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Medical students' conception of elder abuse

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MEDICAL STUDENTS' CONCEPTION OF ELDER ABUSE

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ABBREVIATIONS

CSQ	Caregiving Scenario Questionnaire
FMUC	Faculty of Medicine, University of Coimbra, Portugal
WHO	World Health Organization

ABSTRACT

Introduction: The role of health professionals on diagnosing and managing elder abuse has been highlighted by many authors, however many cases remain underdiagnosed and underreported. It has also been recognized the importance of training and educating professionals. This study aims to investigate students' awareness and knowledge on selected aspects of elder abuse and search for eventual differences between those beginning and those finishing the course, which could be attributed to academic formation.

Materials and methods: A questionnaire was developed and distributed to 1st and 6th year students of the Faculty of Medicine, University of Coimbra, Portugal. Data collected included parameters related to socio-demography, epidemiology, management and intervention techniques, theoretical and clinical training on this subject and fictional case analysis (based on a modified version of the Caregiving Scenario Questionnaire). The sample consisted of 261 students from both years.

Results: Almost all students (96.9%) consider that it is important for their future clinical practice to address this issue in medical school. Most of 6th year students (87,7%) felt that they needed a deeper approach than the one that was given to them. The majority of the 6th year students believed that health professionals are obliged to report all suspicions of abuse and if the elder describes abuse. 6th year students could be considered overall more aware and knowledgeable of other aspects of elder abuse. Worth noting the higher proportion of 6th year students that answered not feeling prepared to diagnose or manage cases of elder abuse (73,6% versus 64,1% and 82,6% versus 65,7%, respectively).

Discussion: Although 6th year students showed increased awareness on elder abuse, namely on diagnosing and managing aspects, than 1st year students, both groups revealed uncertainty of whether they are obliged to report cases of elder abuse and felt that they needed to be

absolute sure of the abuse before reporting, which are some factors identified for underreporting by health professionals. Overall, there seems to be a need for more profound education to boost the (future) professional's confidence.

Conclusions: This study reveals that future health professionals seemed aware of the importance of elder abuse, however, being of particular relevance, 6th year students did not find themselves yet prepared to manage such cases and acknowledged further formation is required.

KEYWORDS

"Elder Abuse"; "Awareness"; "Perception"; "Health Personnel"; "Students"; "Questionnaire".

RESUMO

Introdução: O papel dos profissionais de saúde em diagnosticar e gerir o abuso de idosos tem sido destacado por muitos autores, no entanto muitos destes casos continuam sub-diagnosticados e subestimados. Foi também reconhecida a importância de treinar e educar profissionais. Este estudo tem como objetivo investigar a sensibilização e o conhecimento dos alunos em aspetos selecionados sobre abuso de idosos e procurar eventuais diferenças entre os que iniciam e os que terminam o curso, que podem ser atribuídas à formação académica.

Materiais e métodos: Um questionário foi desenvolvido e distribuído pelos alunos do 1º e 6º ano da Faculdade de Medicina da Universidade de Coimbra, Portugal. Os dados adquiridos incluíram parâmetros relacionados com características sociodemográficas, epidemiológicas, de gestão e intervenção, de educação teórica e prática sobre este assunto e da análise de um caso fictício (com base numa versão modificada do Questionário de Cenário de Cuidador). A amostra consistiu em 261 alunos de ambos os anos.

Resultados: Quase todos os estudantes (96,9%) consideraram que é importante para a sua prática clínica futura a abordagem deste tema na sua formação médica. A maioria dos alunos do 6º ano (87,7%) sentiram que precisavam de uma abordagem mais profunda do que a que lhes foi dada. A maioria dos estudantes do 6º ano acreditava que os profissionais de saúde são obrigados a denunciar todas as suspeitas de abuso e se o idoso descrever abuso. Os alunos do 6º ano poderiam ser considerados mais conscientes e com mais conhecimento sobre outros aspetos de abuso de idosos. Importante ressalvar a grande proporção de estudantes do 6º ano que responderam que não se sentiam preparados para diagnosticar ou gerir casos de abuso de idosos (73,6% versus 64,1% e 82,6% versus 65,7%, respetivamente).

Discussão: Embora os estudantes do 6º ano estejam mais sensibilizados para abuso de idosos, nomeadamente no que se refere ao diagnóstico e gestão destes casos, comparativamente aos

alunos do 1º ano, ambos os grupos revelaram incerteza sobre se eram obrigados a relatar todos os casos de abuso de idosos e sentiram que precisavam da certeza absoluta do abuso antes de o relatar, fatores estes que foram alguns dos identificados como responsáveis pela diminuta denúncia por profissionais de saúde. No geral, parece haver uma necessidade de uma educação mais profunda para aumentar a confiança do (futuro) profissional.

Conclusões: Este estudo revelou que os futuros profissionais de saúde parecem conscientes da importância do abuso de idosos, no entanto, sendo de particular relevância, os alunos do 6º ano não se encontravam preparados para gerir estes casos e reconheceram que é necessária mais formação sobre este assunto.

PALAVRAS-CHAVE

"Maus-tratos ao Idoso"; "Perceção"; "Profissional de saúde"; "Alunos"; "Questionários".

INTRODUCTION

Elder abuse is a complex public health problem and a serious violation of the human rights. There is a wide variation in reported rates, between 10% and 34.3%,[1] which can be explained by the absence of a consensual agreement on a single definition used worldwide[2] and that even nowadays it is still considered a social taboo. People usually struggle to discuss and report this topic,[3] which is often kept hidden in the privacy of the family and/or institutions. This factor associated with the lack of social and familial awareness and limited access to institutions may indicate that elder abuse is being under-reported.[1]

According to World Health Organization (WHO), elder abuse is "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person".[4] It can be manifested through different abusive actions, namely, physical, sexual, physiological/emotional, financial and neglect.[5]

With the ageing of our society, this already significant phenomenon is predicted to worsen. The United Nations projected that between 2015 and 2030 the number of people aged 60 years or over would increase by 56 per cent.[6] A study estimates that one in six older people are abuse victims (roughly 141 million people in the world) and if this proportion remains constant it will increase to 330 million victims by 2050. [7]

The role of health professionals is recognized in many studies as essential [7–16] due to their unique position to prevent, detect and report these cases. Often the lack of protocols and knowledge by health professionals is reported to be another cause of the under-reporting and under-recognition of elder abuse cases.[2,13–15] Some authors even argue that it is more important to train and educate professionals in order to increase their level of awareness than to over-rely on a screening strategy or clinical algorithm[16]. However, little attention has been

given to assessing the knowledge of future health professionals.[2,17–19] As elder abuse is a multifaceted problem with the need of a better approach, investigating how pre-professionals conceive this problematic is needed. In fact, to our knowledge, no studies have been performed for this specific purpose in Portugal.

Thus, this study aims to assess overall conception of medical students on selected aspects regarding this subject through a questionnaire and infer the level of awareness and preparation to deal with elder abuse cases. It additional aims to explore how students self-assess their need for further education regarding this subject and searches for eventual differences between answers given by first year and sixth year students of the Faculty of Medicine, University of Coimbra, Portugal, as they may be related to training during the course.

MATERIALS AND METHODS

A cross-sectional population-based study was performed on a non-probabilistic, convenience sample of the target population – the medical students of the first and sixth years of FMUC. The selection of these two groups enabled the comparison between students at different levels of professional training. First year students were not expected to have been exposed to any significant extent to this subject from a health professional perspective and sixth year students were assumed to, at least, have had some theoretical exposure during the course.

Data Collection

A literature survey was performed using PubMed, Google Scholar and generic search engines to find scientific work concerning elder abuse, health professionals, pre-professionals and questionnaires elaborated in this context. The keywords included but were not limited to different combinations of "elder", "abuse", "violence"', "health professional", "medical", "students", "perception" and "questionnaire", in English and Portuguese.

