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Family functioning and risk of violence in older adults: a comparative analysis by sex

Funcionalidade familiar e risco de violência em pessoas idosas: uma análise comparativa por sexo

Funcionalidad familiar y riesgo de violencia en personas mayores: un análisis comparativo por sexo

ABSTRACT
Objective: To assess family functionality and the risk of violence in older adults residing in a municipality in the interior of São Paulo state, based on a comparison by biological sex. **Methods:** A quantitative, analytical, and cross-sectional study with a sample of 161 older adults. The Family APGAR and Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) instruments were used, with descriptive and inferential analysis. **Results:** It was found that 89.4% of participants had good family functionality and 56.5% had a decreased risk for violence. Family dysfunction was statistically significantly associated with an increased risk of violence for both sexes, with no significant association found for sex, analyzed in isolation. **Final considerations:** Family dysfunction is an important risk predictor for violence against older adults. This finding proved valid for both men and women, indicating that the assessment of family dynamics is a fundamental care strategy for the entire older adult population.
Descriptors: Health of the elderly; Family relations; Elder abuse; Nursing.

RESUMO
Objetivo: Avaliar a funcionalidade familiar e o risco de violência em pessoas idosas residentes em um município do interior paulista, a partir da comparação do sexo biológico. **Métodos:** Estudo quantitativo, analítico e transversal, com amostra de 161 pessoas idosas. Foram utilizados os instrumentos APGAR da Família e Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), com análise descritiva e inferencial. **Resultados:** Identificou-se que 89,4% dos participantes apresentaram boa funcionalidade familiar e 56,5% risco diminuído para violência. A disfunção familiar associou-se de maneira estatisticamente significativa a um risco aumentado de violência para ambos os sexos, não sendo encontrada associação significativa entre o sexo, isoladamente. **Considerações finais:** A disfunção familiar é um importante preditor de risco para a violência em pessoas idosas. Esse achado se mostrou válido para homens e mulheres, indicando que a avaliação da dinâmica familiar é uma estratégia de cuidado fundamental para toda a população idosa.
Descritores: Saúde do idoso; Relações familiares; Abuso de idosos; Enfermagem.

RESUMEN
Objetivo: Evaluar la funcionalidad familiar y el riesgo de violencia en personas mayores residentes en un municipio del interior del estado de São Paulo, a partir de la comparación del sexo biológico. **Métodos:** Estudio cuantitativo, analítico y transversal, con una muestra de 161 personas mayores. Se utilizaron los instrumentos APGAR Familiar (Family APGAR) y Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), con análisis descriptivo e inferencial. **Resultados:** Se identificó que el 89,4% de los participantes presentaba buena funcionalidad familiar y el 56,5% un riesgo disminuido de violencia. La disfunción familiar se asoció de manera estadísticamente significativa con un mayor riesgo de violencia para ambos sexos, no encontrándose una asociación significativa con el sexo de forma aislada. **Consideraciones finales:** La disfunción familiar es un importante predictor de riesgo para la violencia en personas mayores. Este hallazgo demostró ser válido tanto para hombres como para mujeres, indicando que la evaluación de la dinámica familiar es una estrategia de cuidado fundamental para toda la población mayor.
Descriptores: Salud del anciano; Relaciones familiares; Abuso de ancianos; Enfermería.

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INTRODUCTION

With advancing age, it is common for functional and cognitive changes to arise that directly impact the autonomy and social integration of older adults. This increased dependence can make them more vulnerable to various forms of physical, psychological, sexual, and financial abuse or neglect, especially when they are in family contexts marked by overload, conflict, or lack of support[1-4].

The World Health Organization (WHO) defines violence against older adults as an act of omission and/or commission that may cause physical or emotional harm, which can prevent older adults from fulfilling their role in society[2]. Between 2022 and 2023, approximately 408,395 reports of violence against older adults were recorded, with the majority of victims being women with low levels of education[5].

Older women suffer doubly, both because of gender issues, which influence factors related to this problem at all ages, and because of age issues, which make this group more vulnerable[6,7]. It is important to highlight that the difference between sex and gender lies in the fact that sex refers to biological and anatomical characteristics, while gender presents cultural intersections. However, it is also something that relates to life as a whole, since being born a woman, in itself, is a factor that will be conditioned by social constructions of gender roles, given that aging as a woman is no longer understood in isolation as a biological process, but is therefore considered a social phenomenon[8].

