Forensic psychiatry and Human Rights throughout life: children, adolescents and the elderly

Psiquiatria forense e Direitos Humanos nos pólos da vida: crianças, adolescentes e idosos

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Abstract

Objective: *Children/adolescents and elderly are frequent victims of violent acts either because of their frailty and dependency or because they are not considered as reliable subjects to present cases of abuse against the perpetrators. There is an interesting relationship between civil capacities and legal responsibilities of minors and elderly. This is a critical review of minor and elder abuse that also presents and compares the Brazilian laws regarding the rights and responsibilities of elderly and minor subjects.* ***Discussion:*** *Abuse may be examined regarding two aspects: 1) predictive factors of their occurrence (a profile of the abused and of the abuser), and 2) consequences for mental and physical health.* ***Conclusion:*** *This legislation is modern and protective of these vulnerable populations. Examining and diagnosing violence and abuse against children and elderly subjects must be part of the clinical and forensic practice of doctors and especially of psychiatrists.*

Descriptors: *Child abuse; Elder abuse; Violence; Human rights; Forensic psychiatry*

Resumo

Objetivo: *Crianças/adolescentes e idosos são alvo fácil para atos de violência, seja por sua fragilidade e dependência, seja por não serem considerados testemunhas confiáveis para denunciar os casos de abuso e maus-tratos. Temas como violência, capacidade civil e responsabilidade penal de crianças, adolescentes e idosos guardam correlações interessantes de serem avaliadas. Esse artigo faz uma revisão crítica do tema, compara e discute os Estatutos da Criança e do Adolescente e o Estatuto do Idoso no Brasil.* ***Discussão:*** *Os abusos ou maus-tratos podem ser examinados a partir de dois aspectos: 1) fatores preditivos para sua ocorrência (perfil do abusado e do abusador) e 2) agravos à saúde física e mental.* ***Conclusão:*** *O Brasil conta hoje com legislação avançada para proteção dessas populações vulneráveis e o tema de violência e maus tratos contra crianças e idosos deve ser parte da preocupação de clínicos e psiquiatras que tratam desses pacientes.*

Descritores: *Maus-tratos infantis; Maus-tratos ao idoso; Violência; Direitos humanos; Psiquiatria legal*

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Introduction

The manner in which elders and minors are treated reveals, in itself, the degree to which a given society has become civilized. Minors and elders represent age groups of the population deserving special attention, both from a medical and a legal/social standpoint. Given their nature, both groups require measures for the development of specific public policies to ensure their rights. In this context, they can be regarded as vulnerable populations.

Children, adolescents and elders are easy targets for violent acts of all sorts, whether due to their frailty and dependence or because they are not considered reliable witnesses against their abusers, or even due to their exclusion from the culture to which they are exposed. This situation is such that, in Brazil, it was necessary to enact specific laws to protect these age groups. Therefore, the *Estatuto da Criança e do Adolescente* (ECA, Statute for Minors; Federal Law 8.069/90)[1] and the *Estatuto do Idoso* (EI, Statute for the Elderly; Federal Law 10.741/03)[2] were created.

Viewed through this prism, the legal provisions specified in the ECA and EI can be seen to present several points in common, mainly as to the safeguard of civil rights and the social protection of these more vulnerable individuals, although there are particulars with respect to legal capacities and criminal liabilities. To the best of our knowledge, the elderly have full legal and criminal capacities, whereas children and adolescents do not personally exercise any such civil acts until 16 years of age, then having only partial autonomy until the age of 18, as provided for in the Brazilian Civil Code, articles 3 and 4.[3] In contrast, minors cannot be held accountable for crimes and are under the custody of their parents or, in case of the loss or suspension of parental power, legal guardians (articles 33, 34, 35 and 36 of the ECA).[1]

It is important to evaluate, as a whole, the social, medical and legal situations to which elders and minors are subjected in order to arrive at a systemic understanding of the problems affecting these individuals throughout their lives. Topics such as violence, legal capacity and criminal liability harbor interesting correlations worthy of assessment. This could create an opportunity for integrated studies and common interventions to reduce the risk of exposure to violence and to protect civil rights throughout life, despite the fact that the various manifestations of individual and social violence differ depending on whether the victims are children, adolescents or elders.

