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Socioeconomic status, social relations and domestic violence (DV) against elderly people in Canada, Albania, Colombia and Brazil

Dimitri Taurino Guedes [a,*], Beatriz Eugenia Alvarado [b], Susan P. Phillips [c], Carmen Lucia Curcio [d], María Victoria Zunzunegui [e], Ricardo Oliveira Guerra [f]

[a] Faculdade de ciências da Saúde do Trairi, Programa de Pós-Graduação em Ciências da Saúde, Universidade Federal do Rio Grande do Norte, Bolsita CNpQ Brasil, Rua Vila Trairi, S/N, Centro, Santa Cruz, Rio Grande do Norte 59200-000, Brazil
[b] Department of Public Health Sciences, Queen's University, Carruthers Hall Office 205, 62 Fifth Field Company Lane, Kingston, ON K7L 3N6, Canada
[c] Department of Family Medicine and Public Health Sciences, Queen's University, 220 Bagot St., K7L 5E9 Kingston, Canada
[d] Facultad de Ciencias para la Salud, Universidad de Caldas, Edificio Miguel Arango Soto, Carrera 25 N°48-57, Manizales, Colombia
[e] Département de Médecine Sociale et Préventive, École de Santé Publique, Université de Montréal, C.P. 6128, succ. Centre-ville, Montréal, Québec H3C 3J7, Canada
[f] Departamento de Fisioterapia, Programa de Pós-Graduação em Ciências da Saúde, Centro de Ciências da Saúde, Universidade Federal do Rio Grande do Norte, Av. Senador Salgado Filho, Lagoa Nova, 59078-970 Natal, RN, Brazil

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ABSTRACT

Purpose: To determine whether gender, socioeconomic conditions, and/or social relations are related to recent experiences of DV in older adult populations.
Materials and methods: Data on socioeconomic status and social relations were collected in 2012 from 1995 community-dwelling older adults in Canada, Colombia, Brazil, and Albania. Violence experienced in the last 6 months was measured using the Hurt, Insulted, Threatened with harm, or Screamed at (HITS) scale and classified according to type (physical or psychological) and perpetrator (partner or family member). Binary logistic regression analyses were used to assess associations between experiences of violence and gender, socioeconomic conditions, and social relations.
Results: Physical violence (by partner or family member) was reported by 0.63–0.85% of participants; the prevalence of psychological violence (by partner or family member) ranged from 3.2% to 23.5% in men and 9% to 26% in women. After adjustment for socioeconomic status, social relations, age and site, women experienced more psychological violence perpetrated by family members than did men (odds ratio (OR): 1.8; 95% CI: 1.2–2.6). Social relations, such as multifamily living arrangements and low levels of support from partners, children, and family, were associated with psychological DV. Current working status was associated with greater odds of victimization by partners among men (OR: 2.35 95% CI: 1.34–1.41), but not among women.
Conclusions: Gender and social relations are important determinants of experiencing violence in older adults. The findings of this study demonstrate the importance of a gender-based approach to the study of DV in older adults.

1. Introduction

Researchers in gerontology tend to study violence in the context of health vulnerability and neglect of care, defined as elder abuse (Forum on Global Violence Prevention, Board on Global Health, Institute of Medicine, & National Research Council, 2013). As a consequence, older adults are sometimes overlooked as victims of DV, particularly in traditional societies. In this article, we use the definition of DV as "any incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality" (National Health Service, 2014). When appropriate, we distinguish DV perpetrated by an intimate partner, referred to as intimate partner violence (IPV), from that perpetrated by other family members, referred to as family violence (FV).

Studies have revealed wide variation in the prevalence of DV among older men and women, ranging from 1% of physical and

* Corresponding author. Tel.: +55 8488889992; fax: +55 8432912411.
E-mail address: dtaurino@ufrnet.br (D.T. Guedes).

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sexual violence occurring in the last year in Germany (Stöckl, Watts, & Penhale, 2012) to 2.5% of physical and 36.1% of psychological violence in the last year in Hong Kong and 13.8% of physical and 17.1% of psychological violence in the last 5 years in Slovenia (Guček, Švab, & Selič, 2011; Yan & Chan, 2012). Although women outnumber men as victims of DV worldwide, and many studies in North America and Latin America have shown a higher incidence of DV affecting women, some research has contested this asymmetry (Chan, 2012). Many studies of older adults have included only women, limiting comparisons with men or assessment of gender differences in and determinants of violence. Older adults who report being the victims of psychological violence suffer disproportionately from poor general health, muscular/skeletal pain, headache, stomach problems, allergy, anxiety, sleeping problems, stress, and suicidal thoughts. Those who report being the victims of physical violence are more likely to experience incontinence, anxiety, sleeping problems, and stress (Bonomi et al., 2007; Hadeed & El-Bassel, 2006). With few exceptions, most research in older adults has been carried out in North America and Europe (Acierno et al., 2010; Bazargan-Hejazi, Medeiros, Mohammadi, Lin, & Dalal, 2013; Bonomi et al., 2007; Chen, Rovi, Vega, Jacobs, & Johnson, 2005; Hadeed & El-Bassel, 2006; Montero et al., 2013; Stöckl et al., 2012; Weeks & LeBlanc, 2011; Yan & Chan, 2012), with few studies conducted in Latin American settings such as Colombia and Brazil (Abath, Leal, Filho, & Marques, 2010; Espíndola & Blay, 2007; Júnior, 2010; Minayo, 2003).

