Physiotherapeutic interventions aimed at old people in situations of violence: a scope review

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Abstract

Objective: Identify physical therapy interventions aimed at old people in situations of violence. *Method*: This is a scope review, in which the following databases/libraries/search engines and gray literature were accessed: VHL, PubMed, Web of Science, Scopus, CINAHL, PEDro, BDTD, OpenGrey, OpenThesis, RCAAP, CAPES Thesis and Dissertation Portal, DART-Europe E-theses Portal and Theses Canada Portal. The searches used the descriptors and keywords, which were combined using the Boolean operators OR and AND: *Fisioterapeutas, Fisioterapia*, "Physical Therapists", Physiotherapy, "Physical Therapy", "Physical Therapy Specialty", "Physical Therapy Modalities", Rehabilitation, *Reabilitação*, "Elder Abuse", "*Maus-tratos ao Idoso*", "Physical Abuse", "Elder Neglect", "Aged Abuse" *e* "Elder Mistreatment". *Results*: Of the 601 records found, 46 were excluded because they were duplicated, and 555 were selected to read the respective titles and abstracts. 548 publications were excluded because they did not meet the inclusion criteria, and 7 papers were pre-selected. Through the Snowballing strategy, one was identified, resulting in a final result of 8 studies. *Conclusion*: Physical therapy interventions aimed at old people in situations of violence include: health education, measures of caregiver stress, community resources, screening/triage, evaluation, identification, therapeutic/rehabilitation plan and reporting. In view of the findings, it is observed that, despite the lack of knowledge on this topic, the physiotherapist plays an essential role in the conduct of cases of violence against old people.

Keywords: Helth of the Elderly. Violence. Elder Abuse. Delivery of Health Care. Physical Therapy Specialty.

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INTRODUCTION

Violence against old people (VAOP) is a growing international phenomenon. No society is immune from the occurrence of this disease, representing an important public health problem and of global interest, especially in the last decades[1].

The nature of VAOP can manifest itself in different ways: physical, psychological, sexual, financial, abandonment and neglect. Whatever the type of aggression, it represents a violation of human rights, which can result in psychological distress, depression, suicidal thoughts, increased use of health services, pain, physical injuries, trauma or early death[1-3].

Studies point to physical, psychological violence and negligence as the most frequently identified occurrences[4,5]. However, many old people do not report violence due to ignorance of their rights, fear of the consequences or fear of negatively affecting their relationships and family integrity[6].

The following are pointed out as risk factors for VAOP: advanced age, female gender, low family support, unfavorable socioeconomic context, depressive mood, social isolation, caregiver stress, disrespectful intergenerational relationships, cognitive impairment and physical, psychological, financial and functional dependencies of old people[1,7,8].

As it is a phenomenon little recognized and denounced, coping with VAOP requires a multidisciplinary approach. Health professionals have a significant responsibility in this situation, since they maintain contact with victims in health services and homes, and can trigger effective protection and coping mechanisms[9,10].

In this sense, the National Health Policy for the Old Person (PNSPI)[11] establishes that every health professional must promote the quality of life of the old person, through the establishment of actions that involve everything from primary care to rehabilitation. In addition, the National Policy for the Reduction of Accident and Violence Morbimortality (PNRMAV)[12] highlights the role of the rehabilitation of sequelae and disabilities arising from violence, providing conditions for their social and family reintegration and favoring the achievement of the individual's independence within a new situation.

The physiotherapist is a professional who works in the prevention of injuries, health promotion and rehabilitation of the old person, establishing a continuous bond with this population, and often integrating into their family environment, where the aggressors are most commonly found[10,13]. Thus, this professional is able to intervene in the entire context of VAOP: from the prevention and screening of cases to the rehabilitation of functional sequelae resulting from situations of violence experienced by many old people.

Despite this, the literature on this topic is scarce and the official documents are not clear in relation to the management of cases of VAOP by the physiotherapist. It is therefore important to carry out a scope review on publications related to interventions carried out by physical therapists with old people in situations of violence, as a way of examining the extent and nature of evidence on this topic, in order to support the practice of the professionals who deal with this population and favor the decision-making process. Therefore, the objective of the present study is to identify physical therapy interventions aimed at old people in situations of violence.

METHOD

This is a scope review. These studies aim to synthesize and disseminate the results of studies; map concepts that support a given area of knowledge, pointing out the main sources and types of evidence available; and identify gaps in the literature[14].

