



Violence against older people in Brazil: associated factors according to the type of aggressor

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Abstract

Factors associated with violence against older Brazilians were analyzed according to the type of aggressor. Population-based cross-sectional study with secondary data from the National Health Survey in 2013, totaling 11,697 individuals aged 60 years or older in Brazil. The dependent variable was having suffered violence by a known or unknown aggressor, and the independent variables were divided into blocks (Socioeconomic and demographic; Self-perception and health care; Health service use; Health status/disease and Functioning). The effect of the independent variables on the response variable was expressed by the “Odds Ratio” with a 95% Confidence Interval. Hierarchical models of simple and multiple multinomial logistic regression were performed. In the simple analysis, variables with p -value <0.05 were elective for multiple analysis. A thematic map was constructed according to the spatial distribution of violence, by state. White skin color, <68 years, knowing how to read and write, sleep problems, not feeling pleasure in doing activities and having a physical disability were associated with the unknown aggressor. Poor health, smoking, discrimination in the health service and feeling bad about oneself were associated with the known aggressor. Discrimination by type of illness and little difficulty going, out alone were associated for both aggressors. States with the highest number of cases of violence found were Amapá, Paraná, Mato Grosso, Amazonas and Rio Grande do Norte. Thus, estimating the prevalence of violence against older people, the type of aggressor, as well as associated factors, is essential for identifying and preventing individual, institutional and structural abuse.

Keywords: Violence. Old man. Older people abuse. Aged, 80 and over.

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INTRODUCTION

There are 962 million individuals aged 60 or over in the world, the expectation is to at least double in 2050 and triple in 2100, reaching 3.1 billion people¹. Even in the face of such a rise in the number of older people and the increase in life expectancy, society is still not attentive to these subjects and this invisibility exposes them to hidden violence².

With aging, individuals become more vulnerable, due to dependence on other people for basic activities of daily living, there is a cognitive deficit or natural limitations of aging itself, which generates less power of defense and facilitates the action of aggressors³.

According to the World Health Organization (WHO)⁴, violence is the use of physical force or power, in a threat against oneself, other individuals, groups or communities that may cause suffering, death, psychological damage, decline in development or deprivation, and may be physical, psychological, sexual, financial, negligence, abandonment and self-neglect.

When dealing with abuse against older people, the WHO defines it as a punctual or repeated act or, even in the absence of an action, that occurs in the face of a relationship of trust and that causes harm, suffering or anguish for the older person⁵. According to data from a systematic review and meta-analysis developed by Yon et al (2017)⁶, violence affects one in six older individuals in the world, totaling about 141 million victims, among an estimated population in 2015 of 901 million people over 60 years old.

The type of interpersonal violence, intrafamily or domestic, occurs between sexual partners or other family members, however, because the aggressor is known to the victim and is part of their relationship, there is possibly a high underreporting among these abused older people⁶. In these cases, it is clear that there is a greater search for family reorganization than for judicial penalties⁷.

Furthermore, official homicide statistics omit information about the relationship between perpetrator and victim, making it difficult to identify the aggressor. When dealing with non-fatal violence that are referred to hospital emergency services,

several factors influenced the report of the aggression suffered, among them, whether or not the aggressor was known to the victim⁸.

Regarding the aggressor not being known (such as bandits, police, providers of any type of service, or anyone who has no blood or affective bond with the victim) there is in Brazil, as well as in other parts of the world, a culture that belittles and discriminates against individuals based on their age, attitudes identified by the terms ageism or etarism. In addition to structural, contextual violence and negligence on the part of public policies so that all the rights of the older person are guaranteed⁹.

When considering that violence against older people is a complex and multifactorial problem, the relevance of carrying out studies with this population is highlighted, especially the understanding of the prevalence of violence in older people, according to the type of aggressor.

Studies have shown that most aggressors are family members, usually with mutual dependence between victim and aggressor, financial or care, which makes it difficult for the coexistence to be interrupted. In addition to family members, caregivers were highlighted as the main aggressors^{10,11}. From the discovery of the aggressor, the search, detection and notification of violence and the abused older people are evidenced for a cessation of these acts through early interventions by health professionals.

Without this clarification, it is difficult to formulate effective national action plans and structural policies for violence prevention. Given the above, the objective is to identify the factors associated with violence against older people in Brazil, according to the type of aggressor (known or unknown).

