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Institute of Gerontology
Candido Mendes University (UCAM)

Report on Elder Abuse in Brazil

Laura Machado (national expert)
Clinical Psychologist, M.A.
Latin America Representative for INPEA

Romeu Gomes (facilitator)
Researcher, Phd, Public Health

Elizabeth Xavier (assistant)
Geriatric Physician, M.D.
*coordinator of the Programme of the
elderly of the Rocha Maia Hospital*

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1. INTRODUCTION

The purpose of this study is to investigate **elder abuse in Brazil**.

“A definition developed by the UK’s Action on Elder Abuse and adopted by the International Network for the Prevention of Elder Abuse (INPEA) states: “Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. It is usually categorized as:

- physical abuse: the infliction of pain or injury, physical coercion, physical/chemical restraint.
- psychological/emotional abuse: the infliction of mental anguish.
- financial/material abuse: the illegal or improper exploitation and/or use of funds or resources.
- sexual abuse: non-consensual contact of any kind with an older person.
- neglect: the refusal or failure to fulfill a care-taking obligation including/excluding a conscious and intentional attempt to inflict physical or emotional distress on the older person”. (WHO, 2001)

In this study, elder abuse was examined taking as reference the understanding of the violent behavior deriving from the structural

violence that oppresses groups, classes, nations, and individuals (Bulding, 1981). Furthermore, for the concept of elder abuse, there is not always an explicit interpersonal relation, but also a somewhat vague dimension in a context of *silent violence* (Mertes, 1981).

Currently, abuse is already considered a public health problem, which should be focused by governmental agencies and non-governmental organizations in terms of research, prevention, and intervention strategies to tackle it. However, as mentioned by Bennett et al (1997), elder abuse was “the latest form of abuse [that] also gained legitimacy as a political phenomenon alongside child abuse and domestic violence”.

While violence against children became an issue in the 60s, only in 1975 the first British scientific reports on elder abuse were published. Nevertheless, it took some 15 years for this topic to be subject of research and political focus in the United Kingdom (Bennett et al, 1997). Later on, reports on the topic were published in the United States (U.S Congress, 1980; Wolff, 1986, Pillemer & Finkelhor, 1988) and Canada (Podnieks, 1990; McLean, 1995).

Only in the end of the 90s the first studies on and the concern with the problem of elder abuse appeared in Brazil.

In 1997, an investigation was carried out in four Brazilian states (Rio de Janeiro, Minas Gerais, São Paulo and Paraná), replicating an Argentinean study about “How the elderly perceive Mistreatment”. The survey covered people over 60 years old, taken at random among the members of different Third Age Groups, who were able to take care of themselves, and were not living in any institution. The study was designed following a protocol with open and closed questions to be posed to healthy elderly living in the community, and the purpose was to work on the subjective perception of mistreatment. The results showed that mostly, abused is perceived as, on one hand, the

prejudicial way they are treated by society in general, on the other, as abandonment by their families (Machado et al, 1997).

In 1998, surveys on elder mortality due to external causes (i.e. those violent events that end up at hospitals and are thus identified) start to appear. In the State of Rio de Janeiro, for instance, for people aged 60 or more, violent causes rank 6th in most common mortality causes, encompassing traffic & transportation accidents for males, and falls for females. (Souza et al., 1998).

As for elder morbidity due to violent actions, Souza et al (1999) have noted that Brazilian data are quite scarce. The authors have found, in a survey carried out in two emergency care hospitals of the city of Rio de Janeiro that in one month, of the 5,151 cases reported, 384 were of people aged 60 or more. The main cause for admission was falls, representing some 60% of the total. The authors suggest that impaired ambulation/decreased mobility may be one of the reasons associated to this type of event.

When gathering information from some adult protection services in Brazil, data have confirmed the findings above, by verifying reports of complaints about public transportation, accidents and falls on streets, deaths from vehicles run-over, and traffic accidents (SOS/RJ, 1992; SUS, 2001), which points out structural violence as the source of elder abuse in Brazilian society.

In Brazil, there is no published survey on elder abuse incidence and prevalence yet, even though data about the status of the elderly may lead us to conclude that different types of elder abuse and neglect may occur.

Most Brazilian elders remain in their homes, which is a legal right, stated at the Constitution (Brazilian Federal Constitution, 1998) and at the National Policy for the Elderly (1996); fundamentally, just those who have no family or basic survival conditions live in institutions. Brazilian culture is quite prejudicial as to committing elders to a

facility, and the existing nursing homes are few and of poor quality service.

High rates of unemployment combined to high rates of divorce make adults return to their parents' home – “the boomerang generation” (Mitchell, 1998) – financially and emotionally dependants. A number of them became caregivers to parents who are dependant for their daily living activities, and who, many a time, live with grandchildren and great-grandchildren. Therefore, some risk factors for the elderly to become victim of family abuse (Bennett, 1997) arise, specially when the old person is the only source of family income.

The government's omission in providing proper health care services for the elderly, and the lack of social support add strain to the role of Brazilian families. The middle-age woman needs to be in the labor force to add to the family income, has to take care of the children and also of dependent elders.

The lack of intermediate services in Brazil, such as day-centers, day-hospitals, community centers, and specialized centers for dementia patients and their family reflects the lack of support for the care of the elderly.

Considering the described reality the elder faces in Brazilian society, and the lack of information on elder abuse in Brazil, there is a clear need for such a survey to be carried out. It is to be stressed the importance of taking into account the perspective of elders and health professionals in designing actions better suited for these social players.