In order to improve the writing of the manuscript, this review followed the PRISMA Extension for Scoping Reviews (PRISMA-ScR)[15]. However, this study does not have a registered and/or accessible review protocol. The databases/libraries/search engines accessed were: Virtual Health Library (VHL); PubMed; Web of Science; Scopus; Cumulative Index to Nursing and Allied Health Literature (CINAHL); and Physiotherapy Evidence Database (PEDro).

Gray literature research and unpublished studies included: Digital Base of Theses and Dissertations (BDTD), OpenGrey, OpenThesis, Portugal Open Access Scientific Repositories (RCAAP), CAPES Thesis and Dissertation Portal, DART-Europe E-theses Portal and Theses Canada Portal (Aurora and Voilà catalogs). The Snowballing search strategy was also carried out, by reading all references of the articles selected in this review[16].

The methodological path was based on the PCC strategy - acronym for Population (P), Concept (C) and Context (C)[14] – considering P (physical therapist), C (physical therapy interventions in the face of violence) and C (old people in situations of violence). Thus, the following guiding question was established: what are the physical therapy interventions aimed at old people in situations of violence?

From each strategy item, keywords and descriptors were found in the MeSH (Medical Subject Headings) and DeCS (Health Sciences Descriptors): *Fisioterapeutas, Fisioterapia,* "Physical Therapists", Physiotherapy, "Physical Therapy", "Physical Therapy Specialty", "Physical Therapy Modalities", Rehabilitation, *Reabilitação,* "Elder Abuse", *"Maus-tratos ao Idoso"*, "Physical Abuse", "Elder Neglect", "Aged Abuse" e "Elder Mistreatment".

These descriptors and keywords were combined using the Boolean operators OR and AND, and applied to databases/libraries/search engines and gray literature, as shown in Chart 1.

Chart 1. Search strategies used in databases/libraries/search engines and gray literature, included in the scope review of physical therapy interventions aimed at old people in situations of violence. João Pessoa, PB, 2019.

Databases/ Libraries/ Search engines/ Gray Literature	Search Strategies
VHL (BIREME)	(tw:(*fisioterapeutas* OR *fisioterapia* OR "Physical Therapists")) AND (tw:("*maus-tratos ao idoso*" OR "elder abuse"))
PubMed Central: PMC	(("Physical Therapists" OR "Physical Therapy Specialty" OR "Physical Therapy Modalities" OR Rehabilitation OR "Physical therapy" OR "Physiotherapy")) AND ("Elder abuse" OR "Physical abuse" OR "Elder neglect" OR "Aged abuse" OR "Elder mistreatment")
Web of Science: Coleção Principal	("Physical Therapists" OR "Physical Therapy Specialty" OR "Physical Therapy Modalities" OR Rehabilitation OR "Physical therapy" OR "Physiotherapy") AND ("elder abuse" OR "Physical abuse" OR "Elder neglect" OR "Aged abuse" OR "Elder mistreatment")
Scopus (Elsevier)	((Physical Therapists OR Physical Therapy Specialty OR Physical Therapy Modalities OR Rehabilitation OR Physical therapy OR Physiotherapy) AND (Elder abuse OR Aged abuse))
CINAHL (EBSCO)	("physical therapists" OR "physical therapy" OR rehabilitation OR "physical therapists specialty") AND ("elder abuse" OR "aged abuse" OR "elder neglect")
PEDro	Simple search: "Elder abuse", "Aged abuse", "Physical abuse", "Elder Neglect", "Elder mistreatment"
BDTD	*Fisioterapeutas* OR *fisioterapia* OR *reabilitação* AND *"maus-tratos ao idoso"*
OpenGrey	(("physical therapists" OR "physical therapy" OR rehabilitation) AND ("elder neglect" OR "physical abuse" OR "elder abuse" OR "aged abuse"))
OpenThesis	("physical therapists" OR "Physical therapy" OR rehabilitation) AND ("elder abuse" OR "aged abuse" OR "elder neglect")
RCAAP	*fisioterapia* OR "physical therapists" AND "elder abuse" OR "*maus-tratos ao idoso*"
CAPES Thesis and Dissertation Portal	*fisioterapeutas* OR *fisioterapia* OR *reabilitação* AND "*maus-tratos ao idoso*"
DART	("physical therapists" OR "Physical therapy" OR rehabilitation) AND ("elder abuse" OR "aged abuse" OR "elder neglect")
Theses Canada Portal (Aurora and Voilà)	("physical therapists" OR "physical therapy" OR rehabilitation OR "physical therapist modalities") AND ("elder abuse" OR "aged abuse" OR "elder neglect" OR "physical abuse")

Studies that met the eligibility criteria were included: quantitative, qualitative studies, with mixed methods and gray literature (texts by specialists, dissertations and theses, editorial texts, among others); in English, Portuguese, French or Spanish; that were accessible and/or available in full (full texts), in electronic or printed media; that approached physical therapists working with old people in situations of violence; and that described any physiotherapy intervention recognized and/or implemented by professionals in the face of old people in situations of violence.