METHODS

Population-based cross-sectional study with secondary data. The probabilistic cluster sample consisted of individuals aged 60 years or older, interviewed in the National Health Survey (PNS) in 2013, in Brazil, totaling 11,697 people. The interviews were carried out in over 64,000 households (response rate =94%).

The PNS is a survey carried out by the Brazilian Institute of Geography and Statistics (IBGE) and the Ministry of Health, constituting the most complete survey of health and its determinants, part of the Integrated System of Household Surveys (SIPD)¹².

The specific part of the individual questionnaire for individuals aged 60 years or older was selected. The independent variables are described in Chart 1, divided into blocks, according to the hierarchical model.

Chart 1. Independent variables and classification according to the hierarchical model. Brazil, 2022.

BLOCKS	QUESTIONS
Socioeconomic and demographic	Sex? Color or race? Age? Do you live with a spouse or partner? What is the marital status? Can you read and write?
Self-perception and health care	In general, how would you rate your health? Do you currently smoke any tobacco products? In the last three months, did you practice any kind of physical exercise or sport? (do not consider physiotherapy). How often do you usually consume alcoholic beverages?
Use of health service	Have you ever felt discriminated against or treated worse than other people in the health service by a doctor or other health professional for: Lack of money? Social class? Race/Color? Type of occupation? Illness? Religion/belief? Age? Another motive?
State of Health/Illness	In the last 12 months, were you hospitalized for 24 hours or more? Has a doctor or mental health professional (such as a psychiatrist or psychologist) diagnosed you with: -Depression? -Another mental illness, such as schizophrenia, bipolar disorder, psychosis, or OCD (Obsessive Compulsive Disorder)? In the past two weeks, how often did you: -Have you had sleep problems, such as difficulty falling asleep, waking up frequently at night, or sleeping more than usual? -Did you have problems with not feeling rested and ready during the day, feeling tired, without energy? -Did you feel bothered by having little interest or did you not feel pleasure in doing things? -Did you have trouble concentrating on your usual activities? -Have you had eating problems, such as having a lack of appetite or eating a lot more than usual? -Did you feel depressed, “down” or hopeless? -Did you feel bad about yourself, feeling like a failure or feeling like you let your family down? -Did you use any medication to sleep?
Functionality	Do you participate in organized social activities (clubs, community or religious groups, senior living centers, etc.)? Do you drive a car? Do you have a physical disability? Do you have any hearing impairment? Do you have any visual impairment? In general, how difficult is it to go out alone using public transport such as the bus, subway, taxi, car, etc.?

Source: Prepared by the author. The questionnaire and details of the PNS sampling plan are available at: http://www.ibge.gov.br/home/estatistica/populacao/pns/2013/default_microdados.shtm

The dependent variable was derived from two questions: “*In the last 12 months, have you suffered any violence or aggression from an unknown person (such as bandits, police officers, robbers, etc.)?*” and “*In the last 12 months, have you suffered violence or aggression from a known person (such as father, mother, child, spouse, partner, boyfriend, friend, neighbor)?*” In this sense, a single dependent variable was built with three categories of answers: 1) did not suffer violence (reference); 2) suffered violence from a known person and; 3) suffered violence from an unknown person.

To associate the dependent variable with the independent variables, two statistical approaches were used. Initially, the chi-square test with Rao-Scott correction was used for complex samples. The significance level was 5%, and standardized residual values >1.96 were considered. In the second approach, simple and multiple models of multinomial logistic regression were used, based on the assumption of the hierarchical approach of Victora, et al (1997). The reference category of the dependent variable was not having suffered violence and the measure of effect was expressed by the Odds Ratio (OR), and respective 95% Confidence Intervals¹³.

Initially, a simple analysis was performed in blocks and variables with $p < 0.25$ were elective for multiple analysis. At the end, variables with $p < 0.05$ remained in the final model of each block and were considered adjustment factors for subsequent blocks. All analyzes were performed considering the weights and sample strata contained in the PNS database, from the perspective of hierarchical analyses. This type of analysis is based on conceptual models for explaining the associations, which can contribute to elucidate mechanisms that have so far been little explored¹⁴.

A thematic map was constructed according to the spatial distribution of violence against older people according to the type of aggressor, by Federation Unit. The *software* used was QGIS version 2.18 (free tool) which had the functionality of storage, management, manipulation, spatial analysis and generation of thematic map, an important subsidy for decision making.