The purpose of this study was to describe situations of violence against minors and elders, analyzing their common points and specificities. In view of this, we aim to outline a correlation between the ECA and the EI.

Mistreatment and abuse of minors and elders

The psychosocial phenomenon of violence affects these groups via behaviors known as abuse and mistreatment. These are defined as actions in which a subject in a superior position – in terms of age, power, discretion, social or economic class – causes damage of a physical, emotional or sexual nature, either against the will of the victim or even with the consent thereof. Such consent is obtained, however, through inducement, seduction or allurement.[4] The problem is worsened by the imbalance of power (individual or social), resulting from the offensive capability of the agent, and the lack of defensive capability of the victim. This definition also implies the failure, on the part of the caregiver, to provide basic care for, meet the needs of and protect the minor or elder.

Violence can be classified into two major categories: institutional and domestic (intrafamily/interpersonal).

Institutional violence is that in which the violation of rights and the harm to physical and mental health are caused, either by action or inaction, in social institutions such as day care centers, schools, hospitals, educational institutions, judicial institutions, nursing homes and retirement homes, whose primary responsibility is the protection of individual rights. In these institutions, violence can be perpetrated in the form of humiliation, threats or aggression (physical or sexual) by peers, teachers, monitors, inspectors and employees. Some children or adolescents are more susceptible due to distinctive physical features, such as obesity, protruding ears and malformations, and psychological traits, such as shyness and isolation, that are not well accepted by their peers and people with whom they share a daily routine. Sociodemographic conditions can also be a determining factor for those naturally more exposed to violence, which might be the case for individuals from certain social groups and for those living in regions controlled by drug gangs.

Intrafamily violence is under-reported. It is not uncommon to encounter violence occurring against minors and elders – both within the same family structure. The general incidence of violence in the population varies from 0.3% to 4% against women, and is 8% for violent acts among the population as a whole. The incidence throughout life varies from 8% to 22%, and has been associated with the use of drugs, although a causal link has not been established.[5-6]

It is equally important to point out the symbolic violence, occurring when individuals or their families are discriminated against and held accountable for events caused by perverse mechanisms of social selection, such as school failure, dropout and grade repetition. These events are attributed to biological causes or to the morality of the victims, and not to other social variables which may be more strongly associated with such outcomes.[7] Here, state violence is included, represented by the various forms with which state power, the macro-institution defining and shaping all others, mistreats children, adolescents and elders, principally by denying the basic needs provided for in the constitution, namely: education, housing, health care, personal safety and employment.

Table 1 presents the main types of minor and elder abuse.

Clinical and epidemiological aspects of child, adolescent and elder abuse

Abuse or mistreatment can be analyzed from two standpoints: 1) factors predictive of its occurrence (profiles of abuser and victim); and 2) harm to physical and mental health. Throughout this subitem, we will describe some features of the most important types of abuse.

Among the modalities of sexual abuse, we find the following: 1) those which do not involve physical contact (verbal abuse, obscene phone calls, exhibitionism, voyeurism and pornographic exhibitions); 2) those which involve physical contact (the touching of body parts considered sexually arousing, such as thighs and buttocks, and the touching of private parts, intercourse or attempted intercourse – vaginal or anal – and orogenital contact); and 3) those which involve violent sexual abuse (rape and brutalization).[4]

Some indicators may contribute for outlining the profile of minors who are victims of sexual violence. França, in a review of the literature, found that 3–16% of boys and 2–62% of girls present a "risk of being abused".[8] In the United States,

Table 1 – Principal forms of violence against children, adolescents and the elderly