There was no delimitation as to the period of publication of the studies, due to the small number of publications on this topic. The search and selection of studies were carried out by two researchers, independently, from September to November 2019. The selection took place in two stages: an initial screening, considering only the reading of the titles and abstracts, from which studies were selected to read the full texts; and a second stage, when the eligibility criteria were applied after a complete reading of the texts. Disagreeing cases were resolved through a third researcher.

Data extraction took place using an instrument developed by the reviewers, which included: country of study; year and magazine of publication; type and objective(s) of the study; education of the main author; professional category(ies) addressed; and physical therapy interventions recognized and/or implemented by professionals in the face of old people in situations of violence.

The analysis of the quality of the articles and the level of scientific evidence were not used as a criterion for the exclusion of articles, therefore they were not carried out, since this type of review aims to identify the available production on the investigated subject[14].

RESULTS

Crossed between the descriptors in the databases/libraries/search engines, 135 articles were found, two in the VHL, 71 in the Web of Science, 24 in the Scopus, 36 in the CINAHL, two in the PEDro and no article in the PubMed. In the gray literature, 466 productions were identified, of which one in BDTD, five in OpenGrey, 85 in OpenThesis, 22 in the CAPES Theses and Dissertations Portal, 188 in RCAAP, 165 in the Theses Canada Portal, with no material rescued at DART-Europe E-theses Portal.

Of the 601 records found, 46 were excluded because they were duplicated, and 555 were selected to read the respective titles and abstracts. After analyzing them, 548 publications were excluded because they did not meet the inclusion criteria: 13 were published in languages different from those established in the criteria; two were not accessible in full; and 533 did not address physiotherapists working at VAOP and/or did not describe any physical therapy intervention directed at old people in situations of violence.

At the end of this phase, 7 studies were pre-selected to be read in full, a study rescued by the Snowballing strategy[17], resulting ultimately in 8 studies included[17-24]. The result of the search and selection can be seen in Figure 1.