With this, the importance of georeferencing is observed, which consists of showing epidemiological data according to geographic information, taking into account the position on the earth's surface¹⁵. Therefore, when we spatially localize violence against older people and the types of aggressors (known or unknown), we know the spatial distribution of these conditions throughout the Brazilian territory.

The PNS project was approved by the National Commission on Ethics in Research for Human Beings, of the National Health Council (CNS), under opinion number 328,159, on June 26, 2013.

RESULTS

Among the sample studied, 97.1% of the older people stated that they had not suffered any type of violence, while 1.7%, 95% CI (1.5-2.2) reported having suffered violence from an unknown person and 1.3%, 95% CI (1.1-1.7) violence from a known person. In addition, 60.4% were female, 54.6% were white, 54.2% did not live with a spouse or partner, 44.3% were married and 77.4% knew how to read and write.

In the simple logistic regression analysis, of the 34 variables analyzed, 30 had $p < 0.25$ and were tested in the multiple model. At the end, 13 variables remained with statistical significance, $p < 0.05$ (Table 1).

Table 1. Association of violence in older people by known and unknown people with the five blocks of analyzed variables, according to the multiple model of multinomial logistic regression. Brazil-2013.

Variables	Unknown		Known		<i>p</i> -value
	OR	95%CI	OR	95%CI	
Block 1: Socioeconomic and Demographic Factors^a					
Color or race					0.010*
Black	1		1		
White	2.53	1.28~4.99†	1.34	0.63~2.86	
Yellow and Indigenous	3.50	0.83~14.77	0.08	0.01~0.64†	
Brown	1.77	0.88~3.58	1.35	0.63~2.90	
Age					0.038*
>68 years	1		1		
<68 years	1.68	1.07~2.64†	1.35	0.63~2.90	
Can you read and write?					0.001*
No	1				
Yes	2.76	1.63~4.70†	1.01	0.61~1.70	
Block 2: Self-perception and Health Care Factors^b					
Health assessment					0.020*
Very good or good	1		1		
Regular	1.13	0.70~1.83	0.88	0.53~1.44	
Very bad or bad	1.21	0.55~2.65	2.39	1.29~4.43†	
Do you smoke any tobacco products?					0.008*
I dont smoke	1		1		
Yes, daily	1.51	0.76~3.00	2.17	1.21~3.89†	
Yes, less than daily	2.63	0.78~8.83	4.09	1.18~14.19†	
Block 3: Health Service Use Factors^c					
Discrimination in the health service by a health professional due to:					
Disease type?					0.002*
No	1		1		
Yes	3.78	1.37~10.48†	3.04	1.35~6.87†	
Race/color motive?					0.001*
No	1		1		
Yes	3.22	0.75~13.77	0.02	0.00~0.18†	
For religion/belief?					0.006*
No	1		1		
Yes	0.15	0.02~1.29	6.06	1.63~22.52†	

to be continued

Continuation of Table 1

Variables	Unknown		Known		<i>p</i> -value
	OR	95%CI	OR	95%CI	
Block 4: Health/Illness Status Factors^d					
In the past two weeks:					
Did you have sleep problems?	1		1		0.026*
No	1.64	0.91~2.96	1.93	0.10~3.75	
Less than half the days	2.07	0.81~5.32	0.86	0.41~1.81	
More than half of the days	1.83	1.01~3.30†	1.70	0.98~2.95	
Did you feel bothered by having little interest or did you not feel pleasure in doing things?					0.010*
No	1		1		
Less than half the days	0.97	0.47~2.00	1.10	0.51~2.39	
More than half of the days	3.43	1.45~8.15†	1.67	0.71~3.89	
Almost everyday	0.36	0.14~0.90†	0.75	0.34~1.66	
Did you feel bad about yourself, feeling like a failure or feeling like you've let your family down?					<0.001**
No	1		1		
Less than half the days	1.16	0.60~2.22	3.87	1.91~7.85†	
More than half of the days	2.08	0.59~7.31	0.80	0.25~2.56	
Almost everyday	2.61	0.53~12.71	5.14	2.23~11.88†	
Block 5: Functionality Factors^e					
Do you have a physical disability?					0.011*
No	1		1		
Yes	5.53	1.66~18.45†	0.54	0.18~1.68	
Difficulty level to go out alone using transport such as bus, subway, taxi, car, etc?					
Not able	1		1		0.004*
Has great difficulty	1.60	0.31~8.19	2.16	0.67~5.97	
Has little or no difficulty	6.46	1.66~25.08†	3.13	1.14~8.64†	