The research will try to point out **components of elder abuse as identified by older people themselves and by those forming the primary care teams.**

2. METHODOLOGY

The survey is part of a research project on elder abuse, jointly coordinated by the World Health Organization (WHO) and the International Network for the Prevention of Elder Abuse (INPEA), to be developed in Brazil, Argentina, India, Lebanon and Kenya.

The research will take a qualitative approach. “The most fundamental characteristic of qualitative research is ‘the express commitment to view events, action, norms, values, etc. from the perspective of the people who are being studied’” (Hudelson,1994: 2).

The survey was carried out with elderly and health professionals of the city of Rio de Janeiro. Inclusion criteria for de elderly were: 60 years of age or older, with no mental impairment. For health professionals, inclusion criteria were: working in primary health care, at least two years experience working with elders, members of a multiprofessional team, and no experience in dealing with elder abuse.

Any chosen individual, could refuse taking part in the research, if they did not agree to its terms. Those who agreed signed and informed consent form and were referred to focus groups.

For selecting the elderly, the Rio de Janeiro Municipal Health Secretariat (SMS/RJ) and the Candido Mendes University Institute of Gerontology (IG) were of help. These institutions were chosen as they develop specific elderly-oriented work, whether in primary health care (SMS/RJ), or as community centers (both institutions).

Data collection was done through *Focus Groups*. “The focus group is a special type of group in terms of purpose, size, composition, and procedures [...] the researcher creates a permissive environment in the focus group that nurtures different perceptions and points of view,

without pressuring participants to vote, plan, or reach consensus.” (Krueger, 1994: 6). Its use as research technique was proposed and first used in the Social Sciences field by Merton, Fiske and Kendall, for an investigation carried out during World War II on the propaganda persuasion potential. Over the last 30 years, this technique has often been used in Social Psychology and Marketing, as it reaches a higher number of people and allows some in depth information collection in a short period of time. (Morgan, 1988).

For the survey, 8 groups were set up, 6 of elders and 2 health professionals working with the elderly (coded *gp1* and *gp2*). Of the 6 groups of elders, 2 were of males (*gm1* and *gm2*), 2 of females (*gf1* and *gf2*), and 2 of both genders (*gmf1* and *gmf2*). Elders who lived by themselves and those who live with their families were mixed in the groups.

Initially, it was made a discussion on the role of the elderly in the community, and the problems they face. Next, elder abuse was addressed. Regarding abuse, the following aspects were tackled: which, where, when, why, where to seek help, and what to do. In the groups, it was also discussed whether elder abuse should be of concern for health professionals and suggestions to face the problem.

Results analysis was done according to the principles of the Content Analysis Technique (Bardin, 1979), attempting to identify units of meaning from the testimonies made. For the analysis, the following steps were taken: (a) identification, from the testimony of participants of different groups, of the units of meaning; (b) comparison among the different sets of testimonies; (c) finding out axes (more comprehensive units of meaning) around which lie different notions on the problem, and (d) discussion of themes that summarize the meaning of the testimonies.

3. SUBJECTS OF THE STUDY

Elders

Fifty-one elders took part in the study, being 47% of males and 53% of females. Mean age was 73 years, being the youngest 60 and the eldest 95. The elders were split in 6 focus groups.

As for marital status, 46% were widows/widowers, 39% were married, 11% were single, and 4% were divorced. Twenty-five percent of the elders lived by themselves.

In terms of monthly income, 24% received up to one minimum wage, 22% up to five minimum wages, 51% over 5 minimum wages, and 4% did not inform their monthly income.

As to level of education, 37% had a university education, 34% had an elementary school education, 25% high school education, 2% no formal education ???, and 2% had a post-graduate degree.

In terms of health care, 63% had private health care plan, and only 48% used the public health system. The most common health problem was high blood pressure, followed by heart disease.

Before retirement, most worked in business or were professionals.

Comparing males and females, it was noted that there were more widows than widowers; females had a higher degree of education; mean age for males was higher than for females; and males had higher income than females.

Health professionals

Seventeen health professionals who worked in the primary health care network took part in the study, 94% of them females. Mean age was 44 years, ranging from 26 to 58 years.

As for professional disciplines, there were 5 physicians, 4 social workers, 3 nurses, 3 psychologists, and 2 physical therapists. Among physicians, two were Geriatrics/Gerontology experts. Mean number of years of professional experience was 9, ranging from 2 to 30 years of experience. All of them had a monthly income of more than 5 minimum wages.

4. OUTCOME ANALYSIS

Elder – “the actor behind the stage”

When discussing the role of elders, there is an image of “the actor behind the stage” (gm2), which points to someone sensing he lives in **exclusion**. In spite of being active, “normally he is put aside” (gf1). “He is considered as ‘someone excluded from life’ who lost the right to certain things, with no right to be part [of the community]” (gf2). It is as if he was “a newspaper one has already read, it is not good for anything” (gm2), “seen by society as troublesome person, a ‘pain in the neck’, someone who is ‘in the way’” (gm2). Someone who may be “a tragedy” (gmf1). Health professionals also mentioned the elderly as someone who “has no place in [Brazilian] society” (gp2).

For some elders, one of the first signs that triggers the exclusion process is “the hair turning white [for someone] to be treated as an old person” (gmf2), as someone who “was overcome by age” (gm2), and “has no place in society” (gp2). Thus “they are taking out all older people and replacing them at work by younger people, I mean, actually putting away older people” (gf1). And it is not only in

the community this takes place. “Within their own family, [the elderly] are more and more excluded from society, more at home, with no support, no one has time for the elderly, everybody goes to work, run their errands, and the elderly stays home, more and more abandoned” (gf2).