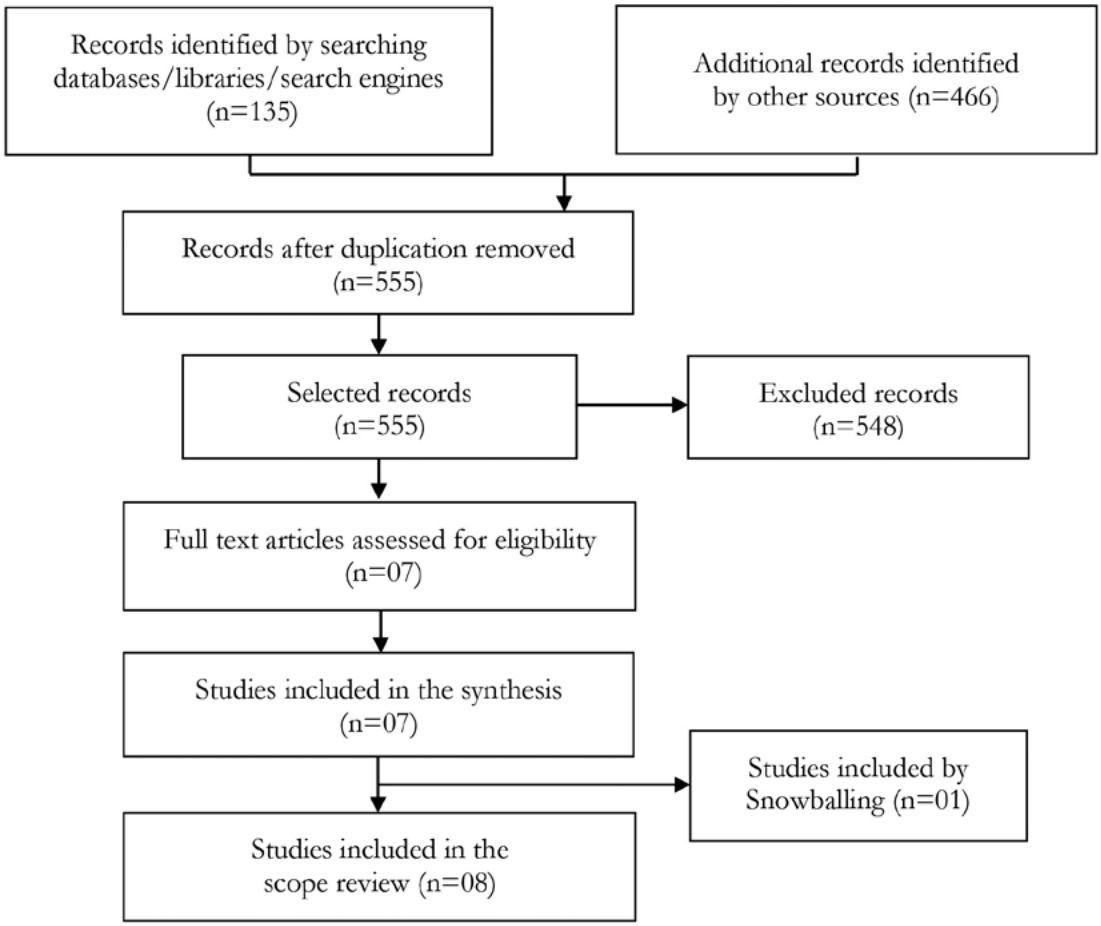

Figure 1. Flowchart of search and selection of studies on physical therapy interventions aimed at old people in situations of violence. João Pessoa, PB, 2019.

Source: Adapted from PRISMA-ScR[15].

All studies (n=8) came from the United States, produced between 1982 and 2005, in magazines in the area of Physiotherapy (n=3), Geriatric Physiotherapy (n=2), Physiotherapy and Geriatric Occupational Therapy (n=2), and Geriatrics (n=1).

With regard to the education of the main authors, half (n=4) of the studies had a Physiotherapist as the main author; one study by an Occupational Therapist; one written by Social Worker; and in two studies it was not possible to identify this information. Regarding the methodological characteristics, one article was identified as descriptive quantitative, five reflective studies and two editorials.

Considering the professional categories covered, six studies presented the Physiotherapist as the only professional approached, while one included both the Physiotherapist and the Occupational Therapist. The last study (n=1) portrayed other professionals such as Doctor, Nurse, Social Worker, in addition to Occupational Therapist and Physiotherapist. These data, as well as the objectives of the studies, can be seen in Chart 2.

Chart 3 shows the description of the physical therapy interventions recognized and/or implemented by the physical therapists directed to the old person in a situation of violence, for each study included in this review.

Chart 2. Description of studies included in the scope review of physical therapy interventions aimed at old people in situations of violence. João Pessoa, PB, 2019.

Author(s), Year/ Type of study	Main Author Formation	Professional category(ies) addressed	Study objective(s)
Dalton, 2005[18]/ Editorial	Not identified	Physiotherapist	Discuss child violence, by the intimate partner and old people, examining the multiple ways that physical therapists and their assistants can recognize and provide care to the victims of such violence.
Saliga et al., 2004[19]/ Quantitative Descriptive	Physiotherapist	Physiotherapist	Determine the extent of knowledge of Physiotherapists in an urban Michigan segment, in three areas of violence management against old people: signs/symptoms of physical violence; mandatory state reporting laws; and professionals' knowledge about institutional reporting protocols. In addition to investigating whether the participants had already suspected or reported a case of violence against old people.
Little, 2002[17]/ Reflection	Physiotherapist	Physiotherapist	Assist physiotherapists to recognize signs and symptoms of violence against old people; show prevalence and provide guidelines for determining this type of violence; and recommend interventions in suspected cases.
Camaratta et al., 2000[20]/ Reflection	Physiotherapist	Physiotherapist	Provide a protocol for physical therapists who face possible violence against old people; provide information on signs and symptoms, laws governing complaints and an approach to intervention and documentation in these cases of violence.
Foose, 1999[21]/ Editorial	Not identified	Physiotherapist	Share experiences of physical therapists' interventions in cases of violence against old people.
Holland et al., 1987[22]/ Reflection	Occupational Therapist	Physiotherapist and Occupational Therapist	Review the literature on violence against old people and describe the potential role of the Physiotherapist and Occupational Therapist in their detection, treatment and prevention.
Mildenberger e Wessman, 1986[23]/ Reflection	Physiotherapist	Physiotherapist	Provide physiotherapists with recognition of violence against old people, intervention procedures, prevention points and available community resources.
Tomita, 1982[24]/ Reflection	Social Worker	Occupational Therapist, Social Worker, Nurse, Physician and Physiotherapist	Describe a protocol for an integrated response by health professionals in the problem of violence against old people.

Chart 3. Physiotherapeutic interventions recognized and/or implemented by physiotherapists targeting old people in situations of violence, identified in the studies included in the scope review. João Pessoa, PB, 2019.