	Children/Adolescents	Elders
Physical abuse	The use of intentional, non-accidental, physical force used by parents, guardians, family members or persons close to the minors with the purpose of causing injuries or damage, leaving or not evident marks. Authors have described some uncommon manifestations of physical abuse in children: "beaten child syndrome", "shaken baby syndrome", "tin ear syndrome" and "Münchausen syndrome by proxy", where the latter can also be included under the category of psychological mistreatment.	Includes the intention of causing physical pain or lesions. Some examples: angry wife/caregiver administers laxatives to husband suffering from Alzheimer's disease, unaware of her intentions, because he goes out every afternoon to meet friends or even women. Elders with dementia who are restless or are constantly moaning can be pinched or beaten without leaving any marks.
Psychological abuse	Psychological abuse, due to its subtleties, lack of evidence or the fact that it is too concealed in other kinds of violence, often goes undetected. All types of discrimination, rejection, disrespect, derogation, disdain, punishment or exaggerated demands are considered psychological abuse.	Acts intended to cause pain or psychological trauma. Humiliation, harsh insults or demands related to past actions within the family environment.
Negligence	Negligence is the "failure of the adult responsible for the minor to provide the basic developmental needs." Said failure can result in physical, emotional or psychological harm, or even in the death of the minor. Negligent acts can be physical (when the child does not receive the basic hygiene care or is not given proper food or clothing) or emotional (when they lack protection, affection, attention or other necessary input for their development as individuals).	Failure to meet the basic, physical or psychosocial needs of the dependent elder.
SexualaAbuse	All sexual acts or games, whether heterosexual or homosexual, performed with the intention of obtaining sexual satisfaction through the minor, perpetrated by individuals at a more advanced stage of psychosexual development by physical violence, duress, enticement or induced consent. It also comprises situations of sexual exploitation for profit, such as child pornography (widely spread on the Internet) and child prostitution (sexual tourism attraction).	
Material exploitation		Appropriation of money or property

the National Committee for the Prevention of Child Abuse (1995), in a study involving one million confirmed cases, identified the causes of the events as negligence in 45%, physical abuse in 26%, sexual abuse in 11%, emotional abuse in 3% and diverse or non-specific in 16%.[9]

In Brazil, there are still few studies addressing this topic. In a survey conducted by Ferreira in a pediatrics unit in the city of Rio de Janeiro, victims of child abuse were predominantly female (70.5%), and most (81.7%) were between 2 and 10 years of age.[10] Intrafamily abuse accounted for 47.3% of the cases, and the most common type of sexual contact was touching of the genitals (31%). According to the *Associação Brasileira de Multiprofissional de Proteção à Infância e à Adolescência* (ABRAPIA, Brazilian Multiprofessional Association for the Protection of Minors), of 1547 charges of abuse against children and adolescents, 52% of the victims were between 7 and 14 years of age, 37% were younger than 6 years of age, and 11% were between 15 and 18 years of age.[11] In 76% of the cases, the victims were female. In a study carried out by the *Fundação Oswaldo Cruz* (Oswaldo Cruz Foundation), the most common types of intrafamily violence are physical and verbal, and family conflicts are resolved through parental violence in 52.8% of cases and by the sibling-on-sibling violence in 75.5% of cases.[12-13] In another study, conducted by the (city of) Campinas *Centro de Referência, Estudos e Ações sobre Crianças e Adolescentes* (CECRIA, Center for Reference, Studies and Interventions for Minors) and involving 3644 cases, it was found that 47.1% had been physically harassed, 20.2% had been neglected/abandoned, 6% had been sexually abused and 10.9% had been psychologically harassed, the remaining 15.8% of the cases being deemed groundless.[14] Such figures, however, might represent only the tip of the iceberg, since it is difficult to identify the nature of the violent acts due to fear and inability to report such abuse on the part of the victims.

The prevalence of abuse against elders varies from 2% to 10%, depending on the type of population studied and research locations, whether in communities or in retirement homes. The extent of the problem in everyday life is exemplified by the fact that a clinician seeing 20 to 40 elders per day will examine at least one victim of abuse.[15]

Among the elderly, the risk factors involved in the cases of violence vary according to the type of abuse or mistreatment. Due to more frequent interpersonal contact, which generates conflicts and tensions, the risk of abuse or physical violence is greater among elders presenting dementia and living with family members. Elders living alone and suffering from isolation are more frequently the victims of economic abuse, which is, in itself, another form of violence.[16]

The psychopathology of the perpetrators of such abuse is principally associated with alcohol addiction and depression, in addition to being economically dependent on the elder. It should be pointed out that elders requiring care are those most often wielding the economic power in their families.