Questionnaire Development and distribution

A questionnaire was developed after the analysis of the selected literature. It was divided in five sections: I – Socio-demographic characteristics; II – Perception of elder abuse; III – Perception of intervention techniques; IV – Training on elder abuse; V – Analysis of a Fictional Case *(view Appendix 1).*

For the purpose of this work, namely to construct the question concerning abuse signs, in section II, the definitions and sub-categories of elder abuse follow WHO.[(4)] Twenty situations were selected, representative of the five types of abuse, as it was unfeasible to list all of signs/symptoms. The participants would value each situation according to the diagnostic

relevance considered by them, on a crescent five-level Likert-type item. Indications were given to evaluate each item individually. As for the risk factors, an extended non-exhaustive selection was based on the literature review.[(4,8,12,20,21)]

Sections III and IV were improved adapted versions from a previous study – "Detection and Intervention Strategies by Primary Health Care Professionals in Suspected Elder Abuse",[(22)] performed under guidance of the same supervisors of the present scientific work.

The fictional case presented in section V was a translated and modified version from the Caregiving Scenario Questionnaire (CSQ) referred in several studies.[(18,23,24)] Participants were asked to indicate on a three-level Likert-type (Not abusive; Potentially abusive; Abusive) their thoughts on the thirteen possible management strategies.

A convenience reduced sample of medical students, not from the target population, were asked to fill the questionnaire in order to test and correct eventual issues.

The questionnaire was distributed to first and sixth year medical students of FMUC between April and June of 2017. Filling the questionnaire was anonymous and voluntary. Due to accessibility and to increase delivery and higher response rates, the instrument was handed out in the context of academic activities gathering larger groups of students, namely classes.

Statistical analysis

Statistical analysis was performed on SPSS version 22 (IBM Corporation, 2013). Descriptive statistics were presented as means (M) and standard deviations (SD) for quantitative variables, medians (Mdn) and 25th and 75th percentiles (P25-P75) for ordinal variables and frequencies (N=total sample; N_1=total sample 1st year students; N_2 = total sample 6th year students) and percentages (%) for categorical variables. Ordinal variables

were compared using Mann-Whitney test and the chi-square test was used to measure the association between categorical variables; alternatively, Fisher exact test was used when more than 20% of cells had expected count <5. Significance for null hypothesis rejection was set at $p<.05$. For most variables missing values did not exceed more than a couple of cases. Pairwise deletion was performed on missing values.

Ethical Considerations

According to the Ethics Committee of FMUC, this type of study, elaborated in the context of a master's degree dissertation, is not required to be submitted to that Committee. Supervisors are incumbent to assess and account for ethical matters regarding scientific works under their guidance.

RESULTS

We analyzed results from 261 medical students of the 1st (n_1=167, 64.0%) and 6th year (n_2=94, 36.0%) of FMUC, 178 females (68.2%) and 83 males (31.8%), mean age 21.22 (SD=3.23), ranging from 17 to 41 years old. The response rate was 58.2% and 29.7%, for 1st year and 6th years groups, respectably.

From the total sample, 229 students (87.7%) still had their grandparents alive, while 25 (9.6%) had not; the remaining 7 (2.7%) were missing responses. Most of the students qualified the relationship with their grandparents as good (n=50, 19.2%) or very good (n=195, 74.7%). 65.5% (n=171) described having personal/familiar experience in caring for elders.

The majority of the students (n=254, 97.3%) considered the term elder abuse as familiar. Television was the means where most have heard about this subject:

Table 1 *Characterization of the sample according to sources of information about elder abuse. (n=261)*

Where did you hear about elder abuse	1st year *n(%)*	6th year *n(%)*
Academic context	10 (14.5%)	59 (62.8%)
Newspaper/magazines	91 (54.5%)	62 (66.0%)
Social network (internet)	90 (53.9%)	64 (68.1%)
Social/family context	18 (10.8%)	17 (18.1%)
Television	151 (90.4%)	81 (86.2%)

There was not a significant difference between groups regarding the estimated prevalence of elder abuse in Portugal:

Table 2 *Comparison between 1st and 6th year students about the estimated prevalence of elder abuse in Portugal. (n_1=167; n_2=93)*

Estimated prevalence	1st year *n(%)*	6th year *n(%)*	p-value
<1%	2.0 (1.2%)	0.0 (0.0%)	
1-5%	14.0 (8.4%)	4.0 (4.3%)	
5-10%	31.0 (18.6%)	19.0 (20.4%)	.331
10-15%	53.0 (31.7%)	31.0 (33.3%)	
15-20%	46.0 (27.5%)	21.0 (22.6%)	
>20%	21.0 (12.6%)	18.0 (19.4%)	

$^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$

There was not a significant difference associated with the most frequent context of abuse, the majority choosing familiar:

Table 3 *Comparison between 1st and 6th year students about the most frequent context of elder abuse. (n_1=165; n_2=93)*

Most frequent context of abuse	1st year *n(%)*	6th year *n(%)*	p-value
Institutional	79 (47.9%)	35 (37.6%)	.112
Familiar	86 (52.1%)	58 (62.4%)	

$^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$

Regarding the most frequent type of abuse, a significant difference was found (p=.013) with more 1st year students considering physical abuse more frequently than 6th year students:

***Table 4** Comparison between 1st and 6th year students about the most frequent type of elder abuse. (n_1=167; n_2=91)*

Most frequent type of abuse	1st year *n(%)*	6th year *n(%)*	p-value
Emotional	49 (29.3%)	35 (37.2%)	
Financial	28 (16.8%)	9 (9.6%)	
Neglect	68 (40.7%)	47 (50.0%)	.013*
Physical	22 (13.2%)	3 (3.2%)	
Sexual	0 (0.0%)	0 (0.0%)	

*p<.05; **p<.01; ***p<.001

Regarding the most likely abuser, there was a considerable number of invalid answers. Analysis of valid cases revealed, nonetheless, that both groups considered children followed by caregivers:

***Table 5** Comparison between 1st and 6th year students about the most likely abuser. (n_1=98; n_2=76)*

Probable abuser	1st year *n(%)*	6th year *n(%)*	p-value
Caregiver	23 (23.5%)	14 (18.4%)	
Children	50 (51.0%)	41 (53.9%)	
Former spouse/partner	1 (1.0%)	0 (0.0%)	
Paid caregiver (home support)	5 (5.1%)	3 (3.9%)	
Sister-in-law/brother-in-law	9 (9.2%)	7 (9.2%)	.906
Spouse/partner	4 (4.1%)	5 (6.6%)	
Stepson(s)	3 (3.1%)	3 (3.9%)	
Other relatives	2 (2.0%)	3 (3.9%)	
Others	1 (1.0%)	0 (0.0%)	

*p<.05; **p<.01; ***p<.001

When comparing the relative importance of factors related to the victim, 6th year students valued cognitive deficit ($p=.036$), psychiatric disorders ($p=.025$), substance abuse ($p=.008$), dependency ($p<.001$) and poor social network ($p=.048$) to a higher degree than 1st year students. There was not a significant difference in all other factors:

Table 6 *Comparison between 1st and 6th year students about the relative importance of victim related risk factors. ($n_1=167$; $n_2=94$)*

Victim related factors	1st year Mdn (P25-P75)	6th year Mdn (P25-P75)	p-value
Age	4.0 (4.0-4.0)	4.0 (4.0-5.0)	.201
Cognitive deficit	4.0 (4.0-5.0)	5.0 (4.0-5.0)	.036*
Dependency	4.0 (4.0-5.0)	5.0 (4.0-5.0)	<.001***
Financial dependency of the abuser	4.0 (4.0-5.0)	5.0 (4.0-5.0)	.233
Introvert personality	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.457
Level of education	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.582
Living alone	4.0 (3.0-5.0)	4.0 (3.0-5.0)	.296
Poor social network	4.0 (3.0-5.0)	4.0 (4.0-5.0)	.048*
Psychiatric disorder	4.0 (4.0-5.0)	5.0 (4.0-5.0)	.025*
Sex (gender)	3.0 (2.0-4.0)	3.0 (2.0-4.0)	.745
Substance abuse	4.0 (3.0-4.0)	4.0 (4.0-5.0)	.008**
Temperamental personality	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.554

*p<.05; **p<.01; ***p<.001

As for factors related to the abuser, 6th year students valued stress associated with taking care of the elder ($p=.008$) more than 1st year students. There was no significant difference in all other variables:

Table 7 *Comparison between 1st and 6th year students about the relative importance of abuser related risk factors. (n_1=167; n_2=94)*