“If he was given a role, he would act it nicely” (gf1). If it happened, the elderly would come from behind the stage and would act a scene. Among so many performances, the elderly could “guide the young, encourage people” (gm2). According to health professionals, theirs would be a decisive role to keep “memory, the heritage through each one’s life story” (gp1). As for the elderly, for their role to be played it would be important, on one hand “to feel their limitations, [on the other hand] to take advantage of their experience” (gm1).

The background of the roles performed by the elderly is whether to feel old or young. People forget that “the aging of the mind is not so fast [...] society does not see [this]” (gm2). But the elders can “get together with young people. This is the secret. It is not to age mentally [because] physically [one must] age” (gmf2). When this does not happen, some of the elders feel “like a living fossil, more and more fossil, less and less alive” (gm2).

Due to this prejudice of young people towards the elderly, “many [young people] do not want to become old” (gmf1); others “don’t know how to age” (gmf1). Even considering “each case is unique” (gmf1), people “are not prepared for this” (gmf1).

On the other hand, there are elderly who believe this scenario can be reverted. One of the ways for this to happen is related to exerting citizenship rights. According to some elders, for this to happen it is necessary to impose “citizenship [because] it never gets old, the citizen does, but not citizenship “ (gm2).

Some elders perceived that in the past the scenario was different. There was “full respect for old age, the elders were very much valued” (gf2). It was “nice to help the elders [and] now [they] have to help the youngsters; [there is] a reversion of values” (gf1). The current generation of old people is seen as “the squeezed generation [...] sandwich-filling generation, because at first they would devote all their attention to their parents, then all their attention to their children [and therefore were} squeezed between both” (gf1). Others believe that now old people “are happy and don’t know it, [because one] must be sorry for the youth of nowadays, who will not reach [this] age” (gm1), as situation tends to get worse.

The interviewees noted that in our society, elders are treated “as a child [...] childlike” (gf1). Even those who promote leisure use words in the diminutive when addressing to elders. At gym classes for the elderly, for instance, the teacher says, “up with little legs, look at your little tummy” (gf1).

There are many requirements made for the elderly. They are required to have a good memory. “He cannot forget anything, otherwise he is sclerotic” (gf2). From elderly ladies, they are required to be “ a full-time grandma” (gf1), who is supposed to look after the grandchildren while the parents are at work.

The role of the elderly can also change, depending whether they live in the country or in a big city. Apparently, in the country the elderly are better treated. In the “big cities, the elderly are put aside, because there is not much time [to pay them attention], and the little income makes worse [this situation]”...”in the big cities, people isolate themselves...if there is an illness, it is too difficult to find a son...therefore one cannot get the family together to treat the elder (gf1).

In this scenario, there are those who refuse to be excluded. They are “people who have a different view of life” (gf2). They are

“part of different elderly groups” (gf2). They don’t want to look after grandchildren, “except in special cases” (gf1). They “went to college” (gf1) so they were not only grandparents. There are old ladies who see themselves as “party grandmas” (gf2), who have a lot of fun in balls and outings. There are also elderly actresses, old people who do “swimming [...] saloon dances, [go on] Carnival Parade” (gmf1), go “to the theater, to the movies” (gmf1). All these people who have “very intense activities [so that] the brain remains alive” (gm2)

Along with the idea that the elderly have to “look for a role” (gf1), there are cases in which not always they manage to perform a role. For instance, when they wish to work, they can’t because jobs are available only for those “aged 30, 25, something like that” (gm1).

In searching for roles one cannot rule out that aging brings along limitation, and some roles cannot be played by the elderly in the community. “There are two types of limitation: one is physical, the other is mental. When the two are combined, then it is a disgrace for the elderly” (gmf2). An elderly lady testifies how difficult it is “to wear diaper” (gmf2), both psychologically and financially. The physical limitation is worsened when the person is handicapped and, like this lady, moves on “a wheelchair” (gmf2).

Being an old lady is different than being an old man. According to the ladies; “the old man [...] is ashamed of having become old. He would play ball, swim, row, and now he cannot do these things anymore, and he feels diminished. Sex is fundamental for him [and not always he can still do it]. It is easier for a woman to find what to do, when she gets old and retired. Man has never been a homemaker [...] he had a call for what he thinks he is the best [...] he was the head of the household, and this and that, he has nothing else to learn in life [...] There are more old man than old women with depression, because for the women, if they have the chance of doing something, they do, [...] sewing [...] cooking” (gf1). Women perceive men as “less

participant [and they have] prejudices [for some types of leisure] (gf1). In the groups of elders, there are more women than men. “Men don’t know they are missed” (gf1). Some men explain, “they don’t take part because they are ashamed [of what other men will think]” (gmf1), differently of the “women [who] are more comely [and] don’t show their age” (gm1). In gender relations, the common sense idea that the woman depends on man is also replicated, when an old lady says she would have more fun “if [she] had a husband, [I would] go out much more often” (gf2).

Reflections on the social role of the elderly were not much different in male and female groups, in both groups, of elders and health professionals. Overall, the testimonies pointed to a structural violence, where people who belong to a certain age group are excluded. This structural violence can get worse if to age one adds the lack of economic conditions to survive because “worse of all is to be old and very poor, this is terrible” (gf1).

