sector due to the changing epidemiological profile of the country.[1] The load of physical and cognitive limitations resulting from senility and senescence, as well as the intergenerational conflicts that these individuals may experience, increase their vulnerability to social illnesses, among which, violence stands out.[2]

The Ministry of Human Rights reported that in 2018 there were more than 37,000 reports of violations against the elderly by Dial 100 (Dial Human Rights), such as neglect; financial and economic abuse; psychological, physical, and sexual violence against the elderly.[3] The state of São Paulo accounted for 21.59% of these reports. A study carried out in Emergency Units in the interior of the state of Paraíba identified a prevalence of 69.17% of risk of violence against the elderly through the Hawlek-Sengstock Elder Abuse Screening Test (H-S/EAST).[4]

According to Law no. 12,461 of 2011, violence against the elderly is considered any action or omission committed in a public or private place that causes death, harm or physical or psychological suffering.[5] It can be represented in the following typology: physical, psychological, sexual, abandonment, negligence, financial and self-neglect.[5]

The literature points out that the elderly often needs special care and attention from one or more family members. Thus, due to the fragility of the situation in which they find themselves, trust is placed in the family member/ caregiver who may become the aggressor/violator of their rights, transgressing them through physical, psychological or patrimonial violation, among other situations/cases. While, for cultural reasons, the elderly often does not believe that their rights have been violated, since they are victims of their own relatives.[6]

The issue of violence against the elderly gained visibility in Brazil in the 1990s with the enactment and regulation of the National Policy for the Elderly and, later, with the approval of the Statute for the Elderly and the Action Plan to Combat Violence against the Elderly, which made it mandatory for health professionals to notify suspicions or confirm all forms of violence.[5]

The literature points out that depression is highly prevalent in elderly people (15%) and increases to 60% in institutionalized elderly. Often the depressive disorder is associated with violence.[7] An integral part of this scenario is the higher level of perceived stress and which is linked to the higher level of depression.[8] In addition, these factors cause loss of autonomy and aggravation of pre-existing pathological conditions in the elderly, as well as social factors that interfere with functional capacity, self-care and their social relations.[9]

In the health field, population aging requires from the health system a continuous and multidisciplinary assistance organization, which renews the work process, assuring the realization of health actions and services that, in turn, promote the quality of life of these individuals, involving physical health and social and psychological well-being.[1,10] However, health professionals are lacking clear guidelines for the detection and evaluation of violence against the elderly, since, to date, there is no consensus on the tracking of risk factors for the occurrence of violence. This makes it difficult to recognize an elderly person as a victim of violence, since it is common for victims themselves to deny the existence of maltreatment.[11]

Violence against the elderly, in addition to being a serious human rights violation requiring urgent action, is a major public health problem that results in serious consequences for the health of victims, including increased risk of morbidity, mortality, institutionalization and hospitalization and has a negative effect on families and society in general.[12]

The phenomenon of violence suggests a greater field of investigation, given the vulnerability and risks to which the elderly is subjected. Health services are privileged spaces to detect violence due to their proximity to the population and their wide coverage. In this sense, the hospital has an enormous potential to program preventive actions, early detection and follow-up of this elderly person in a situation of violence, since its activities tend to strengthen the relationship between the health service and the family, facilitate the identification of elderly people at risk, make it possible to survey the possible social support networks available and allow a satisfactory transdisciplinary practice.[13]

The participation of nursing professionals is of extreme importance in the identification of violence and mistreatment against the elderly, identifying situations of risk, based on careful observation of the communication and behavior of this elderly person, which will reduce and combat situations of violence.[13]

Identifying violence and its risk factors is essential for reducing and stopping cases, providing the victim with adequate health care and subsidizing public policies to prevent violence. This is particularly important in the case of nursing professionals who, in the hospital environment, have great proximity to the patient during the entire period of hospitalization. Thus, the objective of this research was to evaluate the prevalence and factors associated with violence in hospitalized elderly.

METHOD

Epidemiological, transversal and analytical study carried out at Hospital São Paulo (HSP) - teaching hospital of the Federal University of São Paulo (Unifesp) - in clinical and surgical units. The process used to select the individuals included in the sample was for convenience, and the number of participants was defined by the time of data collection, from June 2019 to February 2020. Thus, the final sample of 100 elderly was composed. The study included seniors who were 60 years of age or older, who were able to understand and answer the questionnaires, without any record of dementia on file, and who agreed to participate

in the study and signed the Informed Consent Form. To obtain the data, a structured questionnaire was used with information about age, sex, skin color, schooling, marital status, occupation, days of hospitalization, family income, presence of a caregiver and comorbidities.