Abuser related factors	1st year Mdn (P25-P75)	6th year Mdn (P25-P75)	p-value
Age	3.0 (2.0-4.0)	3.0 (2.0-4.0)	.646
Cognitive deficit	4.0 (3.0-5.0)	4.0 (3.0-4.0)	.378
Financial dependency on the victim	4.0 (3.0-5.0)	4.0 (4.0-5.0)	.486
Hypercritical personality	4.0 (4.0-4.0)	4.0 (4.0-4.0)	.799
Lack of training as a caregiver	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.609
Level of education	4.0 (3.0-5.0)	4.0 (3.0-4.0)	.153
Psychiatric disorder	4.0 (4.0-5.0)	4.0 (4.0-5.0)	.053
Sex (gender)	3.0 (2.0-4.0)	3.0 (2.0-4.0)	.072
Stress associated with taking care of the elder	4.0 (4.0-5.0)	5.0 (4.0-5.0)	.008**
Substance abuse	5.0 (4.0-5.0)	5.0 (4.0-5.0)	.674
Temperamental personality	4.0 (4.0-5.0)	4.0 (4.0-5.0)	.990

*p<.05; **p<.01; ***p<.001

Regarding context related factors, 1st year students rate more social environment (p=.009) than 6th year. All other factors were not valued significantly different:

Table 8 *Comparison between 1st and 6th year students about the relative importance of context related risk factors. (n_1=167; n_2=94)*

Context related factors	1st year Mdn (P25-P75)	6th year Mdn (P25-P75)	p-value
Degradation state of the house	3.0 (3.0-4.0)	4.0 (3.0-4.0)	.056
Equipped house	3.0 (2.0-4.0)	3.0 (2.0-4.0)	.269
Living in a senior home care	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.508
Social environment (rural/urban)	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.009**

*p<.05; **p<.01; ***p<.001

Students were asked to grade the relevance of various isolated findings as related to suspicion of abuse. 6th year students valued more depressive symptoms with affective ambivalence (p=.005), lesions at different evolutionary stages (p=.004) and inappropriate clothing (p=.006). 1st year students considered anogenital complaints (p=.004) and presence of pressure ulcers (p=.040) as more significative than 6th year students. There was not a significant difference for other findings:

Table 9 *Comparison between 1st and 6th year students about the grade of relevance of various isolated findings as related to suspicion of abuse.* *(n_1=167; n_2=94)*

Suspicion of abuse	1st year Mdn (P25-P75)	6th year Mdn (P25-P75)	p-value
Absence of denture, glasses or crutches when needed	4.0 (3.0-4.0)	4.0 (3.0-5.0)	.187
Anogenital complaints	4.0 (3.0-5.0)	4.0 (3.0-4.0)	.004**
Appearance of insomnia	3.0 (3.0-4.0)	4.0 (3.0-4.0)	.536
Avoids looking straight to the caregiver/relative	4.0 (4.0-5.0)	4.0 (4.0-5.0)	.339
Behavior modification with emotional restrain	4.0 (4.0-5.0)	4.0 (4.0-5.0)	.816
Caregiver leaves elder alone for most of the day (even if it is to go to work)	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.512
Change in language normally used	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.959
Depressive symptoms with affective ambivalence	4.0 (3.0-4.0)	4.0 (4.0-4.0)	.005**
Elder worried with money management by the caregiver	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.479

Suspicion of abuse (continuation)	1st year Mdn (P25-P75)	6th year Mdn (P25-P75)	p-value
Evidence of under or overmedication	4.0 (3.0-5.0)	4.0 (4.0-5.0)	.736
Inappropriate clothing	3.0 (2.0-4.0)	4.0 (3.0-4.0)	.006**
Lesions at different evolutionary stages	4.0 (4.0-5.0)	5.0 (4.0-5.0)	.004**
Lesions without a clear explanation about their origins	4.0 (4.0-5.0)	4.0 (4.0-5.0)	.324
Presence of pressure ulcers	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.040*
Presence of sexually transmitted diseases	4.0 (3.0-5.0)	4.0 (3.0-5.0)	.784
Signs of deficient personal hygiene	4.0 (3.0-5.0)	4.0 (4.0-5.0)	.336
Signs of physical restraint (wrists, ankles) in demented elder and usually agitated	4.0 (3.0-5.0)	4.0 (3.0-5.0)	.337
Skips doctors' appointments	4.0 (3.0-4.0)	4.0 (3.0-4.0)	.402
Sudden appearance of fecal and/or urinary incontinence	3.0 (3.0-4.0)	3.0 (3.0-4.0)	.891
Sudden changes in testament	4.0 (3.0-5.0)	4.0 (4.0-4.0)	.426

*p<.05; **p<.01; ***p<.001

No significant differences were found in stating the major type of intervention in cases of elder abuse considered by medical students of 1st and 6th year ($p=.096$):

Table 10 *Comparison between 1st and 6th year students about the major type of intervention in cases of elder abuse. ($n_1=153$; $n_2=88$)*

Major type of intervention	1st year *n(%)*	6th year *n(%)*	p-value
Social	80 (52.3%)	48 (54.5%)	.096
Medical	3 (2.0%)	4 (4.5%)	
Judicial	48 (31.4%)	20 (22.7%)	
None of the above	0 (0.0%)	3 (3.4%)	
Not sure	22 (14.4%)	13 (14.8%)	

$^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$

A significant association was found between who the 1st and 6th year medical students think have the major responsibility in detecting and reporting elder abuse ($p<.001$). Sixth year students tend to attribute more responsibility to health professionals (n=27, 35.1%) and general population (n=25, 32.5%) whilst 1st year students consider that family (n=40, 34.5%) and general population (n=51, 44.0%) have the main responsibility:

Table 11 *Comparison between 1st and 6th year students about who should have a major responsibility in detecting and reporting elder abuse. ($n_1=116$; $n_2=77$)*

Major responsibility detecting/reporting	1st year *n(%)*	6th year *n(%)*	p-value
Family	40 (34.5%)	14 (18.2%)	$<.001^{***}$
General population	51 (44.0%)	25 (32.5%)	
Health professionals	14 (12.1%)	27 (35.1%)	
Neighbours/Friends	6 (5.2%)	2 (2.6%)	
Social services	5 (4.3%)	9 (11.7%)	

$^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$

Almost all students (n=255, 97.7%) believe that health professionals are useful for the diagnosis of abuse cases.

A significant association was found between the perception of the level of preparation of health professionals to detect elder abuse between groups (p<.001). 6th year students tend to consider them as not well prepared (n= 46, 49.5%) while 1st year students, excluding students that neither agree nor disagree, in a greater percentage (n=61, 36,7%) believe that health professionals are well prepared:

Table 12 *Comparison between 1st and 6th year students' perception about the preparation of health professionals to detect elder abuse. (n_1=166; n_2=93)*

Health professionals well prepared to detect elder abuse	1st year *n(%)*	6th year *n(%)*	p-value
Yes	61 (36.7%)	25 (26.9%)	
No	31 (18.7%)	46 (49.5%)	<.001***
Neither agree nor disagree	74 (44.6%)	22 (23.7%)	

*p<.05; **p<.01; ***p<.001

Regarding the assertion that health professionals should have a proactive attitude in the abuse diagnosis, both groups agreed to a high degree it to be true:

Table 13 *Comparison between 1st and 6th year students about whether health professionals should have a proactive attitude in the diagnosis of elder abuse. (n_1=167; n_2=91)*

Proactive attitude	1st year *n(%)*	6th year *n(%)*	p-value
Yes	144 (86.2%)	87 (95.6%)	
No	3 (1.8%)	3 (3.3%)	.003**
Neither agree nor disagree	20 (12.0%)	1 (1.1%)	

*p<.05; **p<.01; ***p<.001

Concerning the health professionals' obligation to report all suspicions of abuse ($p<.001$), most of the 6th year students believe it to be true. Most of 1st year students recognized not knowing the answer to this question:

Table 14 *Comparison between 1st and 6th year students about the obligation of health professionals to report all suspicions of abuse. ($n_1=165$; $n_2=93$)*