“Retirement: the first trauma of the Brazilian worker”

For the elderly, to *be retired* means to *be abused* by part of the social system, personified by government officials. Both in male only and mixed groups, this situation stands out in the context of abuse. The testimonies of the groups are around the following units of meaning: uselessness/exclusion, disrespect, hardships for go on living, and indignity/disgust.

Uselessness is associated to being retired. It doesn’t matter what he was when active in the labor force. He might have worked on a number of different professions, bottom line he is categorized only as *retired*. To live under this category is, somewhat, to be humiliated, because “the retired man is typically considered to be a burden. Both outside and within his own family [he is seen] as an inefficient man,

he does not produce, he does not work, and yet he consumes” (gm2). As soon as “he left the plant, he was turned into a dead weight” (gm2), and was seen as “a useless” (gmf2)/

These testimonies relate uselessness to unproductivity. The logic of the social system is that who doesn’t produce “is out”(gmf2) and therefore is seen as a dead weight, living “in exclusion due to retirement” (gmf2). Thus, being considered useless by society in general leads the elderly to exclusion.

However, along with this general idea, there is a testimony pointing out “the retired person is seen by society as a source of resources” (gm2). The retired person is thus valued when his family depends on the retirement to live, and when they live in such poor survival conditions that the little money the pension pays is one of the few sources of resource.

The testimonies of the interviewees also point to the fact that some retired people “live under great hardships [and] others don’t” (gm2). The latter are those elderly who receive higher pensions than most, thus being a minority in the whole set of retired people.

Behind the label of uselessness of the retired man, there is a huge **disrespect** in the way elders are treated by the social system, starting when they “request retirement” (gf1). At this point, abuse starts. He faces a burdensome bureaucracy, having to go to different departments of public offices, and waiting for a long time before receiving his pension. During this waiting period, a number of them undergo major deprivations.

When he receives his first retirement pension, the elder man suffers “the first trauma of Brazilian worker” (gm1). His pension is not enough, and therefore he starts having **difficulties to live**. An appalled elder questions: “where can a retired person live on a minimum wage?” (gm1). Another testimony adds that if he “were to live only with the [...] pension, I couldn’t even get out of home” (gm2).

This hardship elders face to live with their so little income compromises them physically and psychologically. The feeling for some is that the difficulties get more and more serious: “I am retired until today, earning peanuts [...] year after year [the pension amount] falls, in a while I don’t know if I will even receive any pension at all” (gm2).

This is a “really afflictive” situation (gm2), leading some elders to feel **outraged and disgusted**. Outraged because they have seen throughout their lives that all resources coming from the monthly payments of the workers were “used for totally distinct purposes” (gm2) than providing resources for retired people to live. Also health professionals show outrage and disgust when they denounce, “a person works his entire life thinking that when he retires he will be able to live with decency, and this is not real” (gp2).

As the elder keeps on living as a retired, his outrage increases “day after day [because he feels] despised [by the government]”(gm2). The pessimism of this situation is translated by the idea that “there is nothing one can do” (gm2).

***“No stopping here ...[at this bus station]...
there is plenty of sixty five”***

The public transportation system is another source of elder abuse. The testimonies mention that, in spite of those who reached 65 years of age being entitled by law to free public transportation, not always they can enforce it. From the set of testimonies, the main unit of meaning is **disrespect**. As an elderly lady said, “when catching a bus we see how the elderly are [poorly] treated” (gf2). So elders feel disrespected in both, *being retired* and *being a passenger* of the public transportation system.

Disrespect starts from the moment the elder gets to a bus stop. When he hails for the bus to stop, “the first thing the driver says [to himself] is ‘don’t stop here, as it is full of six five [people 65 years old or more]” (gf1). The elder “hails, but them [drivers] keep going. Or they stop way ahead, so the poor old guy has to run to catch the bus. It is mean” (gm1). “This is acting cowardly” (gmf1).

There is a testimony from the group of elders denouncing violation of their right in having a free ride, and thus getting on the bus by the front door, which is the exit one. Sometimes, this violation may end in tragedy: “the elder insisted on going on the bus by the front [door], the driver said ‘don’t’, and kicked the elder, who fell, hit the head on the curb [and] died” (gm2).

When the elder “gets on the bus, they [drivers] start to [step on the pedal] for the [elderly] to fall” (gm1). Inside the bus “it is a disaster. It is a total lack of respect for the elderly” (gf2). “Sometimes, there is a good soul who gives [the elderly] a seat. Sometimes there isn’t” (gf2). About this, health professionals also feel outraged, when they say “no one gives a seat for a lady anymore” (gp2). They also say, “students dispute with the elders who are getting [on the bus] first, they run in, put their backpacks to seat first” (gp2). Thus, it is common to “leave the poor old guy behind, they just don’t care”(gm1) about giving them a seat.

The problem of not getting a seat, in spite of being entitled to, also take place in the subway “where some yellow painted seats are for the elderly” (gm2), but people “don’t give [the elderly] the seat” (gf1).

A lady reports an act of disrespect that takes place in buses: “they mock of us [...] I took a bus and went out in the second bus stop. The driver looked at me [and asked] ‘did you enjoy the ride?’” (gf2).

On the other hand, a testimony states, “there are drivers who respect us [elders]” (gmf1). Another reports, “those drivers who do it are the old ones, because the younger ones are patients” (gmf1). There is also one opinion stating that “there’s been abuse [by the elderly], in not wanting to walk from one bus stop to the next”(gmf1) and they take the bus instead of walking a short way.