The Hawlek-Sengstock Elder Abuse Screening Test (H-S/EAST)[14] Scales were also used to assess the risk of violence against the elderly, Perceived Stress[15] and Geriatric Depression.[16] All scales are validated and transculturally adapted to the Brazilian language.

The Hawlek-Sengstock Elder Abuse Screening Test (H-S/EAST) is a 15-item instrument that covers three main areas of violence against the elderly: evident violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations. It evaluates the installed or presumed violence based on the perspective of the elderly themselves. One point is assigned to each affirmative response, except for items 1, 6, 12 and 14, where the point is given to the negative response. The score of three or more points may indicate increased risk of some kind of present violence.[14]

The Perceived Stress Scale that measures the perceived stress of the elderly has 14 questions with response options ranging from 0 to 4 (0= never, 1- almost never, 2- sometimes, 3- almost always, 4- always). The questions with positive connotations (4, 5, 6, 7, 9, 10 and 13) have their scores summed up inverted as follows (0= 4, 1= 3, 2= 2, 3= 1, 4=0). The others are negative and must be added directly. The total of the scale is the sum of the scores of these 14 questions and the scores can vary from zero to 56; the closer to 56 points the higher the stress.[15]

The Geriatric Depression Scale evaluates the depressive symptoms. In the score accounting, a point is assigned for each affirmative response, except for items 1, 5, 7, 11 and 13, where the point is given for the negative response, where six or more responses indicate the presence of depressive symptoms. The score varies from 0 to 15 points, where 0 to 5 points indicates a normal psychological picture, 6 to 10 points indicates a picture of mild depression, and 11 to 15 points indicates a picture of severe depression.[16]

Daily, the hospitalization sector was requested the list of patients aged 60 years and older and hospitalized in clinical and surgical units of HSP. Afterwards, the researcher went to each place, consulted the medical records to make sure that the researcher was able to understand and answer the questionnaires and instruments of the research and then made contact to verify if they fulfilled the other inclusion criteria. The confirmed elderly was invited to be part of the study and, when they agreed, they were interviewed individually. The reading of the instruments was made by the researcher in a single moment, with an average duration of 30 minutes.

Descriptive analysis was used for the socio-demographic and economic characterization, besides days of hospitalization, presence of a caregiver and comorbidities. The Mann-Whitney test was used to associate continuous variables to H-S/EAST and the Chi-square test was used to associate categorical variables to H-S/EAST; the T test was used to associate perceived stress to H-S/EAST and the likelihood ratio test was used to associate the occurrence of depressive symptoms to H-S/EAST. A significance level of 5% (p-value < 0.05) was used and the program used for the analysis was the Statistical Package for the Social Sciences, version 19.

This study was approved by the Research Ethics Committee of Unifesp (CAAE: 05900919.1.0000.5505), opinion number: 3.156.971.

RESULTS

The average age of the elderly was 70.39 years (SD= 7.18). Most were white, married, elementary school, retired/pensioner, no caregiver, 12.20 days mean of hospitalization, most prevalent morbidity was systemic arterial hypertension and the most used drug was the antihypertensive (Table 1).

Table 2 shows that 56.0% of those surveyed presented increased risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations. In relation to perceived stress 39.0% presented scores above the average value of the scale, which may indicate the presence of stress. And 44.0% presented a picture of mild to severe depression.

Table 3 shows that the elderly with increased risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations were older. The other variables were not statistically significant.

Patients with increased risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations obtained a higher average score on the perceived stress scale and a psychological picture of mild to severe depression (Table 4).

DISCUSSION

In this study there was a prevalence of men. This result may be related to men's lower adherence to self-care practices, placing them in a better position to be hospitalized, since the literature indicates that men are resistant to caring for their health due to gender-related issues such as feelings of fear and shame.[17]

The average age of 70.3 years is in line with the age range of studies related to violence suffered by the elderly.[9,18] It was observed in this study that elderly people with increased risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations were older.

Of the elderly interviewed, most make use of continuous medications, information in harmony with the literature. One research found a relationship between medication and depression, in which the greater the relationship between medication and the elderly, the greater the chance ratio for depression.[8] Projecting this scenario to the reality of this research, the risk for violence

Table 1 - Sociodemographic, economic and clinical characteristics of hospitalized elderly. São Paulo, Brazil, 2019 (n=100)