Mistreatment of older adults is mainly at the hands of their caregivers, who are almost always family members. Studies show that the greater the dependence, the more susceptible the elderly person is to suffering some type of violence, and this factor may be linked to the overload on caregivers, who are unprepared to provide the necessary care and make the environment unsuitable and traumatic for the individual to enjoy a healthy old age [1-4].

Family support is highly relevant in the aging process, as it can affect the physical and psychological integrity of older adults. A strong family unit has a positive impact on the aging process, highlighting the importance of families preparing for the demands that will arise due to the complexity of aging. In functional families, the likelihood of physical or psychological abuse is lower compared to dysfunctional families [3-9].

Family functioning, in turn, is conceived as a set of actions related to an individual's family context, which verifies the absence or existence of consolidated bonds. A family can be characterized as functional or dysfunctional, with functional families being those that maintain emotional stability and commitment to their members, having a welcoming and supportive relationship[9].

In this context, understanding family functioning becomes essential for recognizing possible risk factors and directing more effective care actions. Thus, investigating the relationship between family functioning and risk of violence, especially considering the context experienced by older women, contributes to the improvement of health practices and the promotion of dignified and protected aging[1-4,9-11].

Despite the growing relevance of the topic, it is observed that most research still focuses on characterizing violence against older adults in general, without exploring in depth the nuances related to

biological sex and gender constructs. Furthermore, studies that integrate the concept of family functioning into the analysis of the risk of violence remain scarce, especially in community contexts and outside capital cities[4,6,8]. In this sense, this study seeks to fill these gaps by investigating family functioning and the risk of violence in older adults comparatively, with special attention to the specificities of female aging, aiming to assess family functioning and the risk of violence in older adults living in a municipality in the countryside of São Paulo, based on a comparison of biological sex.

METHODS

This study is part of a multicenter quantitative, cross-sectional, and analytical research project conducted in the municipality of Araras, São Paulo, Brazil. The sample consisted of 161 elderly individuals, who were included based on the following criteria: being aged 60 years or older, residing in Araras, being registered at Basic Health Units (BHU), and scoring at least 17 points on the Mini Mental State Examination (MMSE). Those with neurological or physical disabilities that prevented them from participating in the study were excluded.

Data collection was conducted in person through individual interviews carried out between July 2021 and December 2024, using validated instruments transcribed to Google Forms®. Participants were approached in public spaces in Araras or directly at their homes, whose addresses were obtained from the BHU registry, and then invited to answer the questionnaires. The interviews were conducted individually by researchers previously trained in data collection procedures in order to standardize the application of the instruments and preserve participants' privacy. For sociodemographic characterization, questions from the Elderly Health Hand Book were used to identify the variables: biological sex (male or female); race/color (white, non-white, or did not declare); age group, categorized as youngest-old (60-70 years), middle-old (71-80 years), and oldest-old (> 80 years); religion (Christians: Catholics, Evangelicals, and Spiritists; millenarian beliefs, such as Jehovah's Witnesses; among others); and living arrangements (alone, with family, or with non-family members).

For this section, the following instruments were used: Family Functioning Scale (Family APGAR), consisting of questions about the individual's perception of their family's functioning, classified using scores of 0-4 for high family dysfunction, 5-6 for moderate family dysfunction, and 7-10 for good family functioning; and the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), which identifies the risk of violence against older adults through questions about psychological and physical abuse, violation of rights, isolation, and financial abuse, considering a risk score of 3 or higher on a scale of 0 to 15.

After collection, the data were organized in a spreadsheet from Google Forms® and subsequently categorized. For H-S/EAST, 0-2 points were considered a decreased risk for violence, and ≥ 3 points an increased risk for violence. As for the Family APGAR, 0-6 was considered to indicate family dysfunction, and 7-10 good family functionality.

The data were then analyzed descriptively by absolute and relative frequencies and inferentially by Pearson's non-parametric chi-square test, with a significan-

ce level of 5% ($p<0.05$), chosen because it is appropriate for assessing associations between categorical variables. All analyses were performed using the Statistical Package for the Social Sciences (SPSS) software, version 23.0.