“The utmost lack of respect” at the public services

Discussion of the focus groups have revealed a number of public instances where elder abuse takes place. Two units of meaning were pointed out by the testimonies: abandonment and disrespect.

At the **health care facilities**, the elderly “suffer violence from the entrance door to care delivery” (gp1). The “medical visits [...] take 10 minutes at the most” (gf1). When they have to make a more sophisticated test, “the equipment is broken”(gmf1). Particularly “at hospitals [...] most [of the elderly] are poorly treated” (gm1).

On the other hand, the elderly are also abandoned by their families in these facilities. The professionals “face a great difficulty in discharging [an elderly] patient. The families give a number of reasons not to take him [home] and the elderly patient feels rejected” (gp1). The fact that “people leave their sick relatives [abandoned] at hospitals”(gf2) was also mentioned by the elderly.

This abandonment, just like what happens at home, seems to be seasonal. A health professional notes that “it is quite common for terminal patients to be taken [to hospitals for admission] in those long weekends” (gp2), which reveals their being abandoned in specific times of the year.

Testimonies from one of the health professional’s groups (gp2) report elderly being poorly treated upon care delivery: “the disoriented elder, who may be intoxicated by medication is taken [and

treated] as a headstrong child. This is quite a violence; a professional “threatens to take out the prosthesis, take out the device, take out the eyeglasses [from the elderly], then he [the elderly] agitates. When he agitates [the professional] medicates [...] this is violent; there are also cases in which he [the professional] says, “I won’t let your daughter in if you keep [behaving] like that”.

Two testimonies somewhat soften elder abuse in health care facilities. The first relates to the fact that some elders feel “quite well treated” (gmf1). It is interesting to note that abuse at health care facilities were more reported by health professionals than by the elderly themselves. The second is the fact that, not only the elderly, but users in general are poorly treated at public health care facilities, for lack of structural conditions.

Nursing homes are also mentioned as a place elders are poorly treated. In them, people “are dumped [...] or, sometimes, forgotten” (gmf1). Even at more luxurious nursing homes, many a time the elders are lonely, when “there is no one to talk to, to chat or tell a joke” (gmf1).

According to health professionals, at nursing homes the elderly themselves abuse one another. The one “who is in better shape abuses the one who is dependent, bedridden”(gp2). There is also “a story about old ladies who were raped by healthy old men. They would go in the evening [to the ladies’ bedrooms] to take [sexual] advantage of them” (gp2).

Abuse is also identified at **the banks**. There is “a big lack of respect [...] the counter for the elderly has a huge line [...] while there are 4, 5, 6 tellers for young people, for [the elderly] there is only 1” (gmf1). Along with this idea, it is also mentioned “the elder who goes to the specific teller with a bunch of bills [from other people]” (gmf1) to pay, thus delaying service to other elders.

This action was justified at a health professionals' group, where it was said, "the elder does it to increase a bit his family income" (gp2).

It was also mentioned that some elders themselves abuse of their rights.

***"The burdensome elder and the relic elder":
two faces of domestic abuse against elders***

Apart for the public scenario as a setting where elder abuse in Brazilian society is perpetrated, domestic interactions also reveal aspects of abuse. Testimonies addressing domestic violence reveal three units of meaning: displacing physical violence to other families; broadening the concept of abuse, and relativizing abuse considering the economic status of the elderly.

Discussing domestic abuse begins by reducing it to physical violence. Perhaps due to this reduction, and because this type of abuse is, in principle, unconceivable within the family, the elderly **displace physical violence** to families other than theirs. So, they say: "I have no complaints from my family" (gf2), "I have no complaints" (gf1). Regardless of this type of elder abuse actually taking place or not, a testimony of a health professional warns than this situation "tends to be kept inside four walls, preferably under the rug" (gp2).

When physical abuse is mentioned, typically the interviewees speak in the third person, admitting than "many [elders] suffer abuse" (gf2). They report a number of cases: there was a "90-year old lady whose daughter hit her" (gf2); "we have in our [religious] Order little brothers and sisters who are hit by their children" (gm2); "I have a neighbor whose daughter blind her [...] with a fingernail" (gmf1); "one day, the granddaughter kicked his stomach [these elders were acquaintances of the interviewee]"(gmf2).

Another explanation that adds to the absence of physical abuse at the investigated elders' household is that they are all independent from their families. About that, there is an anecdotal statement: "if I do not go to my son's house to ask for help, he will not hit me"(gm2).

Over the discussion at the focus groups, it was noted some **broadening of the concept of abuse**. The elders become aware of other sorts of abuse in their household other than physical violence. Among these other types of abuse, abandonment is one, reflected by the fact that "I have 7 grandchildren, 3 great-grandchildren, but no one visits me" (gmf1), or when they say, "lack of affection is also abuse" (gf2).

In all most groups, changes in the family structure was pointed out as one of the main reasons for all troubles the elderly face at the moment in the Brazilian society.

According to testimonies of elders, abandonment seems to be seasonal. Over Carnival, the family "to have fun [...] put him [the elder] aside" (gmf1). Also "over school holidays, the first thing a family who has a country cabin does is to grab the elder and put him in a hospital" (gmf1). In one of the focus groups, an old lady vents: "we feel hurt [...] we spend Christmas [...] alone" (gf2).

Testimonies of health professionals also point to other types of domestic abuse against the elderly. One of these types is reflected by the fact that "the elder is alone all day long, and when everybody gets home [...] no one cares for him" (gp2). They also report, "many elders are disrespected at home, specially by grandchildren" (gp2). One of the professionals reported a case of a lady with dementia who is forced by her husband to some "sexual practices she would not admit before having dementia" (gp2).