Variables	n (%)
Average age (years)	70.39 (7.18)
Gender	
Male	56.00 (56.00%)
Female	44.00 (44.00%)
Color	
white	45.00 (45.00%)
Black	18.00 (18.00%)
Parda	34.00 (34.00%)
Yellow	3.00 (3.00%)
Marital Status	
Married	55.00 (55.00%)
Single	15.00 (15.00%)
Widower	15.00 (15.00%)
Divorced	15.00 (15.00%)
Education	
Illiterate	11.00 (11.00%)
Incomplete elementary school	15.00 (15.00%)
Elementary school	40.00 (40.00%)
High School	19.00 (19.00%)
Higher Education	15.00 (15.00%)
Employment	
Employee	18.00 (18.00%)
Unemployed	6.00 (6.00%)
From home	9.00 (9.00%)
Retired	67.00 (67.00%)
Family income (in R$) (minimum-maximum)	1.000.00 a 10.000.00
Presence of a caregiver	
Yes	40.00 (40.00%)
No	60.00 (60.00%)
Hospitalization (days) average (PD)	12.20 (15.90)
Morbidities	
Systemic Hypertension	77.00 (77.00%)
Diabetes Mellitus	35.00 (35.00%)
Neoplasms	28.00 (28.00%)
Drugs	
Antihypertensives	77.00 (77.00%)
Hypoglycemic	33.00 (33.00%)
Anti-ulcer drugs	17.00 (17.00%)

increases even more, since the symptoms of depression generate greater vulnerability in the elderly, and may interfere with their functional capacity, self-care and social relations.

The most prevalent morbidity in this study was HAS. Hypertension is the most common chronic disease among the elderly, because the changes proper to aging make the elderly more prone to its development.[19] In line with yet another study that showed that having chronic diseases is a preponderant criterion for cases of violence against the elderly, as it can generate a degree of permanent stress, which in itself is an important risk factor for chronic diseases.[20]

Retirement was mentioned by most of the interviewees and the family income of those surveyed varied from one to nine and a half minimum wages. Higher income can provide better preventive care and lower incomes can compromise the elderly's access to health services,[21]but, the range of income seen in this sample suggests a heterogeneous scenario and that in both, there is a risk for violation of personal rights, which may or may not be related to financial violence.

As for schooling, data from this survey identified that 40% had completed elementary school, information consistent with a study conducted in Ribeirão Preto, where most of the victims had completed first grade, but most were women.[22]

The most prevalent marital status in this sample is that of the married, which is consistent with a survey conducted in Minas Gerais, in which there was a predominance of married elderly victims of violence.[18] However, other literature suggests that marriage may be a positive factor for healthier aging and that the absence of a partner may also be a factor for neglect.[23] In contrast, another study showed that the degree of kinship that is most involved in aggression against the elderly is related to that of the spouses themselves.[24]

As far as caregivers are concerned, the sample reflected a little present reality, which may contribute to negligence, refusal and omission of care needed by the elderly or abandonment, which suggests characteristics of vulnerability, pointed out in other literature.[22] The lack of adequate care by the caregiver also configures violence against the elderly, moreover, the limitation of support from the state and society to families of dependent elderly becomes one of the conditions of the genesis of violence.[2]

Hospitalization can have a great impact on the elderly person, favoring functional decline due to iatrogenic factors such as excessive time restricted to bed, sleep deprivation, isolation, malnutrition and development of negative thoughts.[25,26] In this study, the average hospitalization was long, this time should be seen by health professionals are only as an opportunity to restore the physical health of the elderly, as well as a time to identify risk factors for direct abuse, in addition to drawing up lines of care and post-discharge follow-up and make the necessary notifications, foreseen in law.

Mild to severe depression was found in 44% of patients. Depression is one of the most prevalent chronic diseases in this age group and is associated with compromised functional capacity and

Table 2 - Risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations, perceived stress and symptoms of depression in hospitalized elderly. São Paulo, Brazil, 2019 (n=100)

Scales	Score	n (%)
H-S/EAST*	From 0 to 2 points	44.0 (44.0%)
	3 or more points	56.0 (56.0%)
Stress Scale	From 0 to 28 points	61.0 (61.0%)
	From 29 to 56 points	39.0 (39.0%)
Geriatric Depression Scale	Normal psychological picture	56.0 (56.0%)
	Light depression board	38.0 (38.0%)
	Severe depression	6.0 (6.0%)

* Hawlek-Sengstock Elder Abuse Screening Test

Table 3 - Sociodemographic and economic characteristics related to increased risk for violation of personal rights or direct abuse of hospitalized elderly. São Paulo, Brazil, 2019 (n=100)