Although members of the general public, and even health care professionals, tend to view the topics of abuse and mistreatment as falling under the purview of the judiciary and law enforcement, these are also medical concerns, at least with regard to their complications. From a clinical identification viewpoint, victims of different forms of violence may present various reactions, as well as emotional, behavioral and somatic symptoms, which, even

if not specific or pathognomic, can be viewed as forensic biological markers.[17]

Among the physical and mental injuries resulting from violence, traumas have been the most widely studied. Collin-Vezina & Hebert found that, among school-age girls who had been sexually victimized, there was an eight-fold greater likelihood of dissociate symptoms and a four-fold greater likelihood of post-traumatic stress syndrome.[13] In addition, traumas experienced during childhood tend to affect the general development of the child.[18] There is a strong association between post-traumatic stress symptoms and violent events, such as violence in the community, natural disasters, abuse/mistreatment of minors, traffic accidents, exposure to diseases and death.[19] In Brazil, behavioral disorders (hyperactivity, aggressiveness, depression and anxiety) have also been reported among minors living in violent communities, similarly to what occurs in countries at war or subject to frequent terrorist acts. In summary, abused minors are at risk for post-traumatic stress syndrome, self-aggressive behavior, mood disorders, substance abuse, sexual problems, positive psychotic symptoms and dissociative disorders.

Cases of abuse are not always easily recognized, since perpetrators do everything to ward off suspicion and distance themselves from the crimes they have committed. At the same time, minors and elders do not always spontaneously report what happens to them. Therefore, it is important that health professionals remain alert to indications of abuse of these individuals. The following is a list that can help the clinician to recognize or suspect abuse and mistreatment.

1) Indications of sexual abuse

In minors: imitative behaviors or heightened interest in sexually-related activities incompatible with age and sociocultural group; inclination to avoid anything related to sexuality; sexually-aggressive play; signs of abuse in drawings, games or play; embarrassment and excessive timidity; self-aggression; claims of abuse; suicidal ideation or suicide attempts; fear of having something bad strike the sexual organs; regressive attitudes; suspicion of adults; running away from home. In elders, there are no reliable statistics on the topic.[20] Lesions of the skin or mucosa, as well as bleeding or infection (urinary or vaginal), can be signs of abuse. Common signs in minors and elders: nightmares, night terrors, insomnia, anxiety, sadness, depression and isolation from friends and family.

2) Indications of physical abuse

The indications of physical abuse include the following: pain, blemishes and physical lesions, such as burns, cuts, bruises, wounds and fractures (including previous, consolidated fractures) incompatible with the alleged causes; highly aggressive or apathetic behavior; discipline problems; feelings of low self-esteem and poor self-image; frequent absences from day-care or preschool; reports of aggression by parents, children, caregivers or guardians; passive or introverted behavior; feelings of sadness; self-destructive and self-injurious behavior; fear and anxiety; reliving of aggressive experiences; nightmares; running away from home; difficulty in trusting and showing affection for others. Lesions of the skin and contusions appear more rapidly and disappear more slowly in elders than they do in minors. Due to less extensive vascularization, lower regeneration capacity and greater tissue atrophy, such injuries tend to persist for months in elders, whereas they disappear after one or two weeks in minors.[8,17]

3) Indications of neglect

Indications of neglect are as follows: deficient growth pattern in minors; malnutrition and dehydration in elders; fatigue or lack of energy; unmet needs; illnesses; weather-inappropriate clothing. As in all social classes, it is important not to confuse neglect and abandonment with the great number of extremely difficult situations caused by poverty and misery. In elders, self-neglect must also be considered, since individuals refusing care offered might not be capable of providing for their own basic daily needs in terms of hygiene and nutrition, which can result in health problems. In such cases, it is necessary to assess whether these individuals present dementia or cognitive processes attributed to self-neglect.[17] A decline in hygiene can be a forensic marker of neglect.[15]