Obligation to report all suspicions	1st year *n(%)*	6th year *n(%)*	p-value
Yes	64 (38.8%)	59 (63.4%)	
No	8 (4.8%)	8 (8.6%)	<.001***
Do not know	93 (56.4%)	26 (28.0%)	

*p<.05; **p<.01; ***p<.001

A significant association was found between obligation to report if the elder describes abuse and year ($p=.011$). First year students did not know the answer in a greater level than the sixth-year students:

Table 15 *Comparison between 1st and 6th year students about the obligation of health professionals to report if the elder describes abuse. ($n_1=165$; $n2=94$)*

Obligation to report if the elder describes abuse	1st year *n(%)*	6th year *n(%)*	p-value
Yes	85 (51.5%)	55 (58.5%)	
No	12 (7.3%)	15 (16.0%)	.011*
Do not know	68 (41.2%)	24 (25.5%)	

*p<.05; **p<.01; ***p<.001

Another significant association was found between the existence of an exception to medical confidentiality in the Portuguese Medical Association Code of Ethics and year

(p=.002). First year students did not know the answer in a greater level than the sixth-year students:

Table 16 *Comparison between 1st and 6th year students about the existence of an exception to medical confidentiality in the Code of Medical Ethics. (n_1=165; n_2=93)*

Existence of an exception to medical confidentiality in the Portuguese Medical Association Code of Ethics	1st year *n(%)*	6th year *n(%)*	p-value
Yes	42 (25.5%)	32 (34.4%)	
No	12 (7.3%)	17 (18.3%)	.002**
Do not know	111 (67.3%)	44 (47.3%)	

*p<.05; **p<.01; ***p<.001

On the subject of what to do in case of suspicion, it was not found a significant statistical difference between the two years – both groups chose to interview the elder alone:

Table 17 *Comparison between 1st and 6th year students about what to do in case of suspicion of elder abuse. (n_1=129; n2=89)*

What to do in case of suspicion	1st year *n(%)*	6th year *n(%)*	p-value
Ask opinion to more experienced colleagues	23 (17.8%)	14 (15.7%)	
Interview the elder alone	59 (45.7%)	56 (62.9%)	
Report to other entities so they can investigate	26 (20.2%)	11 (12.4%)	.07
Treat the situation that motivated the medical assistance and investigate the suspicion in the next appointment	21 (16.3%)	8 (9.0%)	

*p<.05; **p<.01; ***p<.001

Sixth year students would choose to report the abuse to social services while first year students would choose to report to judicial authority (p<.001):

Table 18 *Comparison between 1st and 6th year students about the entity they would choose to report elder abuse. (n_1=154; n_2=91)*

What entity would you report to	1st year *n(%)*	6th year *n(%)*	p-value
Judicial authority	87 (56.5%)	28 (30.8%)	
Social security	26 (16.9%)	13 (14.3%)	<.001***
Social services	41 (26.6%)	50 (54.9%)	

*p<.05; **p<.01; ***p<.001

When asked about situations that could influence the students' decision to not report, there was a significant statistical difference found (p=0.011) in one situation. 6th year students disagreed more than 1st year students with not reporting because of fear that the attacker might take legal action against them, if the abuse is not proven in court. No significant differences were found in the other situations presented:

Table 19 *Comparison between 1st and 6th year students about situations that could influence the decision to not report. (n_1=166; n_2=93)*

Situations that could influence your decision to not report	1st year *n (%)*			6th year *n (%)*			p-value
	Agree	Disagree	NnD	Agree	Disagree	NnD	
Despite having a strong suspicion of abuse, the victim denies it.	32 (19.3%)	110 (66.3%)	24 (14.5%)	24 (25.8%)	55 (59.1%)	14 (15.1%)	.435

Situations that could influence your decision to not report (continuation)	1st year *n (%)*			6th year *n (%)*			p-value
	Agree	Disagree	NnD	Agree	Disagree	NnD	
Despite suspecting the abuse, you are not sure of it.	101 (60.5%)	33 (19.8%)	33 (19.8%)	55 (61.1%)	22 (24.4%)	13 (14.4%)	.466
It is hard to be sure if the complaints of abuse by the elder are reality or a distorted reality (due to cognitive deficit, tendency to exaggerate or lie).	81 (48.5%)	42 (25.1%)	44 (26.3%)	46 (49.5%)	28 (30.1%)	19 (20.4%)	.492
It represents a higher risk to the victim and/or you and you believe the situation will stay the same in spite of it.	30 (18.1%)	98 (59.0%)	38 (22.9%)	23 (25.6%)	50 (55.6%)	17 (18.9%)	.344
The elder asks strongly not to report the case, even though you think it is a case of serious risk.	16 (9.8%)	119 (73.0%)	28 (17.2%)	9 (9.6%)	73 (77.7%)	12 (12.8%)	.631
The elder tells you to not report the case.	29 (17.6%)	94 (57.0%)	42 (25.5%)	17 (18.7%)	54 (59.3%)	20 (22.0%)	.823
You fear that the attacker might become more violent with the victim.	55 (33.1%)	88 (53.0%)	23 (13.9%)	39 (41.9%)	40 (43.0%)	14 (15.1%)	.281
You fear that the attacker might become violent with you.	28 (17.0%)	123 (74.5%)	14 (8.5%)	15 (16.3%)	63 (68.5%)	14 (15.2%)	.250

Situations that could influence your decision to not report (continuation)	1st year *n (%)*			6th year *n (%)*			p-value
	Agree	Disagree	NnD	Agree	Disagree	NnD	
You fear that the attacker might take legal action against you, if the abuse is not proven in court.	48 (29.1%)	85 (51.5%)	32 (19.4%)	13 (14.0%)	64 (68.8%)	16 (17,2%)	.011*
Your professional obligations only apply to your clinical practice, other professionals are responsible to report.	7 (4.2%)	147 (88.6%)	12 (7.2%)	3 (3.2%)	88 (94.6%)	2.(2.2%)	.198

*p<.05; **p<.01; ***p<.001 NnD – Neither agree nor disagree

A significant difference was found in the statement "You feel you are not prepared to manage cases of elder abuse" (p=.013). A higher percentage of 6th year students considered they are not prepared than 1st year students. There was not a significant difference in other statements:

Table 20 *Comparison between 1st and 6th year students about selected aspects of case management. ($n_1=166$; $n_2=93$)*

	1st year *n (%)*			6th year *n (%)*			p-value
	Agree	Disagree	NnD	Agree	Disagree	NnD	
The severity of the abuse will have influence on whether you report the case or not.	56 (33.5%)	90 (53.9%)	21 (12.6%)	32 (34.4%)	51 (54.8%)	10 (10.8%)	.909
To report elder abuse without consent is a violation of the elder rights.	29 (17.5%)	94 (56.6%)	43 (25.9%)	19 (20.4%)	52 (55.9%)	22 (23.7%)	.816
To report elder abuse without consent is a violation of the medical deontology.	34 (20.5%)	66 (39.8%)	66 (39.8%)	18 (19.6%)	45 (48.9%)	29 (31.5%)	.322
You feel you are not prepared to diagnose cases of elder abuse.	107 (64.1%)	34 (20.4%)	26 (15.6%)	67 (73.6%)	15 (16.5%)	9 (9.9%)	.264
You feel you are not prepared to manage cases of elder abuse.	109 (65.7%)	30 (18.1%)	27 (16.3%)	76 (82.6%)	7 (7.6%)	9 (9.8%)	.013*
You should be certain of the abuse before reporting it.	101 (61.2%)	36 (21.8%)	28 (17.0%)	54 (58.7%)	30 (32.6%)	8 (8.7%)	.060
You would only report the case if your own security was assured.	22 (13.4%)	114 (69.5%)	28 (17.1%)	15 (16.3%)	61 (66.3%)	16 (17.4%)	.805

*p<.05; **p<.01; ***p<.001 NnD – Neither agree nor disagree

Almost all students (n=253, 96.9%) consider that it is important for their future clinical practice to address this issue in medical school.