Another axis that crosses the groups' discussion is **relativizing abuse from the economic conditions of elders**, i.e., differences due to social-economic factors. A testimony made in one group is quite

anecdotal about this issue: “When the elder is poor, who doesn’t help [...] he is considered a burden [...] and he becomes [...] a target for more violence than the relic elder [...] no one abuses the relic elder, but no one listen [him], he is not respected [...] Both of them are disrespected. It is not a matter of existing violence or not [...] But if the elder is a financial burden on the family and does not help moneywise, he is a dead weight, and then he is actually victim of violence” (gmf2).

According to this reasoning, the interviewees state that abuse “takes place in all social classes” (gf1), but “in lower-income families there is [...] physical violence” (gf1). But in better off families, there is “another type of violence” (gf1). Typically, in these families financial exploitation of the elderly is more common.

This type of exploitation was also mentioned by the elderly, speaking in the third person: “there are some elders who are important, in the economic point of view” (gmf2); a son lived with his mother and “now, with all her money, she [the mother] is living in a tiny windowless room. She was dumped there, and he [the son] is who spends her money” (gf2). Health professionals also report cases of financial exploitation: “the daughter overspent with the credit card and asked him [the father] to sell the house; he did and now lives in a tiny studio” (gp2); “the house belongs to the family, the pension belongs to the family, the money belongs to the family” (gp2), and there is nothing left for some exploited elders.

It is not only at home that elders are well treated due to a good financial status. At the public services, there are anecdotal cases: “if the elder has money, he is well treated” (gmf1); “the rich elder is really allured [...] the highest form of prejudice is the social one, [because] the poor elder is a nuisance, a junk, has to disappear” (gm2)

There are a couple of testimonies that address the wealthy vs. poor elderly under a new light. One of them states, “lower-income communities, because people live close to each other, have more respect for the elderly” (gm1). The second is reported by a health professional mentioning that “the elder bargain for this situation [allowing the use of his money] to keep some power within the family” (gp2).

Explanations for abuse to occur

Testimonies of both categories, elders and health professionals, express ideas that, somehow, explain the occurrence of elder abuse. There is really no difference from one category’s ideas to another, and they can be classified according to the following units of meaning: changes in the family setting, impatience towards the elder, unreadiness to deal with old age, types of elders, and changes of cultural values.

As to **changes in the family setting**, some testimonies report that new family layouts and family roles accounting for new social demands may contribute to elder abuse, especially in term of neglect and abandonment.

“Nowadays, the wife had to leave home and go to work, [and] not always the husband helps, because not everybody likes to share domestic tasks” (gf1). “The children [of the elders] work. When they get home, they are tired and have to look after their children [elders’ grandchildren], and have no time” (gf2). In this scenario, “no one has time for the elder” (gf1) and “the family does not get together to take care of the elder” (gf1).

Also, due to lack of financial conditions, sometimes “there is no structure in the families” (gf2) to take care of the elderly. “These cases happen when the son also faces difficulties [...] the children are

also abused [by society]" (gm2). Sometimes, this situation is wrongly taken as neglect. In an environment of poverty, "when he [the elder] no longer adds something for the family, he is typically rejected" (gp1).

Impatience towards the elderly is another explanation for abuse. The children, because they have "no patience [...] abuse their mother, not physically, but by the way they treat her" (gf2). "When a person gets older, no one has patience"(gf2), one can see " the impatience of young people [because] the young is generally intolerant" (gmf2). Therefore, "many a time the elder is poorly treated due to impatience of their interlocutor" (gm2).

According to health professionals, impatience goes hand to hand with the lack of understanding of what being old means. "The family member does not understand [it]" (gp1). "Not understanding the elder is part of a cultural background that has been there for a long time"(gp1)". In the case of dementia patients, lack of understanding can be even more acute. "The family does not know it [the disease], many a time they think the elder is acting out of naughtiness, aggressiveness, stubbornness, and because they don't understand this process [of dementia], they abuse. They abuse because they don't know these factors"(gp2).

Besides this lack of knowledge, there may be "an exhaustion of the person [who cares for the elder] (gp2)", thus unlash impatience. This typically happens to "handicapped elders [...] at first things are fine, but after some time [caregivers] can't stand any longer" (gf2).

Elder behavior can also trigger abuse. Elders and health professionals share this explanation. Whether because the elder "is a pain in the neck, always complaining" (gm2) or because "he snoops in everything, then [he] is always abused"(gm1). It is thus "hard to deal and live with someone like that. It is really hard" (gmf2). These

testimonies point to the fact that “sometimes, one think the elder is the subservient, submissive guy, but many a time he is the villain of the story” (gp2). Therefore, “elder abuse depends on the elder himself” (gmf2).

Change of cultural values is also an explanation for abuse. In this case, “people now is more individualist, they only think about themselves” (gmf1). Besides, people “lack humanity” (gf2). Also, youth is a spread out virtue. “The media praises youth [and] this gets in the way” (gf1) of fostering a good relationship with old people. A testimony about the reflexes “of a liberal education” (gm1) was also included in the change of values that hazards the relationship of youngsters and elders, preventing the parents to have “more authority over their children” (gm1).

In many groups, the fact that today's children's education has been too permissive, thus leading to a disrespectful attitude towards the parents and grandparents was considered to be a source of family violence.