Clinical problems, such as infections, are also common among the elderly. Neglect can, for instance, result in insufficient doses of medications for the control of metabolic diseases, or even excessive doses, causing severe intoxication. The risk of falling, whose main complication is fracture of the femoral neck, can also be increased by inattention to the personal safety of the fragile elder. However, such cases are rarely confirmed. Therefore, the same causes that led to this complication, namely, violence or negligence, can continue, increasing morbidity and mortality in such cases. Mortality among abused elders is three times higher than among individuals of the same age group not suffering from this problem.[15] Weight loss, malnutrition and abuse of medications are some of the clinical factors that should call attention to the possibility of abuse in minors and elders. In elders, failure to adhere to drug treatment regimens, often evidenced by uncontrolled diabetes and hypertension, can also raise the suspicion of mistreatment if adherence depends on the caregivers or family members.

In summary, based on risk factors and on the most common cases of abuse and mistreatment, the profile of the minor or elder most vulnerable to violence can be outlined. The profile of abused minors can be summarized as follows: female; belonging to a family with high levels of spousal conflict, with little parental connection, alcoholic parents, living with step-parents; and presenting delayed development or deficiencies. Although 5% of all cases are attributed to the mother, the general profile of the abuser is mainly male, the majority of cases being attributed to men who are members of the victim's family: father (33%); stepfather (35%); grandfather (10%); uncle (7.5%); or brother (3%).[11] The prototype abused elder is an individual with cognitive impairment who is socially isolated and living with persons with mental problems, especially alcoholism and depression.[15,21] It should be borne in mind that the possibility of abuse and mistreatment can be greater, in terms of frequency and of severity, if the physician seems distracted or negligent.

Forensic assessment of children, adolescents and elders in cases of violence

Psychiatrists should define and explain to the involved individuals their role in the assessment of the situations of abuse and mistreatment. They can act either as forensic psychiatrists or as clinicians and therapists. In the former case, they are required to develop and present reports and opinions assessing the capacity of the child or elder to testify regarding the incidents of abuse, the repercussions for the mental health of the victim, and the risks of maintaining contact with the alleged aggressor. In the latter case, the major concern is to intervene on behalf of the minor or elder and those responsible therefor. To that end, it is necessary to identify the needs and

possible psychopathological impairments presented by the examined subject. Psychiatric assessment, in principle, is carried out, from one case to another, in the same way: anamnesis and collection of the most complete data possible, together with the examination of the mental state of the patient and the responsible caregivers. In addition to those directly responsible, every person with significant information should be heard and all existing documents should be analyzed. The history should focus on the form and content of the victim claims and the examiner should be alert to the possibility of influence and contamination. Physical and behavioral symptoms are indications or evidence that can suggest or lend support to the clinical diagnosis (signs of trauma, post-traumatic stress, anxiety, depression, disassociation, changes in sexuality patterns and spatiotemporal disorientation, among others). Interviews should be conducted very carefully, so as to avoid leading questions and not further victimize the minor or elder. In the case of minors, the use of graphic techniques, tests and anatomical dolls can be useful, although they present limitations and should only be used by experienced professionals. Complete and accurate physical examinations should be conducted by a pediatrician specializing in the appropriate area, depending on the nature of the abuse. In elders, physical examinations should be conducted with special attention paid to lesions, contusions, scars, signs of malnutrition and dehydration, as well as indications of neglect of hygiene in elders who require assistance in performing their routine daily activities.

The forensic report should include identification and qualification of the assessor, identification of the assessed individual, the information obtained, description of exams, results of conducted procedures, coded diagnosis under DSM-IV[22] or ICD-10,[23] and, finally, include the conclusions, recommendations and answers to the inquiries.

Rights of minors and elders in Brazil: similar and complementary points in both statutes

The purpose of Federal Law 8069/90, the ECA, is to specify and regulate the rights granted to children and adolescents by the Federal Constitution (article 227), and to create legal instruments to ensure them. The ECA was enacted on July 13, 1990 and supersedes the former view, in which minors were regarded as objects. Brazilian Law thus entered a new phase, adopting the doctrine of full protection of minors. After 13 years, with the same view of full protection and with the purpose of regulating the fundamental rights of elders (articles 229 and 230 of the Federal Constitution), the EI was enacted through Federal Law 10.741/03 and was put in force on January 1, 2004.[1-2] Within this context, the EI is, in many of its articles, a copy of ECA, changing the designations "child and adolescent" to "elder", with the necessary adaptations. Both statutes equally address policies regarding care and entities dealing with these segments of the population, as well as administrative violations and legal actions applicable thereto, also regulating access to the judicial system and the role of the Public Prosecutor's office.