The majority of 6th year students (n=64, 69.6%) referred knowing of curricular units during the course that addressed this subject, most indicating in at least two occasions (=35, 53.0%) and 36,4% (n=24) stating to have attended more than 50% of the classes related to this subject. While most of 1st year students did not recollect approaching this subject in class (n=157, 94%). 87,7% (n=57) of 6th year students felt that a deeper approach to elder abuse is needed, as well as 80% of 1st year students:

Table 21 *Characterization of the sample about academic contact with the subject of elder abuse and the need for a deeper approach. (n_1=167; n_2=92)*

Theoretical training	1st year *n(%)*	6th year *n(%)*
Curricular units		
Yes	10 (6.0%)	64 (69.6%)
No	157 (94.0%)	28 (30.4%)
Number of times		
1	2 (20.0%)	16 (24.2%)
2	5 (50.0%)	35 (53.0%)
3 or more	3 (30.0%)	15 (22.7%)
Deeper approach needed		
Yes	8 (80.0%)	57 (87.7%)
No	2 (20.0%)	8 (12.3%)
Percentage of classes gone to		
None	3 (30.0%)	5 (7.6%)
<50%	5 (50.0%)	18 (27.3%)
>50%	2 (20.0%)	24 (36.4%)
All	0 (0.0%)	19 (28.8%)

During clinical training, 37.1% (n=56) of 6th year students mentioned having had contact with abuse cases, most students (n=14, 43.8%) three times, but only 5 (12.8%) had the chance to follow-up on these cases. As for 1st year students, 5.7% (n=7) mentioned already having contacted with such case (n=6) in their clinical training and just 2 (28.6%) were able to follow-up:

Table 22 *Characterization of the sample about clinical contact with cases of elder abuse. (n=212)*

Clinical training	1st year *n(%)*	6th year *n(%)*
Contact with elder abuse		
Yes	7 (5.7%)	33 (37.1%)
No	116 (94.3%)	56 (62.9%)
Number of times		
1	6 (100.0%)	6 (18.8%)
2	0 (0.0%)	12 (37.5%)
3 or more	0 (0.0%)	14 (43.8%)
Present in the follow-up		
Yes	2 (28.6%)	5 (12.8%)
No	5 (71.4%)	34 (87.2%)

Worth noting that 78.0% (n1= 71) of the 6th year students believed it would be relevant to include the management of cases of abuse (including elder) in the curricular units of the final year.

In the statement "Accept that it is her choice not to be clean" a statistical difference was found between 1st and 6th year (p=.006) with a higher percentage of the 1st year considering this hypothesis as non-abusive (n=41, 24.6%) than 6th year students. As for the scenario "Hide the tablets in her morning cereal or tea." (p=.025), more students of the 1st year found this hypothesis to be abusive (n=39, 23.5%) than 6th year students (n=9, 9.8%). There is no significant difference in all other hypothesis:

Table 23 *Comparison between 1st and 6th year students about a fictional case (based on CSQ). (n_1=166; n_2=93)*

Fictional case	1st year *n (%)*			6th year *n (%)*			p-value
	Non-abusive	Potentially abusive	Abusive	Non-abusive	Potentially abusive	Abusive	
Accept that it is her choice not to be clean.	41 (24.6%)	86 (51.5%)	40 (24.0%)	13 (14.0%)	41 (44.1%)	39 (41.9%)	.006**
Arrange for his mother to wear an ID bracelet so people will know who she is if she wanders again.	137 (82.0%)	27 (16.2%)	3 (1.8%)	81 (87.1%)	10 (10.8%)	2 (2.2%)	.446
Ask her doctor about medication that might help the situation.	146 (88.0%)	18 (10.8%)	2 (1.2%)	82 (87.2%)	11 (11.7%)	1 (1.1%)	.929
Camouflage the front door by covering it with a curtain to prevent her wandering out of the house.	66 (39.5%)	75 (44.9%)	26 (15.6%)	35 (37.2%)	46 (48.9%)	13 (13.8%)	.413
Contact local services to request day care because she is not safe to be left alone.	153 (91.6%)	11 (6.6%)	3 (1.8%)	91 (96.8%)	2 (2.1%)	1 (1.1%)	.272

Fictional case (continuation)	1st year *n (%)*			6th year *n (%)*			p-value
	Non-abusive	Potentially abusive	Abusive	Non-abusive	Potentially abusive	Abusive	
Hide the tablets in her morning cereal or tea.	43 (25.9%)	84 (50.6%)	39 (23.5%)	27 (29.3%)	56 (60.9%)	9 (9.8%)	.025*
Lock her in the house while he is at work.	8 (4.8%)	54 (32.7%)	103 (62.4%)	6 (6.5%)	33 (35.5%)	54 (58.1%)	.601
Not answer when she asks about her pension book because anything he says makes her angrier.	61 (36.5%)	81 (48.5%)	25 (15.0%)	28 (29.8%)	47 (50.0%)	19 (20.2%)	.405
Not take her to family gatherings such as her granddaughter's birthday if she is likely to behave in an embarrassing way.	7 (4.2%)	49 (29.5%)	110 (66.3%)	4 (4.3%)	27 (29.0%)	62 (66.7%)	.996
Put a daily chart in her room reminding her to have a bath.	152 (92.1%)	11 (6.7%)	2 (1.2%)	90 (95.7%)	4 (4.3%)	0 (0.0%)	.491
Sit her in an armchair with a table over her lap so she cannot get up while Tom is out shopping.	3 (1.8%)	18 (10.8%)	146 (87.4%)	2 (2.2%)	8 (8.8%)	81 (89.0%)	.888
Tell her she cannot have her breakfast until she has had a bath	40 (24.1%)	89 (53.6%)	37 (22.3%)	17 (18.5%)	43 (46.7%)	32 (34.8%)	.089
Tell her that if things continue the way they are going then she will have to live elsewhere.	39 (23.5%)	73 (44.0%)	54 (32.5%)	22 (23.7%)	49 (52.7%)	22 (23.7%)	.278

DISCUSSION

Elder abuse is highly variable worldwide, not only in terms of prevalence, but also in terms of context and in Portugal literature available on this topic is scarce.[22,25–27] However, the relatively recent study, "Aging and Violence", estimated that the overall prevalence of elder abuse was 12.3%[26], in fact within the range estimated by the highest percentage of first year and sixth year students. Also relevant was the fact the majority of individuals in both groups set the estimated prevalence rate above 10%. As highlighted in the aforementioned study, this percentage is substantially high compared to other countries, which evidences that the magnitude of elder abuse in Portugal is of significance. Yet, there are studies that estimate the prevalence at levels as high as 23.7%[25] or 27.6%,[28].

As for the choice for the most likely abuser, no significant differences were found between groups, and although there was a dispersion in the answers, most chose "children" followed by "caregiver". Overall, students considered that elder abuse was more frequent on familiar context than institutionalized. A study has shown that the most frequent abuser is someone from the family (usually partners and children), caregivers come in third place[29] and estimates the percentage of institutional abuse to be inferior to familial.[27,29]

Several studies estimate that psychological abuse is the most frequent type and/or immediately followed, by financial abuse.[1,26,27] Both groups of students chose neglect as the most frequent type of elder abuse, in contrast with such results, even though the physiological and financial abuse were the following selected types. The choice of neglect is very interesting as it suggests how students perceive how most elders are being mistreated in Portugal.

Victims of elder abuse have a higher risk of social isolation, depression and twice the risk of death compared to elders who were not victims of abuse.[4] It is extremely important to

detect and report these cases as early as possible. However, the diagnosis of elder abuse is complex. It is necessary to combine signs and symptoms, as well as recognize risk factors to allow an early identification.(12)

According to several studies, different types of abuse are associated with different victims' and perpetrator's characteristics.(11,26) Nonetheless, some victim related risk factors are associated with a strong evidence of overall abuse: poor physical and/or mental health, social status (social isolation, low income),(4) dependency and cognitive impairment.(4,29) The influence of victims' gender is not consensual, with numerous studies demonstrating that females have a higher risk of abuse(1,4,26) and others not finding a correlation.(10) Age was also considered an important risk factor in the study "Aging and Violence".(26) As for risk factors associated with the perpetuators themselves, these include substance abuse, mental illness, financial difficulties, social problems (e.g. isolation) and caregiver stress (which was a significantly important factor in these studies).·(4,16,21,26,29,30)

In this study, most of risk factors presented were considered relevant by students from both years. Nonetheless, 6th year students attributed more importance to dependency, poor social network and cognitive deficit of the victim, as well as, stress of the abuser associated with taking care of the elder. These findings suggest a different validation of risk factors by 6th year, possibly related to higher awareness.