Finally, **the lack of skills to deal with ageing** is an explanation for abuse. The elders note that “people are not ready” (gm2) to look after them, and health professionals realize that they are not ready for “ageing” (gp2). Because of this state of unreadiness “people cannot establish a healthy relationship. Either they abandon, abuse, neglect or overprotect [the elderly]”(gp2). So, “it lacks education” (gp2) for this scenario to be reverted, and there must be “a policy for this, because we don't learn it [to grow old] spontaneously”(gmf2).

Consequences of abuse

Loneliness comes as consequence of abandonment. “Have you imagined a 90-year old person not having anybody to talk to, if his friends are already dead. So, there is no way, because young people,

when we start talking, always asks us to shut up” (gmf1). Contrary to this idea, other testimonies state, “we make loneliness” (gf1) and that “a good portion of old people feel lonely because they lock themselves” (gf1).

A compromised health and fatal outcomes were also pointed as consequence of abuse by all the groups: “depression comes, everything come, it is a chain” (gm2); “what takes the elder to death is depression, sorrow, family abandonment” (gf2); “if the elder is not in good health [...] and if he is despised, scolded, he may have a reaction, a heart attack, a stroke” (gmf1); “loosing health [...] a major illness [...] even suicide” (gp2). These compromises are quantitative and qualitative. In balancing these two ends, “worse than shortening life is to reduce quality of life” (gp2). As for fatal outcomes, a testimony blames the government: “to reduce the number of elders – that’s the government’s policy. The welfare system will only be balanced if the old die” (gm2).

Banalizing abuse is also a consequence of a violent setting. This will “become natural. People will be indifferent [...] and getting used to it” (gf1). This situation “will worsen more and more” (gm2) and this banalization “impoverishes humanity as a whole” (gp2).

In one of the elderly groups, a member gave a testimony on a possibility of the elderly becoming violent. Reporting a quarrel he had with a young man, he reacted by saying “I resent not having a 38 [gun] to kill you, here and now” (gmf1).

Abuse: who to ask for help?

Discussion about elder abuse, according to the testimonies of the focus groups, encompassed two areas of service. In the first, there are those services that develop actions to ensure elder civil

rights, and act on the repression of crimes against the elders. The second area relates to health care delivery.

For the first area, two units of meaning arise: lack of knowledge of the services and case solution. These units of meaning are articulated, as the presence of the first somehow makes unfeasible the discussion of the later.

In general, the testimonies from the focus groups, at first, reveal **lack of knowledge** of these services. Only in two testimonies out of 17, the existing services are pointed out: “Special Precinct for the Rights of the Elderly (*Delegacia Especial do Direito da Pessoa Idosa*), Elderly Affairs Center of the Public Defendant’s Office (*Núcleo de Atendimento ao Idoso da Defensoria Pública*), [...] Association of Retired and Pensioned from the State of Rio de Janeiro Welfare System (*Associação dos Aposentados e Pensionistas pela Previdência Social do Estado do Rio de Janeiro*)” (gm2), and “[...] State Council for the Rights of the Elderly (*Conselho Estadual de Defesa dos Direitos da Pessoa Idosa*)” (gm2). The Special Precinct is mentioned in more than one testimony.

Not knowing these services may reveal at least to issues to be investigated, and that may be articulated. The first is the fact that little is mentioned about these services in the media, the second is lack of awareness of the elderly about their rights. The first issue can be seen as cause to the second. On the other hand, unawareness about rights of the elderly may contribute for people not seeking these services.

Another issue tackled in the testimonies was resolution of elder abuse cases. In general, the groups are skeptical that these services may effectively solve abuse cases: “There is the Elderly Help Line [...] you never get through [...] when you do, someone answers and says ‘ah, this is not with me” (gf1); “You make a complaint and nothing happens” (gmf2); “[...] I’ve phoned once [for a service], they gave me

guidance over the phone [...] but [they said] they could not solve it immediately”(gp1).

In two groups, lack of case resolution is softened by two testimonies. The first confirms effectiveness of a service, when a participant states that “I denounced [a daughter who was abusing her mother]” (gmf1) and the daughter was arrested. The second testimony, in a way, blames the elder for the case not being effectively solved: “The investigation does not go forward because the plaintiff, the elder, normally withdraws the complaint. He is still the father, then he forgives” (gm2).

There is not much thinking about whether it is pertinent for abuse to be focused by health care services. Some testimonies from elders were in favor of such pertinence, but without solid grounds. Another testimony states that health professionals “should be [concerned with this matter] but, how can they see everybody? They can’t [because the medical visits are too short]”(gm1).

Health professionals agree that they should address this matter, but justify why they don’t do it satisfactorily, many a time because they don’t know how to identify abuse: “[health professionals] are not yet prepared, we have to work a lot on that” (gp1); “[health professionals] sometimes don’t have time to listen, [he] just does not have the time” (gp1); “most of the time [...] health professionals [...] are not attentive” (gp2); “some [health professionals] are afraid to report, they fear retaliation [from those who abuse the elderly]” (gp2).

Suggestions: “the old actor playing his role”

In general, the discussion of suggestions to deal with elder abuse reflected the high involvement of focus groups participants. A number of ideas are expressed in the testimonies. Behind these ideas, a unit of meaning stands out, **the possibility of the elder himself to seek solutions**. In general, suggestions point to the role

the elder must play in facing the problem as a citizen. This is highly positive, as there is a shift from the “actor-behind-the-stage” idea to the idea of the elder-player, acting his role on the social stage.