Multiple logistic regression. OR *odds ratio*; 95% CI 95% confidence interval; * $p < 0.05$; † variable category with $p < 0.05$; ^a Adjusted by Block 1 variables; ^b Adjusted by Block 1 and Block 2 variables; ^c Adjusted by the variables of Block 1, Block 2 and Block 3; ^d Adjusted by the variables of Blocs 1, Block 2, Block 3 and Block 4; ^e Adjusted by the variables of Block 1, Block 2, Block 3, Block 4 and Block 5.

In the multiple logistic regression of Block 1, admitting the reference category of color or race “Black”, whites were approximately 2.5 times more likely to suffer violence from an unknown person and the yellow and indigenous people had a 92% less chance of suffering violence from a known person.

With regard to age, older people below the median (68 years old) were 1.68 times more likely to suffer violence from an unknown person. And those who could read and write (reference “does not know how to read and write”) were 2.76 times more likely to suffer violence also from an unknown person.

In Block 2, after adjusting the variables of Block 1, in the health assessment variable (reference “very good or good”), those who evaluated their health as “very bad or bad” were 2.39 times more likely to suffer violence from a known person; smoking any tobacco product (reference “I do not currently smoke”), those who smoked daily were 2.17 times more likely to suffer violence from a known person and those who smoked less than daily, approximately 4 times more likely to suffer the same type of violence

In Block 3, after adjusting the variables in Blocks 1 and 2, the variables of discrimination in the health service: by type of disease, were 3.78 times more likely to suffer violence from an unknown person and 3 times more from a known person, compared to those who have not suffered. Discrimination by religion/belief generated 6 times more chances of suffering violence from a known person compared to those who denied having suffered.

When analyzing Block 4, after adjusting the variables in Blocks 1, 2 and 3, who had sleep problems, such as difficulty falling asleep, waking up frequently at night or sleeping more than usual (reference “no day”), “almost every day” was 1.83 times more likely to suffer violence from an unknown person. Those who felt bothered by having little interest or did not

feel pleasure in doing things (reference “no day”), more than half of the days were 3.43 times more likely to suffer violence from an unknown person.

The older person who felt bad about themselves, thinking they were a failure or thinking they had let their family down (reference “no day”), in “less than half of the days” were 3.87 times more likely to suffer violence from a known person and in “almost every day”, 5.14 times more chances of this type of violence.

In the last block, after adjusting the variables with statistical significance from the previous blocks, those with physical disabilities, compared to those without, were 5.53 times more likely to suffer violence from an unknown person. Those who had little or no difficulty going out alone, using transport such as the bus, subway, taxi, car, etc. (reference “not able”) were 6.46 times more likely to suffer violence from an unknown person and 3.13 times more likely to suffer violence from a known person.

With regard to violence against older people, by Federation Unit, according to Figure 1, it was observed that the state with the highest rate was Amapá (7.1%), followed by Paraná (6.4%), Mato Grosso (6.2%), Amazonas (5.9%) and Rio Grande do Norte (5.0%). While the lowest rates of violence against older people were in Pernambuco (2.4%), Piauí (2.3%), Minas Gerais (2.0%), Rio de Janeiro (1.6%), Bahia (1.4%) and Paraíba (1.1%).

Violence by unknown person was considerably higher than by known person in Mato Grosso (4.7%), Amazonas (3.8%), Rondônia (3.0%), Roraima (2.9%), Federal District (2.6%), São Paulo (2.2%), Alagoas (1.9%) and Bahia (1.1%). By known person was considerably higher in Rio Grande do Norte (3.2%), Tocantins (3.0%), Santa Catarina (2.6%), Pará (2.4%) and Espírito Santo (2.1%). In the other states, the types of violence were similar.