Most students considered proposed items for signs/symptoms of suspicion of abuse as importance. However, it is worth noting 6th year students valued more depressive symptoms with affective ambivalence, lesions at different evolutionary stages and inappropriate clothing, whereas 1st year students graded more the presence of pressure ulcers. A hypothesis for this finding is that 6th year students may be more used to seeing bedsores, because of their clinical practice. However, this maybe be a very important sign of neglect and/or lack of

proper caregiver training, as there are many known procedures that should be applied to prevent or limit pressure ulcers. Also, for consideration, is the fact that students graded some items as "pathognomonic", the most common being lesions in different developmental stages. It must be pointed out, generally speaking, there is not one symptom or sign that is pathognomonic of elder abuse and the diagnosis is made after conjugating different signs/symptoms. There seems to be a lack in the literature of the prevalence of signs/symptoms of elder abuse, which might be explained by the fact that the diagnosis is difficult, as there are many forms of presentation and they vary by type of abuse.(31)

Regarding to whom is credited more responsibility in detecting and reporting elder abuse, 35.1% of 6th year students (n_2=27) believe that health professionals play a key role, although a similar proportion chose the general population. In contrast, the majority of 1st year students (roughly 75% – n_1=91) value more the general population and family, by that order. Although there is clearly a higher awareness by the 6th year students of health professionals' relevance in this context, it is very worrisome that the majority attributed responsibilities to other groups. Clearly, it is necessary to increase the awareness, most particularly to students already finalizing their education, as hospitals and clinics may be the only location where an elderly person has contact with people outside of their residence.(20)

Nonetheless, almost all students (97.7%) recognize that health professionals are useful for the diagnosis of abuse and should have a proactive attitude towards it. Despite this, the majority of 6th year students (49.5%) believed that these professionals are not well prepared to detect elder abuse. Considering their contact with clinical activities, this could result from their observation of difficulties that health professionals have when dealing with this subject or, in alternative, a projection of their own sense of lack of preparation onto the generality of health professionals. In this context, it must be pointed out that while answering another question, 6th year students admitted not considering themselves as being well prepared to deal

with this type of situation. And, surprisingly at first, they did so in a significant higher percentage than 1st year students. However, this can be easily explained by the Dunning–Kruger effect, which refers to the fact that incompetent people are often ill-suited to recognize their own incompetence and that the overestimation of their competence decreases as they become more knowledgeable and aware.[(32)]

Overall, there seems to be a need for more profound education to boost the (future) professional's confidence. This is an aspect that 6th students agreed on, when the majority stated it would be relevant to include the management of cases of elder abuse in the final year of training, besides the curricular units they had until then with classes on this subject.

About the management of suspected abuse cases, there were significant differences between years, pointing towards 6th year students having more knowledge on how to deal with these cases. Nonetheless, 28.0% of 6th year students and 56.4% 1st year students did not know if they are obliged to report their suspicions and 25.5% of 6th year students and 41.2% 1st year students do not know if, when faced with reports by the elder of abusive behavior, they are required to file a complaint. Comparing these percentages with the percentages of the same questions made to health professionals in a previous study, we can see that the "Do not know" responses by 6th year students are quite similar to those given by health professionals (28.0% vs 28.4%; 25.5% vs 26.8%).[(22)] This finding may indicate that there is not a lot of training or evolution of knowledge about this theme after graduation, which reinforces the need for a deepen education about elder abuse during the basic training. When asked about the existence of an exception to medical confidentiality in the Portuguese Medical Association Code of Ethics, the majority of both groups (n_1=111; n_2=44) did not know the answer, a fact naturally more relevant for students in the final year of training.

Health professionals only report 2% of all elder abuse and the uncertainty of whether they are obliged to report cases is one of many factors of this underreporting.(13) In the Portuguese Penal Process Code, on article 242º, it is stated that is an obligation for employees to report to judicial authorities any situation of abuse or maltreatment of an elder that they got acquainted when performing their duties and because of them.(33) It also should be noted that article 27º of the Portuguese Medical Association Code of Ethics explicitly indicate that a physician should use particular care for the older people, especially when the family or other caregivers are not capable or careful enough to care for their health or ensure their well-being and they should take appropriate measures to protect them, including alerting the competent authorities.(34)

In case of suspicion it is essential to interview the elder in a private conversation and inquire a series of questions to better understand the case, the option the majority of both groups chose.(16) However, it is interesting that given the alternative option to ask the opinion to more experienced colleagues, 1st year students also responded with the more "hands-on" approach of interviewing the elder alone.

When asked to assess their position on selected situations regarding case management, students from both groups agreed that being unsure of the abuse and the uncertainty if the complaint of abuse was reality or a distorted reality (due to cognitive deficit, tendency to exaggerate or lie) could influence their decision to not report. The majority also agreed with the statement "You should be certain of the abuse before reporting". This need to have certainty of the abuse before reporting mirrors the findings of previous studies.(17,35) It must be emphasized to students that finding definitive proof of elder abuse is outside of the responsibility of healthcare professionals and it should not be a criteria to the decision to report suspicious.(13)

A significant difference was found with 1st year students opting for reporting the cases directly to a judicial authority while the 6th year group preferring social services. This suggests that later in academic and professional life, (future) professionals tend to prefer a more social than a judiciary approach or feel more at ease with social than judiciary services to assist managing these cases. The fear of implication in a legal process may explain this option to not report to judicial authority.[36]

The CSQ, a widely used instrument, is a caregiving scenario about a man that works full-time and must take care of his mom with dementia. This vignette measures the recognition of elder abuse and its use has demonstrated acceptable validity when compared with performance in real consultations.[23] According to WHO, three strategies are considered abusive ("Accept that it is her choice not to be clean.", "Lock her in the house while he is at work." and "Sit her in an armchair with a table over her lap so she cannot get up while Tom is out shopping."). Analyzing the results, some answers from both years raise concerns. Neither of the majority of the groups correctly identified the attitude "Accept that it is her choice not to be clean." to be an abusive option, even though a higher percentage of 6th year students (41,9%) were able to identify it as abusive. This finding is in concordance with a study where the majority of the participants were unable to identify the neglect item.[18]

Finally, it must be noticed that the study was formally based on a convenience sample, and although for 1st year group, namely sample size reduces selection bias, such risk is higher with the 6th year group. Also, to improve filling time and response rates there was a selection of the aspects to be analyzed. Nonetheless, the amount of data collected was actually very significant, allowing for different analytical perspectives. Thus, data was selected, presented, analyzed and discussed in accordance to the generic stated purposes of this work and word counting constraints, and so further scientific work on the collected data must be considered. Also, in the context of future perspectives, it would be interesting to extend this study to other

Faculties of Medicine, to be able to generalize results to the Portuguese medical student population, or even repeating the study to assess eventual differences.

CONCLUSIONS

With the ageing of the world population, elder abuse is becoming an increasingly global problem. Health professionals have been said to often be the only contact elders have with the exterior world and, thus, should be able to recognize and manage these cases. However, many cases remain underdiagnosed and underreported. Awareness for this problem and case management skills should be developed in medical schools.

To adjust training and anticipate possible learning challenges is important to understand how students conceive this subject in its objective (knowledge) but also more subjective aspects, as both can influence global awareness and the decision-making process. Also relevant is how students self-evaluate their skills to detect and manage abuse cases.

This study suggests interesting and relevant differences between 1st and 6st years students and implied an overall (and desirable) higher level of awareness in this last group. These findings may relate to an evolution during training and clinical exposure and are aspects to be considered, namely, upon deciding education models.

Finally, considering the magnitude of the problem, the likelihood of future professionals having to deal with abusive contexts and in accordance with the self-assessment of finalist students, it is believed that a more profound training is needed to prepare future doctors to feel confident and adequately intervene when confronted with these often complex type of cases.