The study was conducted in accordance with Brazilian ethical standards for research involving human subjects (CNS Resolution No. 466/2012) and was approved by the Research Ethics Committee (REC) of the Centro Universitário da Fundação Hermínio Ometto under Opinion No. 4,393. 230, with funding from the Programa de Bolsas de Iniciação Científica (PIC Sustainability) of the same institution. During the initial approach, participants received information about the study's objectives and procedures and signed the Free and Informed Consent Term (FICT) by hand, agreeing to participate voluntarily in the research.

RESULTS

The sociodemographic characteristics, organized in Table 1, showed that 76 individuals (47.2%) were women, while 85 (52.8%) were men. Regarding self-declared race/color, 112 (69.6%) identified themselves as white, with the majority (84; 52.2%) aged between 60 and 70 years, considered the youngest-old. It was also observed that 151 (93.8%) declared themselves to be Christian and 97 (60.2%) lived with a family member.

Table 1 - Sociodemographic characteristics of participating older adults (n =161). Araras, São Paulo, Brazil, 2025

Sociodemographic variables	n(%)
Biological Sex	
Woman	76 (47,2)
Man	85 (52,8)
Race/Color	
White	112 (69,6)
Not white	47 (29,2)
Undeclared	2 (1,2)
Age group	
Youngest-old	84 (52,2)
Middle-old	52 (32,3)
Oldest-old	25 (15,5
Religion	
Christianism	151 (93,8)
Millenarianism	3 (1,9)
Others	4 (2,5)
None	3 (1,9)
Living Arrangement	
Alone	43 (26,7)
With family	97 (60,2)
With non-family members	21 (13,0)
TOTAL	**161 (100)**

Source: Prepared by the authors.

The assessment of family functioning using the Family APGAR showed that most families had good functioning, and in relation to the risk of violence, assessed using the H-S/EAST, most families had a reduced risk. None of the associations with biological sex showed statistical significance in isolation (Table 2).

Table 2 - Association between family functioning (Family APGAR) and risk of violence (H-S/EAST) with biological sex (n = 161). Araras, São Paulo, Brazil, 2025

Variables	Woman n (%)	Man n (%)	Total n (%)	p-value*
Family functioning (Family APGAR)				
Good family functioning	67 (41,6)	77 (47,8)	144 (89,4)	0,616
Family dysfunction present	9 (5,6)	8 (5,0)	17 (10,6)	
Risk of violence (H-S/EAST)				
Reduced risk of violence	37 (23,0)	54 (33,5)	91 (56,5)	
Increased risk of violence	39 (24,2)	31 (19,3)	70 (43,5)	0,058
TOTAL	**76 (47,2)**	**85 (52,8)**	**161 (100)**	

Source: Prepared by the authors.
*Pearson's Chi-Square Test.

In the analysis of the association between family functioning and risk of violence, performed according to biological sex (Table 3), family dysfunction proved to be a significant risk factor for both sexes. The association was statistically significant in both the female group (p = 0.016) and the male group (p = 0.017). It was observed that, in both cases, individuals with family dysfunction had a higher prevalence of increased risk for violence.

Table 3 - Association between family functioning (family APGAR) and risk of violence (H-S/EAST), according to biological sex (n = 161). Araras/SP, 2025

Biological sex	Family Functioning (Family APGAR)	Risk of violence (H-S/EAST) Decreased n (%)	Increased n (%)	Total n (%)	p-value *
Woman (n = 76)	Good family functioning	36 (47,4)	31 (40,8)	67 (88,2)	
	Family dysfunction present	1 (1,3)	8 (10,5)	9 (11,8)	0,016
Man (n = 85)	Good family functioning	52 (61,2)	25 (29,4)	77 (90,6)	
	Family dysfunction present	02 (2,4)	06 (7,1)	08 (9,4)	0,017
TOTAL (n = 161)	Good family functioning	88 (54,7)	56 (34,8)	144 (89,4)	
	Family dysfunction present	03 (1,9)	14 (8,7)	17 (10,6)	0,001

Source: Prepared by the authors.
*Pearson's Chi-Square Test.

In summary, the results show that most older adults in the sample have good family functioning and a low risk of violence. Although there was no significant association with biological sex alone, the presence of family dysfunction was found to be a factor associated with an increased risk of violence. These findings provide the basis for the following discussion.

DISCUSSION

The analysis of this study's findings allows us to reflect on the complex intersections between family functioning and the risk of violence in aging. Although the data present a mostly positive scenario and good family functioning in the sample, a statistically significant association emerged between family dysfunction and increased risk of violence, standing out as the main finding of the study. Based on this, the discussion focuses on the importance of identifying vulnerable family dynamics as a protective measure for older adults.