Table 2 summarizes the principal points in common and the specificities of each one of these documents. Just as the ECA was fundamental for the progress of civil society, introducing rights for children and adolescents in Brazil, the

Table 2 – Statute for the Child and Adolescent vs. Statute for the Elderly

	ECA	EI	Comments
Age group	Children (up to 12 years old) and adolescents (between 12 and 18 years old): article 2	60 years old or older: article 1	On an exceptional basis, the ECA applies to individuals under 21 years of age: article 2
Scope	Minors who are victims of violence or in irregular situations; and juvenile delinquents.	Considers abused elders only.	Elderly committing crimes are subject to the Criminal Code
Rights	Fundamental rights: articles 7 to 69. Preemptive rights.	Fundamental rights: articles 8 to 42. Fast-track procedures: Pre-emptive rights.	Minors' absolute priority is specified in article 227 of the Federal Constitution. Hence, they are above infra-constitutional laws.
Prevention of violation of rights	General statutes for the prevention of threats or violation of rights: articles 70 to 73 and articles 208 to 224		
Special prevention of violation of rights	Statutes on information, culture, leisure, sports, entertainment, products and services, and travel authorizations: articles 74 to 85		
Protective measures	Articles 99 to 102	Articles 43 to 45	Protects the elderly from all abuses mentioned in Table 1
Punishment for perpetrators of acts against individuals in this age group	Measures applicable to parents and guardians: articles 129 and 130. Violation of rights: articles 228 a 244. Administrative violations: articles 245 to 258	Crimes against the elderly: articles 95 to 108.	All crimes against children, adolescents and the elderly are subject to criminal proceedings, not requiring that victims file charges
Punishment for individuals from this age group committing crimes.	In the case of adolescents, social instructional measures – articles 112 to 128. In the case of children: protective measures– articles 101 to 105	No. Elderly committing crimes are subject to the Criminal Code. Individuals over 70 years of age have their punishment mitigated.	Individuals under the age of eighteen have no legal capacity.
Guardianship	Appointment of guardian in case of loss or suspension of parental power.	Appointment of guardian for elders judicially declared unfit	In the New Civil Code, in effect since January of 2003, parental power is named family power.
Notice of violence	Mandatory notice: articles 13 and 245. Notice of either suspicion or confirmation of abuse against minors is mandatory.	Mandatory notice: articles 19 and 57. Notice of either suspicion or confirmation of abuse against the elderly is mandatory	Ministry of Health Ruling No. 1968/GM, of 2001, requires that a Notice of Suspicion or Confirmation of Abuse Against Minors be filled out.

same can be said of the EI, although it has only recently been enacted and put into effect. They both govern the care that society, the family and the state should provide to these two age groups, establishing sanctions against those depriving them of such rights, and create institutional provisions at all levels of government (local, state or federal), within the executive, legislative or judiciary branches, so that all the rules thereof are observed. These are extremely advanced and comprehensive laws. However, they are still rather insipient, insofar as the social, cultural and economical difficulties, as well as those related to the technical instrumentalities of the state, do not yet allow them to be observed as intended.

Conclusion

Ethics and respect for human rights should be the guiding principles of medical interventions and public policies. Violence against children, adolescents and the elderly is more common than that observed by health agents and needs to be actively studied, in the clinical context as well as in the social sphere. Physicians, especially psychiatrists and other mental health care professionals, should be sensitive and skilled in preventing, identifying, diagnosing and treating cases of abuse and negligence among minors and elders. Physicians should also inform the appropriate authorities, conduct expert examinations and draw up requested reports and opinions.

Knowledge of the ECA and EI is essential so that health professionals treating minors and elders can identify risk situations, know how to take proper measures and therefore practice medicine of a higher standard, taking a more defensive stance in relation to civil rights, including those of the practitioners themselves.

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