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APPENDIX

Appendix 1 – Questionnaire

Questionário

ABUSO DE IDOSOS

O meu nome é Ana Catarina Fernandes Moreira e frequento o Mestrado Integrado em Medicina da Faculdade de Medicina da Universidade de Coimbra. Venho por este meio solicitar a sua colaboração no preenchimento deste questionário, enquadrado no trabalho final de 6ºano, no qual se pretende conhecer a perceção dos estudantes de medicina (1º e 6º ano) relativamente ao abuso de idosos (situação de violência em que há uma expectativa de confiança), incluindo aspetos relativos ao diagnóstico e orientação deste tipo de casos. O preenchimento tem uma duração estimada de 15 minutos, sendo a sua participação voluntária e anónima. Os dados obtidos serão tratados em conjunto com os dos demais questionários destinando-se aos fins exclusivos deste trabalho, sendo muito importante que responda de forma sincera e a todas as questões. Agradeço desde já toda a disponibilidade e colaboração,

Ana Moreira

A resposta "NC/ND" significa Não concordo nem discordo

I. ENQUADRAMENTO SOCIO-FAMILIAR

1.1. Sexo: O Masculino O Feminino 1.2. Idade (anos): [|] 1.3. Ano curso: O 1º Ano O 6º ano

1.4. Ainda tem avós/avôs vivos: O Sim O Não O Não Respondo

1.5. Como caraterizaria a relação que tem/teve com o avô ou avó mais emocionalmente significativo para si:

O Não existente (nunca conheceu/estabeleceu contacto)

O Afastamento

O Neutra

O Razoável

O Boa

O Muito Boa

O Não Respondo

1.6. Vivenciou alguma experiência pessoal/familiar de prestação de cuidados a idosos? O Sim O Não O Não Respondo

1.7. Já ouviu falar em abuso de idosos? O Sim O Não

1.7.1. Se SIM, em que contexto(s)?

O Televisão O Revistas/jornais O Redes Sociais O Contexto académico O Contexto social/familiar O Outros

P7_1Outro contexto

Indique quais: [| | | | | | | | | | | | | | | | | | |]

1.8. Teve conhecimento ou acompanhou alguma situação de abuso de idosos que conheça? O Sim O Não

II. PERCEÇÃO DO ABUSO DE IDOSOS

2.1. Estima a prevalência do abuso em Portugal (% população idosa):

O «1 % O 1-5% O 5-10% O 10-15% O 15-20% O »20%

2.2. Em que contexto considera ser mais frequente? O Institucional O Familiar O Outro

Qual: [| | | | | | | | | | | | | | | | | | |]

2.3. A forma de abuso mais frequente é:

O Física O Sexual O Financeira O Emocional O Negligência

2.4. Qual das seguintes categorias de pessoas considera que é <u>mais provável</u> que pratique atos abusivos sobre uma pessoa idosa:

O Cônjuge/companheiro

O ex-cônjuge/ex-companheiro

O cuidador lar de idosos

O Filho (s)

O Enteado (s)

O Nora/genro

O Cuidador pago (apoio ao domicílio)

O Outros familiares

O Outros (s), quais: [| | | | | | | | | | | | | |]

2.5. Indique para cada categoria de fatores, como valorizaria a sua importância relativa no cálculo do risco global de uma pessoa idosa poder ser vítima de uma situação de abuso (sinalize com um 'X'):

Fatores relativos à vítima	*Irrelevante*	*Pouco relevante*	*Moderadamente relevante*	*Relevante*	*Muito Relevante*
Género (masculino ou feminino)	O	O	O	O	O
Idade (aumento da idade)	O	O	O	O	O
Personalidade conflituosa	O	O	O	O	O
Personalidade introvertida	O	O	O	O	O
Nível de educação (básica/secund/...)	O	O	O	O	O
Défice cognitivo (estados demenciais)	O	O	O	O	O
Patologia psiquiátrica	O	O	O	O	O
Consumo de álcool/substâncias de abuso	O	O	O	O	O
Dependência de terceiros	O	O	O	O	O
Dependência financeira do agressor	O	O	O	O	O
Rede de contatos sociais pobre ou nula	O	O	O	O	O
Viver sozinho(a)	O	O	O	O	O

Fatores relativos ao agressor	*Irrelevante*	*Pouco relevante*	*Moderadamente relevante*	*Relevante*	*Muito Relevante*
Género	O	O	O	O	O
Idade	O	O	O	O	O
Personalidade hipercrítica do cuidador	O	O	O	O	O
Personalidade conflituosa	O	O	O	O	O
Nível de educação	O	O	O	O	O
Défice cognitivo	O	O	O	O	O
Patologia psiquiátrica	O	O	O	O	O
Consumo de álcool/substâncias de abuso	O	O	O	O	O
Stress do cuidador de idosos dependentes	O	O	O	O	O
Ausência de treino para cuidar de idosos	O	O	O	O	O
Dependência financeira da vítima	O	O	O	O	O

Outros Fatores	*Irrelevante*	*Pouco relevante*	*Moderadamente relevante*	*Relevante*	*Muito Relevante*
Meio social (rural/urbano)	O	O	O	O	O
Residir lar de idosos	O	O	O	O	O
Estado de degradação da habitação	O	O	O	O	O
Nível de equipamento (casa equipada)	O	O	O	O	O

2.6. Indique o grau de relevância que atribui às seguintes situações como sinal de abuso (consideradas individualmente):

	1	2	3	4	5
Sintomas depressivos com indícios de ambivalência afetiva para com o cuidador	O	O	O	O	O
Preocupação do idoso com a gestão do dinheiro pelo cuidador	O	O	O	O	O
Mudança súbita de testamento	O	O	O	O	O
Ausência de dentaduras, óculos ou canadianas, quando são necessárias	O	O	O	O	O
Lesões (ex: equimoses) em diferentes estados de evolução	O	O	O	O	O
Evidência de sobre ou submedicação	O	O	O	O	O
Sinais de infeções sexualmente transmissíveis	O	O	O	O	O
Alteração no comportamento com retraimento emocional	O	O	O	O	O
Mudança do tipo de linguagem utilizado	O	O	O	O	O
Surgimento de insónias	O	O	O	O	O
Lesões sem explicação consistente sobre a sua origem	O	O	O	O	O

	1	2	3	4	5
Queixas anogenitais	O	O	O	O	O
Presença de úlceras de pressão	O	O	O	O	O
Sinais de higiene pessoal deficitária	O	O	O	O	O
Vestuário desadequado	O	O	O	O	O
Sinais de contenção física (punhos, tornozelos) em idoso demenciado e habitualmente agitado	O	O	O	O	O
Cuidador deixa idoso sozinho grande parte do seu dia (mesmo que seja para ir trabalhar)	O	O	O	O	O
Acompanhamento médico irregular, faltando às consultas marcadas	O	O	O	O	O
Evita olhar diretamente para familiares/cuidador	O	O	O	O	O
Incontinência urinária fecal e/ou urinária de aparecimento repentino	O	O	O	O	O

Legenda: 1 - Irrelevante; 2- Pouco relevante; 3 - Relevante; 4- Muito Relevante; 5- Patognomónico

III. PERCEÇÃO SOBRE AS ESTRATÉGIAS DE ATUAÇÃO

3.1 Considera que o abuso de idosos é um problema maioritariamente de intervenção social, médica ou judical?

O Social O Médica O Judicial O Nenhuma das anteriores O Não tenho a certeza

3.2. Quem acha que tem maior responsabilidade em detetar e denunciar abuso nos idosos?

O Profissionais de saúde O Vizinhos O Técnicos de Serviço Social O Entidades policiais O Autarquias

O Amigos O Generalidade da população O Familiares

3.3. Os profissionais de saúde podem ser úteis no diagnóstico de abuso?

O Sim O Não O Não concordo nem discordo

3.4. Os profissionais de saúde **encontram-se bem preparados** para a deteção de abuso?

○ Sim ○ Não ○ Não concordo nem discordo

3.5. Os profissionais de saúde devem assumir uma atitude pró-ativa no diagnóstico de abuso?

○ Sim ○ Não ○ Não concordo nem discordo

3.6. Em Portugal, é obrigatório aos profissionais de saúde denunciar todas as suspeitas de abuso de idosos às autoridades judiciais:

○ Sim ○ Não ○ Não sabe

3.7. Em Portugal, se o idoso relatar situações de abuso, é obrigatório aos profissionais de saúde denunciar às autoridades judiciais:

○ Sim ○ Não ○ Não sabe

3.8. O Código Deontológico dos Médicos prevê alguma exceção ao sigilo médico relativamente a pessoas idosas?

○ Sim ○ Não ○ Não tenho a certeza

3.9. Perante um caso de **suspeita** (mas não certeza), o que acha mais provável que neste momento fizesse:

○ Tratar a situação que motivou a assistência médica e investigar as suspeitas na próxima consulta

○ Chamar o suspeito de abuso, caso seja familiar/cuidador, e confrontá-los com as suspeitas

○ Entrevistar o idoso sozinho

○ Fazer denúncia para outras entidades para que investiguem

○ Pedir opinião a colegas mais experientes

○ Aguardar na expectativa que surjam elementos mais concretos de abuso

3.10. Suponha que decidia **REPORTAR** a situação, a que entidade provavelmente o faria?

○ Autoridade Judiciária (GNR, PSP, Ministério Público)

○ Serviço Social (Estab. Saúde)

○ Segurança Social

○ Outra (s) entidade (s) Indique ________________

3.11. Indique se concorda (ou não) que as situações apresentadas **poderiam favorecer** a sua decisão de **não efetuar** denúncia:

	Concordo	Não concordo	NC/ND
Apesar de ter fortes suspeitas de abuso, a vítima nega a ocorrência dos mesmos.	○	○	○
Apesar de suspeitar de abuso, não tenho a certeza absoluta de ser esse o caso.	○	○	○
É difícil ter a certeza absoluta se as queixas (que configuram abusos) dos idosos correspondem à realidade ou a uma perceção distorcida da mesma (devido a alterações cognitivas, tendência para exagerar as queixas ou mentir).	○	○	○
As minhas obrigações profissionais restringem-se à prática clínica, cabendo a outros profissionais essa responsabilidade.	○	○	○
O idoso solicita-lhe diretamente para que não reporte o caso.	○	○	○
O idoso solicita-lhe veementemente para que não reporte a situação, embora considere que é um caso de risco grave.	○	○	○

	Concordo	Não concordo	NC/ND
Receia que o agressor possa tornar-se mais violento para a vítima.	O	O	O
Receia que o agressor possa reagir violentamente contra si.	O	O	O
Receia que o agressor possa agir judicialmente contra si caso não seja dado como provado no Tribunal que houve abuso.	O	O	O
Representa um acréscimo de risco para a vítima e/ou para si e considera que o mais provável é a situação permanecer inalterada.	O	O	O

Outras situações a relevar: ____________________

3.12. Indique se concorda (ou não) com as seguintes frases:

	Concordo	Não concordo	NC/ND
Denunciar abuso de idosos sem o seu consentimento é uma violação dos direitos do idoso.	O	O	O
Devo ter a certeza absoluta do abuso antes de reportar a situação.	O	O	O
Denunciar abuso de idosos sem o seu consentimento é uma violação da deontologia médica.	O	O	O
A severidade do abuso terá influência no facto de o reportar ou não.	O	O	O
Só denunciaria caso a minha segurança estivesse assegurada.	O	O	O
Sinto que ainda não estou preparado para diagnosticar casos de abuso de idosos.	O	O	O
Sinto que ainda não estou preparado para gerir casos de abuso de idosos.	O	O	O

IV. FORMAÇÃO NA ÁREA DOS ABUSOS DE IDOSOS

4.1. Considera importante para a sua prática clínica futura abordar esta temática durante o curso?

O Sim O Não O Indiferente

4.2. Tem conhecimento de unidades curriculares que já tenha frequentado onde tenha sido abordada esta temática?

O Sim O Não

Se respondeu SIM:
4.2.1. Qual o número de vezes que este tema terá sido abordado? O 1 O 2 O 3 O 4 O 5 O »5

4.2.2. Considera que teria sido importante uma abordagem mais aprofundada deste tema? O Sim O Não

4.2.3. Indique a percentagem estimada de aulas que assistiu: O Nenhumas O «50% O »50% O Todas

4.3. Durante a **formação prática** já contactou com situações de **suspeita ou evidência clara** de abuso de idosos em contexto clínico? O Sim O Não

Se respondeu SIM, qual o número de vezes? O 1 O 2 O 3 O 4 O 5 O »5

4.3.1. Teve oportunidade de acompanhar a gestão de algum desses casos: O Sim O Não

4.4. Teve alguma **formação extra curricular** sobre esta temática? O Sim O Não

4.4.1. Se SIM, onde? ____________________

4.5. Se frequenta o 6º ano, pensa que seria relevante estar curricularmente previsto o tema da gestão de casos de violência (incluindo sobre o idoso) durante esse ano? O Sim O Não O Indiferente

V. ANÁLISE DE CASO

Apresenta-se de seguida um cenário hipotético:

Conceição Silva vive com o filho Jorge Silva.
Tem demência e a sua memória está bastante afetada, o que leva a que esteja sempre a fazer as mesmas perguntas e a esquecer-se onde coloca o seu dinheiro da reforma, sendo que acusa constantemente o seu filho de a estar a roubar.
Encontra-se regularmente agitada durante a noite e costuma acordar o filho quando entra no quarto deste e começa a esvaziar as gavetas.
Jorge Silva trabalha das 8 da manhã até às 18h da tarde, estando a Conceição Silva sozinha durante este tempo. Não é costume sair de casa sozinha, porque se costuma perder.
No entanto, no mês passado, saiu duas vezes sozinha durante o dia, tendo-se perdido e sido a polícia a encontra-la e levá-la de volta para a casa.
Ultimamente, Conceição Silva tem tido uma atitude cada vez mais hostil para o filho e recusa-se a tomar banho, estando a sua higiene pessoal a deteriorar-se significativamente.
A sua médica de família prescreveu-lhe um medicamento sedativo mas ela costuma recusar tomá-lo.
Jorge Silva quer continuar a tomar conta da sua mãe mas não sabe o que fazer relativamente ao seu comportamento.

Relativamente a uma série de hipóteses abaixo colocadas, <u>indique como qualificaria</u> as diferentes opções de Jorge Silva para lidar com esta situação:

	Não abusivo	Potencialmente Abusivo	Abusivo
Arranjar uma pulseira de identificação para Conceição Silva, para caso se volte a perder, as pessoas a possam identificar e ajudar a voltar para casa.	○	○	○
Disfarçar a porta da frente, cobrindo-a com uma cortina por exemplo, para impedir que Conceição Silva encontre a saída e volte a sair de casa sozinha.	○	○	○
Aceitar que a Conceição Silva não se quer lavar e é a sua escolha.	○	○	○
Fechar a Conceição Silva dentro de casa enquanto está no trabalho.	○	○	○
Perguntar ao médico por medicação que possa ajudar nesta situação.	○	○	○
Não responder quando Conceição Silva pergunta pelo seu dinheiro da reforma, porque qualquer coisa que lhe diga enfurece-a ainda mais.	○	○	○
Dizer a Conceição Silva que não pode tomar o pequeno-almoço enquanto não tomar banho.	○	○	○
Dizer a Conceição Silva que se as coisas continuarem assim, terá de ir viver para outro lado.	○	○	○
Colocar Conceição Silva numa cadeira de maneira a que não se consiga levantar durante o tempo em que está ausente.	○	○	○
Contactar serviços locais a pedir apoio, já que Conceição Silva não estará em segurança se for deixada sozinha durante o dia.	○	○	○
Colocar uma agenda diária no quarto de Conceição Silva, recordando-a para tomar banho todos os dias.	○	○	○
Administrar às escondidas os comprimidos sedativos no seu pequeno-almoço.	○	○	○
Não a levar a encontros de família, como o aniversário da neta, porque muito provavelmente se vai comportar de maneira embaraçosa.	○	○	○

VI. COMENTÁRIOS / REFLEXÕES PESSOAIS

(Caso a observação tenha sido suscitada por alguma questão em particular, sugere-se colocar um símbolo à frente da mesma e do comentário, para facilitar a interpretação)