Variables	Hawlek-Sengstock Elder Abuse Screening Test		p-value
	0 to 2 points	3 or more points	
Average age (years)	68.34 (6.21)	72.00 (7.53)	0.0161*
Average (real) family income (SD)	3619.41 (2166.17)	3814.89 (2190.33)	0.6334*
Gender			
Male	26.00 (46.40%)	30.00 (53.60%)	0.5810**
Female	18.00 (40.90%)	26.00 (59.10%)	
Marital Status			
Married	29.00 (52.70%)	26.00 (47.30%)	0.0559**
Single	3.00 (20.00%)	12.00 (80.00%)	
Widower	4.00 (26.70%)	11.00 (73.30%)	
Divorced	8.00 (53.30%)	7.00 (46.70%)	
Skin color			
White	19.00 (42.20%)	26.00 (57.80%)	0.9543**
Black	8.00 (44.40%)	10.00 (55.60%)	
Brown	16.00 (47.10%)	18.00 (52.90%)	
Yellow	1.00 (33.30%)	2.00 (66.70%)	
Presence of a caregiver			
Yes	18.00 (45.00%)	22.00 (55.00%)	0.8693**
No	26.00 (43.30%)	34.00 (56.70%)	
Schooling			
Not literate	4.00 (36.40%)	7.00 (63.60%)	0.7083**
Incomplete elementary school	6.00 (40.00%)	9.00 (60.00%)	
Elementary school	16.00 (40.00%)	24.00 (60.00%)	
High School	11.00 (57.90%)	8.00 (42.10%)	
Higher Education	7.00 (46.70%)	8.00 (53.30%)	

* Mann-Whitney test, ** Chi-square test

Table 4 - Association between the risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations, perceived stress and symptoms of depression in hospitalized elderly. São Paulo, Brazil, 2019 (n=100)

Scales		Hawlek-Sengstock Elder Abuse Screening Test		p-value
		0 to 2 points	3 or more points	
Stress Scale	Average (Standard Deviation)	23.93 (8.84)	30.64 (8.77)	0,0003* 0.0003**
GDS*	Normal psychological picture	35.00 (62.50%)	21.00 (37.50%)	0.0001***
	Light depression board	8.00 (21.10%)	30.00 (78.90%)	
	Severe depression	1.00 (16.70%)	5.00 (83.30%)	

GDS- Geriatric Depression Scale, **test T, ***test Ratio of Likelihood

quality of life, financial expenditure, increased demand for health services, and often has suicide as an outcome.[27] The compromised functional capacity may be related to the finding in this study, in which the elderly who scored higher for a psychological picture of mild to severe depression had increased risk for violation of personal rights or direct abuse.

Regarding the perceived stress, 39.0% presented a score above the average value of the scale, a result that comes partially in line with another research that describes the stressors experienced by hospitalized elderly people. Aging is marked by the decrease of physiological reserves and chronic diseases and can make the elderly more susceptible to stress, relating it to hospitalization, which further amplifies the feeling of loss.[25]

Although it is a relevant theme, publications on violence against the elderly in Brazil are still incipient. This phenomenon can be related to the difficulty of addressing the issue and the formation of a cultural shield that prevents the acceptance and recognition of the facts.

As a limitation of the study, the fact that the sample was collected in a single service is noteworthy, which may not substantially represent other realities; however, these results may support the practice, since the health service should be seen as a privileged place to investigate violation of rights, since the factors explained in this research have great relevance in identifying violence.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The results of this study contribute to alerting educational institutions and health services of the need to instrumentalize the student/nurse for the investigation and identification of elderly people at risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations. In this study, most of the elderly presented increased risk for violation of personal rights or direct abuse, characteristics of vulnerability and potentially abusive situations and presence of stress. Elderly people with higher age had increased risk for violation of personal rights or direct abuse. And, those with increased risk for violation of personal rights or direct abuse had higher average scores on the scale of perceived stress and psychological picture of mild to severe depression.

Regarding this scenario, stress, as a consequence of longevity or not, should be seen as an important factor for the vulnerability of the elderly and should not be treated naturally, since in this study, patients with increased risk for violation of personal rights obtained a higher average score on the perceived stress scale.

The nurse has a fundamental role in preserving the integrity of the elderly person and in identifying situations of violence, in addition to being more likely to face situations of risk for violence against the elderly because he is in direct care of the patient almost routinely. Therefore, the use of qualified scales for tracking violence against the elderly such as the Hawlek-Sengstock Elder Abuse Screening Test (H-S/EAST) should be part of hospital care protocols for this population. This can allow preventive actions, coordinated with other professionals, as well as the correct referral of each situation with effective interventions for each case, thus avoiding late or traumatic forms of interventions. In addition, it allows the fulfillment of the legal duty of the profession and the citizen role and the care focused on the needs of the elderly patient, identifying risk factors for direct abuse, such as depression and stress.

The hospital also has a responsibility in combating violence against the elderly, so it must train its professionals to face this problem, supported by the understanding of social conflicting relationships, which is urgent and necessary given the results presented in this research.

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