According to this reasoning, the testimonies state that there should be “education and instruction”(gf1) for the “elderly not to be isolated, not to be ashamed of being old” (gf1). Next, the elderly should “be organized” (gm1), they have “overcome contempt” (gm2), “struggle” (gm1) to make a “national mobilization” (gf2) to face the problem. One of the strategies to be developed is “to vote in a state representative we have access to” (gf1) because “we can have power” (gf1). This undertaking is not seen as a short-term process, because “[one] doesn’t change a people’s behavior in one generation” (gm1). In short, solutions to prevent or intervene elder abuse are responsibility of the citizens: “we have to join ourselves to fight, to have a legislation that supports us, to have the power to impose our rights” (gm2).

Connected to the idea the elderly are capable of seeking solutions, a testimony points out the need for reflecting on how the elder should develop actions: “we have to be psychologically prepared, because it is very complicated on our minds. It is not only the stamina to do things, to go out, for sex. There is a number of things we have to set our minds for” (gmf2).

Some testimonies, however, are in the opposite sense as to mobilization, by revealing a **disbelief with politics**: “unfortunately, I don’t believe in the government anymore” (gm2); “[the elderly] can get organized, but when one is elected, will become a politician, will have a mansion, won’t do much for those retired” (gf1); he [the candidate the elderly chose] will be elected and won’t do a thing” (gmf1).

Along with this movement of the elderly in seeking their rights, some testimonies relate solving the problem of abuse to the

development of **structural solutions**: “there is a need to improve society as a whole” (gm1); “to reduce poverty” (gmf2).

Other testimonies find solutions via **mass media**: “to make a campaign ‘Hope for the Elderly’ [...] to put it to the masses, so that the problem is solved” (gf1); there should be “a TV station that could advocate such an issue” (gf1), and this campaign “must be massive” (gmf2).

Another idea present in the solutions is to prevent abuse by **articulating the elderly to the youngsters**. So, “there should always be a day-care next to an nursing home, so that children would interact with elders [...] the child will learn from the elder, and will give him affection and vice-versa” (gf1). Another idea present in this unit of meaning is that in seeking solutions, one should “get young people to work in favor of the elders, so that they [young people] also enjoy this [solution, when they get old]” (gf1); for this “it would be fundamental that every youngster realized one day he will be old” (gf1).

Other testimonies point to the need for an **improvement of public services**: “there should be more facilities to [lovingly] support these [abused] people, and not by fits and starts” (gf1); “to have a retreat [...] to have people same age to talk to” (gf2); to promote “a special care [for abused elderly]” (gm2).

There are few testimonies leaving solution to the **power of God**: “there is no solution [...] to fix it, only if Jesus came again to look after [the elderly]” (gm1); “only God has the power [to sort things out]” (gm1). Interestingly, a testimony counterpoints this idea: “I plead a lot to God, but it doesn’t help”(gm1).

As to health professionals, their testimony reflects that they must receive **special training** to deal with elder abuse. “The first thing is to identify and ascertain what abuse is” (gp1) so that, among other things, “this hidden violence, for those who have the means and ways to hide it, is uncovered” (gp1). “Training of human

resources”(gp1) and “a reflection, a study group, for a movement to begin”(gp2) are ways to “properly prepare [health professionals]” (gp2). It is also important to provide guidance “not only for those professionals who are delivering care for the elderly” (gp1). One must “expand” [guidance]” (gp1) to all primary care health professionals.

Health professionals also point out the need for specific **public policies** “as part of an [overall] public health policy”(gp1), and that this policy was “effectively in tackling the elderly and the family, because the elder is in the family” (gp2).

5. CONCLUSIONS

The mentioned types of abuse did not vary in the different groups, according to gender. The difference was in the order and emphasis given. While men mentioned first the suffering of having their income decreased, women mentioned first abuse due to changes in family structure.

In general, the groups stressed more the structural violence against the elderly than abuse within the family. This may be somewhat explained because group members did not actually depended economically on their family to survive. It is possible their independence and autonomy allowed them to have standing in their family.

In general, the testimonies reveal people and institutions are not prepared to deal with aging and elders. Somehow, it can potentialize some sorts of elder abuse.

There is also a match between the types of problems raised in the groups and the solutions proposed to solve them. In both, problems and solutions, there is a strong focus in the importance of education to build an elder’s citizenship.

Finally, it is fundamental to underline that the issues raised by the groups are just part of a broad and complex reality of elder abuse in Brazil. Therefore, to deepen this discussion, other studies with other subjects are needed, reflecting other segments of Brazilian reality, specially with elders who are dependent, live in nursing homes/facilities, or are of lower social-economic status.

7. RECOMMENDATIONS

From this study, there are some recommendations for actions to fight elder abuse.

- a) To promote gerontological education for families, and education on citizenship for all age groups on the issue of ageing and being old;
- b) To design and implement Public Policies on elder abuse;
- c) To implement Public Policies to establish community services for comprehensive health care delivery to the elderly;
- d) To set up a social support network for families;
- e) To train professionals in primary health care to identify, prevent and intervene, in case of elder abuse;
- f) To design a Consensus Guideline for health professionals to identify, prevent and intervene, in case of elder abuse;
- g) To design a care delivery protocol for the elderly that includes screening for abuse;

Finally, as core recommendation, we suggest this investigation to go deeper, through broader epidemiological surveys on external causes and at nursing homes. As for elder abuse in the family, we suggest investigation at the Emergency units of the main city hospitals, as this is the best place for abuse by the family to be detected, with

individual interviews, setting a proper environment for the secrecy surrounding elder abuse within the family come to light.

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