The predominance of living arrangements with family members, an expected finding for the older population, nevertheless reveals a complex duality. The intra-family environment, although perceived as the main space for care, is also where violence against older adults most often occurs. This contradiction is reinforced by the value placed on the family unit as an asset that must be protected, a dynamic that can hinder access to the real situation experienced by older adults[6-7,11-19].

The reality of this silencing is evidenced by data from the Management Report of the National Human Rights Ombudsman (Ouvidoria Nacional de Direitos Humanos - ONDH), which revealed that in 2024, 179,615 complaints of violence against the elderly were filed, ranking as the second-highest reason for complaints that year. Of these, it was revealed that 56.9% of the victims were women and that the violence occurred mainly within the home, caused by their own children[20]. Furthermore, the fact that almost 78% of cases are reported by third parties highlights the difficulty older adults have in identifying violence and reporting it, as they believe they must provide for and preserve the family, considering the profile of the aggressor[6,7,11-19].

In this sense, the true extent of violence against older women remains largely invisible, masked by a cultural normalization of gender roles. Although the association between sex and the risk of violence did not reach statistical significance in this study, the higher prevalence of increased risk among women observed in the results is consistent with the literature, which points to the normalization of violence, representing a point of attention. Historically constructed ideals derived from a patriarchal society, which associate the female figure with roles of submission and domesticity, can make it difficult for older women to perceive and report violence[6,7,11-19,21-23].

Furthermore, the significant Christian predominance declared by the participants invites reflection, in light of the literature, on the role of religious doctrines in maintaining patriarchal family structures. Historically, certain religious interpretations of Christian institutions reinforce a traditional family model that delegates to women the role of devoted caregivers, whose responsibility for family cohesion transcends their own well-being. By promoting the indissolubility of marriage, this precept can inadvertently create an environment that normalizes conflict and si-

lences the victim. In this context, elderly women may feel responsible not only for maintaining the home, but also for the violence they suffer, perpetuating a cycle of blame and violation[6,7,11-19,21-23].

When the analysis is extended to both sexes, it becomes necessary to recognize that older men are also exposed to situations of violence, albeit to a lesser extent than women. Studies indicate that hegemonic masculinity, associated with ideals of strength and self-sufficiency, can make it difficult to identify older men as victims and reduce the likelihood of reporting, rendering their vulnerability invisible. Thus, both men and women suffer the impacts of violence in different contexts, marked by social constructions of gender that influence perception, coping, and the support search. Therefore, prevention and care strategies need to consider the specificities related to both sexes, avoiding generalizations and promoting approaches that are sensitive to the different realities of aging[17,24,25].

Thus, although focused on the reality of a specific municipality, this study points to the possible existence of family dynamics in similar contexts beyond this particular case. The results reinforce the need for nursing professionals in Primary Health Care to take a broader view that goes beyond biological aspects and includes the complex social interactions that determine the safety of aging. Family functioning, therefore, emerges not only as an indicator of well-being but also as a tool for identifying vulnerabilities, enabling the planning of preventive and protective interventions for the elderly population.

FINAL CONSIDERATIONS

The results indicate that most of the older adults evaluated had good family functioning and a reduced risk of violence. Although no significant associations were observed with biological sex alone, the presence of family dysfunction was associated with a higher risk of violence in both sexes. These findings reinforce the importance of assessing family functioning as a relevant component in identifying vulnerable older adults, providing support for health professionals in planning prevention strategies and individualized care.

At the local level, recognition of these variables can also contribute to the improvement of professional practices and care protocols that take into account the living conditions of older adults. In this sense, understanding the association between family functioning and the risk of violence helps municipal health and social assistance teams to be more attentive and provide more appropriate care. Health services must be prepared to listen sensitively, capable of identifying demands and risks, even when they are not explicitly stated.

The limitations of the study include its cross-sectional design, which allows for the identification of associations but not the establishment of cause-and-effect relationships over time. In addition, the quantitative approach, with the use of structured instruments, although effective for risk screening, does not delve into the subjective perceptions and experiences of the participants. It is therefore suggested that future research adopt qualitative or longitudinal methods for a more in-depth understanding of the phenomenon.

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