Social relations and socioeconomic status are key determinants not only of older adult health and well-being, but also of DV, although evidence is limited. In this study, we used the convoy model of social relations as a guiding framework to understand the roles of social relations and socioeconomic status in the occurrence of DV among older adults (Akiyama & Antonucci, 1987; Antonucci, 2001). The convoy model proposes that individuals are surrounded by supportive others in their life courses, and that these relations vary in terms of closeness, quality, function (social support), and structure (social networks) (Antonucci, 2001). Living arrangements (part of the social network structure) and lack of social support have been related to victimization of older adults (Acierno et al., 2010; Dong, Beck, & Simon, 2009). Social support may be a key factor in the reduction and prevention of vulnerability and isolation among older people, and its poor quality could be considered an indicator of risk for experiencing psychological violence (Lundy & Grossman, 2004; Melchiorre et al., 2013). Some evidence has indicated that low education and income also predispose older adults to victimization (Berkman & Gurland, 1998; Ryser & Halseth, 2011; Weyers et al., 2008). As the structure and function of social relations vary according to gender, place, and socioeconomic status, a complete framework for understanding DV in older adults should consider these factors (Ajrouch, Antonucci, & Janevic, 2001; Ajrouch, Blandon, & Antonucci, 2005; Akiyama & Antonucci, 1987; Antonucci, 2001; Streeter & Franklin, 1992).

Thus, studies that assess DV in older adults, with the examination of gender differences in and determinants of victimization, in settings beyond North America and Europe will broaden our understanding of the social and cultural circumstances that give rise to violence (Espíndola & Blay, 2007). The International Mobility in Aging Study (IMIAS) (Sousa et al., 2014), a multicenter study set in four countries (Canada, Albania, Colombia and Brazil) with diverse cultures and socioeconomic conditions, provides comparative data to estimate the prevalence of and factors associated with DV (physical and psychological) in older adults. The international nature of these data enables comparisons of violent experiences linked to contexts; living arrangements; social support by friends, family, and partners; and socioeconomic opportunities across the life course (including consideration of education, work, and income). We propose that the inherent contextual population-level variability of IMIAS data will aid explanation of the roles of social factors in DV.

Our objectives were: (1) to determine whether socioeconomic conditions, social relations (marital status, living arrangements), and social support (social support exchange and satisfaction) are related to recent experiences of DV in old age; and (2) to explore whether experiences of and factors associated with DV differ between older women and men.

2. Materials and methods

2.1. Study characterization and context

Data were collected as part of a multicenter and multidisciplinary population-based longitudinal study (IMIAS) conducted at five sites: Tirana (Albania), Natal (Brazil), Manizales (Colombia), Kingston (Canada), and Saint-Hyacinthe (Canada). These cities were chosen due to the relative social and cultural homogeneity of each population, although societal norms, particularly aspects of gender equality, and living conditions vary significantly across cities (Fund UNP, 2008; United Nations, 2008).

Tirana, the capital of Albania, an ex-communist country of Muslim tradition in the process of rapid transition to capitalism, is a city of approximately 700,000 situated in the central valley of Albania. Manizales is a city of 400,000 located in a relatively wealthy area of the coffee-growing zone of Colombia (Andes Mountains, Caldas Department). Kingston, which has 110,000 inhabitants, was the first capital of Canada and has a government-/university-based economy. Saint-Hyacinthe (population 50,000) is an urban center in an agricultural region 50 km from Montreal, Canada. Natal has approximately 800,000 residents and is the capital of a relatively poor region of northeastern Brazil (state of Rio Grande do Norte) (Sousa et al., 2014).

2.2. Participants

The population-based IMIAS cohort was composed of community-dwelling men and women aged 65–74 years at the time of recruitment. The sample was stratified by sex, with approximately 200 men and 200 women enrolled at each site. Participants were recruited through neighborhood primary care center registers in Tirana, Manizales, and Natal, where random samples of elderly people registered at health centers were invited to participate. Albania, Canada, and Brazil have universal health care systems, with more than 90% of the population aged 65–74 years registered at health centers and having a primary care physician. In Colombia, approximately 82% of individuals in this age group were registered in the public medical system (Gomez, Curcio, & Duque, 2009). Education distributions in the Natal and Manizales samples were similar to 2010 and 2005 national census data, respectively, for the target age range (Brasil, 2010; Colombia, 2005). Education data were not available from Tirana. In Canada, as researchers were not allowed to make direct contact with clinic patients, potential participants in Kingston and Saint-Hyacinthe received letters from their primary care physicians inviting them to contact our field coordinator if they were willing to participate. In Saint-Hyacinthe, the sample was stratified proportionally by neighborhood to adjust for socioeconomic variability; in Kingston, this stratification was not feasible. As a result of this sampling scheme, the education distribution of the Saint-Hyacinthe sample paralleled that of the community for a comparable age range, according to the 2006 Canadian census (Statistics Canada, 2006) (according to the census, 46% had finished high school; 50% in the IMIAS sample had done so). Educated people were overrepresented in the Kingston sample (77%, in contrast to 55% according to the 2006 Canadian census), which

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