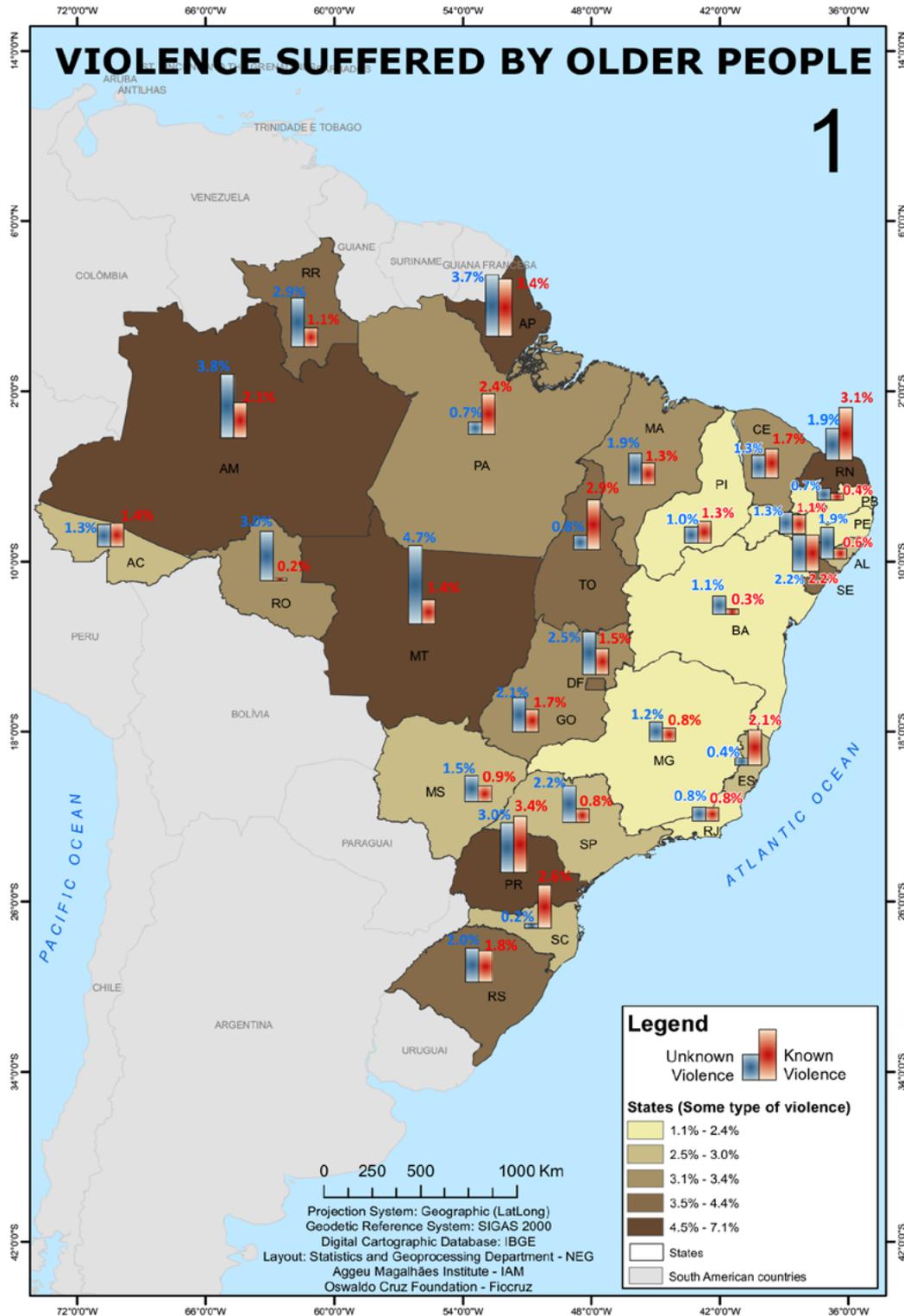


Figure 1. Map of violence against older people in Brazil. Brazil,2013.

DISCUSSION

These results constitute a collaboration for the recognition of violence at the national level, through them, the violence perpetrated by known and unknown family members and their associated factors are evidenced. Such findings were based on questions about having suffered violence from an unknown person, that is, who are not part of their coexistence, such as bandits, police officers, robbers, etc. Or if they suffered violence from a known person, such as a father, mother, child, spouse, partner, boyfriend, friend, neighbor in the last 12 months.

As a result, there was a divergence of this study in relation to research carried out in Mexico and Korea, given that in these countries most cases of violence were perpetrated by members of the family. In Brazil, most cases of violence were committed by unknown persons. This finding suggests that in Brazil the high rates of social violence reflect on the older population and make them more susceptible victims^{17,18}.

Color or race, age, knowing how to read and write, health assessment, smoking, discrimination in the health service, depressive symptoms, physical disability and degree of difficulty going out alone seem to explain the differences in the type, frequency and place of violence against older people. In this sense, it is necessary to increase knowledge about the dynamics of the social determinants of violence.

Regarding race/color, white older people were more likely to suffer violence from an unknown person compared to black people. The fact that white people historically have better living and employment conditions makes them more functionally independent for basic and instrumental daily activities, leading to greater exposure to external causes of violence. Additionally, this group has greater purchasing power, which makes it a more attractive victim¹⁸.

The yellow and indigenous people were less likely to suffer violence from a known person, which can be explained by the unity and respect for elders in the indigenous tribes. Corroborating this thought, a study carried out with indigenous people of the Guarani-Mbyá ethnic group demonstrated that older people

in the tribe are important for organizational decision-making, policies, protection and implementation of the rights and duties of the community. In addition to transmitting traditions, they are respected for the life experience they have¹⁹.

The younger the individual and the less difficulty he has going out alone, the more independent he will be to take walks, have a more active social life. As a result, they become more exposed compared to the oldest, who are often unable to go out unaccompanied due to the natural limitations of aging. In addition, it is known that it is common for a person with compromised health to demand greater care from relatives or close people and, therefore, they are more likely to be abused by family members^{3,18}.

Descriptive study with a qualitative approach, carried out with older people in the northwest of Rio Grande do Sul, showed that between 60-69 years old, it is common that the functional capacity is not compromised by the aging process, consequently they interact with more people and have greater decision-making power, thereby decreasing the chances of being targets of abuse²⁰. In addition, there is a high level of violence reported in this age group, which can be justified by the autonomy of life, greater demand for health services or protection services for older people, thus allowing greater detection and investigation of cases of violence, which justifies the findings³.

It is suggested that those who can read and write are more empowered, due to access to education, in some cases, better income and quality of life, which makes them more exposed to violence by unknown persons. As well as improving the reporting of violence, denunciation and notification³. However, according to Gil et al.²¹, older people who have no schooling are more likely to report violence, those with ten years or more of schooling are 60% less likely to make a complaint.

While Miya Chang¹⁷ stated in her research that those who have less years of education are more vulnerable and at greater risk of violence, however by a known person. This fact can perhaps be explained because domestic violence can often happen due to a historical naturalization in the social context where the older people live. In addition to dependence, fear

of retaliation or abandonment and the embarrassment that older people have to denounce their own spouses, children, nephews or other close people¹⁰.

Older people who use tobacco were more likely to suffer violence from a known person. According to Zaitune²², there is an association between older smokers and self-reported depression/anxiety. Regarding smoking cessation, people who did not suffer physical violence had a 67% greater chance of quitting smoking²³. It is not possible to infer whether older people suffer more violence because they are smokers or whether they are smokers as a result of the violence suffered, due to the cross-sectional nature of the study.

Discrimination in the health service, or in any environment, can be classified as psychological violence. This type of violence is characterized by verbal or gestural offense, to terrify, humiliate or exclude from social life²⁴. All this can lead to low demand for health services in cases of violence.

The health service can also be the locus of reproduction of institutional violence, as it favors the repetition of violent behaviors in the treatment and care of the older people. This type of violence is understood to mean that practiced in health services, through actions or omissions, namely, from lack of access to rights to poor quality of services, such as lack of attention, respect, consideration of popular knowledge, discrimination, unnecessary queues, among others²⁵.

Ignorance of the aging process, combined with prejudice, can lead to violent acts such as those mentioned above, in addition to mistakes in prescriptions for medications, exams and diets. So the health professional does not recognize it as a practice of violence due to the naturalization of these processes in daily practice²⁵. Therefore, according to Ruela-Gonzalez¹⁶, the low demand for health services in cases of violence may explain the underreporting and low prevalence of these cases in health systems, making it essential to investigate the factors associated with the underutilization of health services after an event of violence or abuse.

Regarding the block "State of health/disease", the questions are similar to those contained in the Beck-

II Depression Inventory (BDI-II)²⁶. The BDI-II was adapted to the Brazilian population by Gorenstein, Pang, Argimon and Werlang in 2011 and measures the severity of depressive symptoms and can be applied to different samples^{27,28}.

Therefore, through the questions contained in that block, symptoms of depression were associated with violence, coinciding with other studies. The more intense the symptoms, the more chances of violence¹⁶. A systematic review found that the diagnosis of depression was a risk factor found in almost all types of violence, but could not infer whether older people suffered violence because they were depressed or whether they acquired these depressive symptoms due to the mistreatment suffered, since most of the studies were cross-sectional and therefore suspend causality⁰³. The importance of screening for depressive symptoms in the older people is evident, in order to prevent abuse, through interventions according to risk factors.

Those with physical disabilities were more likely to suffer violence from an unknown person. Disability generates an additional limitation to those typical of aging, increasing vulnerability and exposure to violence, as it reduces the power of defense and makes victims more susceptible. In addition, it is also in line with ageism, discrimination can generate violence when the older people have some type of disability that takes them away from a standard of normality that society attributes, as well as dependence for locomotion and lack of accessibility also make them more exposed to violence⁹.

With regard to violence against older people by Federation Unit, it was observed that the states with the most violence against older people were Amapá, Paraná, Mato Grosso, Amazonas and Rio Grande do Norte. While Pernambuco, Piauí, Minas Gerais, Rio de Janeiro, Bahia and Paraíba had the lowest rates of violence against older people.

While the homicide rate/100,000 inhabitants by Federation Unit in 2016 showed the following: Sergipe (64.7), Alagoas (54.2), Rio Grande do Norte (53.4), Pará (50.8), Amapá (48.7), Pernambuco (47.3), Bahia (46.9), Goiás (45.3), Acre (44.4) and Ceará (40.6), with 6 states in the Northeast region, 3 in the North region and 1 in the Midwest²⁹.

As a methodological limitation, this study presented intrinsic restrictions to studies that use secondary databases, namely: the researcher cannot interfere in the questionnaire that was used, the studied variables were pre-established; the objectives of the primary research were different from the current research and prevented new information from being acquired; long questionnaires, such as those applied in the PNS, can generate memory bias, in which the participant forgets or loses the will to report past events.

Furthermore, violence was not asked by type (physical, psychological, sexual, abandonment, neglect, financial or economic, self-neglect, medication, emotional or social). Only the term violence was used, which may have been associated only with physical violence; and finally, the fear of talking about violence to unknown people (interviewers), which certainly led to underreporting.

It has been shown that the confinement generated by COVID-19 increased the levels of stress, anxiety and depression in the population³⁰. In addition, for the older person with cognitive impairment, quarantine with a family member was recommended to avoid acute confusion or delirium in the older person and contamination by caregivers³¹. According to the newspaper “O Globo”³², during this period there was an increase of almost 600% in reports of violence registered on the “Dial 100”. The absence of specific policies aimed at this public in order to face the impacts of the pandemic enhances the feeling of abandonment and indicates negligence on the part of the public power towards this population, characterizing structural violence.

Despite the time limitation of this study, with data from almost 10 years ago, knowing the violence in 2013 will become a baseline for comparison with data from 2019, since at the time of conclusion of the study, data from the PNS 2019 were not yet available. Associated with new studies related to the increase in violence due to the COVID-19 pandemic.

However, despite the limitations common to the methodological design, this study deals with an essential contribution to the field of violence against older people in the Brazilian population, with

emphasis on the type of aggressor, generating the possibility of a new look at the theme and serving as an instrument for planning and institutions of actions and public policies for the prevention of violence. Therefore, there is a need to train health professionals to detect, notify and actively search for the older people and aggressors, in order to stop violent practices, which are often interpreted as an acceptable pattern of relationships.

CONCLUSION

It was evident that being white, being < 68 years old, declaring knowing how to read, suffering discrimination in the health service due to some type of illness, having sleep problems almost every day, having no interest or pleasure in doing things, having a physical disability or a small degree of difficulty going out alone, using transportation such as the bus, subway, taxi, car were risk factors for aggression by a known person.

While those who assessed their health as very bad or poor, use tobacco, suffered discrimination in the health service due to illness, religion/belief, or who felt bad about themselves, feeling like a failure or disappointing their family were risk factors for violence by an unknown person.

Estimating the prevalence of violence against older people, the type of aggressor, as well as associated factors, is essential for identifying and preventing individual, institutional and structural abuse. Additional research on this topic is recommended, with a focus on social determinants that may use different methodologies, considering the sociocultural, economic and health context of this population.

Also noteworthy is the encouragement of public policies and strategies in families and communities to prevent violence against older people, based on a culture of respect for human rights and the participation of multiple actors in the social process of improving the well-being of these people in family and in society.

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