Author(s), Year	Physiotherapeutic interventions recognized and/or implemented by physical therapists aimed at old people in situations of violence
Dalton, 2005[18]	Routine screening and triage (incorporate into the evaluation protocol); Observation of the patient's behavior (nervousness and tendency to distance themselves from others; non-adherence to the treatment program) and family members (impatience and unreasonable expectations on the part of family members); Documentation (history of multiple fractures, contusions, bruises or unusual skin injuries), using body maps; Report to the supervising physiotherapist; Guidelines (where to get advice, shelter and assistance from professionals); Provision of informative material to the patient; Complaint in accordance with current state law.
Saliga et al., 2004[19]	Observations/behaviors identified by professionals as potential sources of violence: malnutrition, wound healing, behavior changes, untreated injuries, inconsistent wound sites, caregiver refusal to leave the old person alone during visits, unilateral contusion, difficulty for the old person to walk/sit without evidence of musculoskeletal disease, family/caregiver who answer questions and do not allow decision making by the old person; poor hygiene with the use of inappropriate clothing. Knowledge of local laws; contact with a social worker or supervisor when faced with a case of violence; and complaint.
Little, 2002[17]	Identification: warning signs and indicators of physical abuse (multiple fractures/injuries at various stages of healing, contusions grouped in a regular pattern, bilateral bruises, groin injuries, dental fractures, injuries around the face and neck, glove and sock-shaped burns, irregular hair loss); emotional (confusion and disorientation, fear of strangers and the environment, depression or anger, ambivalence about the caregiver, hesitation of the patient to speak in the presence of the caregiver, low self-esteem, yearning for attention); financial (unexplained loss of social security, anxiety and lack of knowledge about financial status, lack of payment for contracted services, lost belongings); and negligence (deterioration of health, dehydration or malnutrition, dirt and excessive odor on clothes/body, absent auxiliary devices, inappropriate clothing for environmental conditions, unexplained apathy or fatigue, over/under-medication causing sedation). Assessment: interview with questions about security; observation of the patient's general condition, behavior and care; caregiver-patient interaction; neuro-musculoskeletal review (including fractures) and functional activities; geriatric scales. Interventions: documentation (description of injuries, use of body model and photos) and report to the authorities; educating the patient about his/her protection (staying active, sociable and informed about financial, legal and protection obligations for old people); functional independence plan (through therapeutic exercises and functional activities).
Camaratta et al., 2000[20]	Screening and triage incorporated into the care routine, involving direct questions away from family members/caregivers and observation of general signs of violence (frequent unexplained crying, anxiety, tremors, irritability, abuse of alcohol or prescription drugs, fear or suspicion of certain people in the residence); physical violence (bruises, black eyes, rope marks, open wounds, cuts, punctures, burns, fractures, broken glasses, laboratory findings of over/under-dosage medications, untreated injuries and in various stages of centralized healing - head, neck, breasts, abdomen, back and genitals); negligence (dehydration, malnutrition, untreated bed sores and poor hygiene). In all American states (with the exception of six of them), there are laws that require health professionals to report cases of violence against old people. Assessment including complaints, financial status, social support, emotional stress, observation of patient-family/caregiver interaction and physical examination to provide evidence. Intervention involving a specific security plan, education and validation of patient rights. Documentation, containing a record with body graphic, descriptions and photos of injuries.

to be continued

Continuation of Chart 3

Author(s), Year	Physiotherapeutic interventions recognized and/or implemented by physical therapists aimed at old people in situations of violence
Foose, 1999[21]	Recognition of the signs of violence, understanding its origins, referring to social services and reporting. Differentiation between real violence and the result of an accident/illness. Assessment of the need to indicate institutionalization in the absence of a family support network and/or caregiver. Screening for: physical/biomechanical problems; physical evidence of violence (contusions, hand-shaped bruises, head/neck injuries, dislocations, open wounds, broken glasses); signs of neglect (malnutrition, dehydration, poor care, multiple contractures and decubitus ulcers); inappropriate emotional interactions (aggressive behavior); social well-being. Assessment of the caregiver's physical, cognitive and social capacity to provide assistance to old person; need for additional assistance in care; and ways to relieve caregiver stress. Caregiver education regarding patient safe positioning/transfers, hygiene care, skin inspection and health-disease process. Ensuring fitness for the old person through exercise, making them less vulnerable, as part of the Conditioning against Crime Program.
Holland et al., 1987[22]	Detection of violence during assessment and treatment. More direct intervention consists of the rehabilitation of adaptive self-care skills (decreasing the old person's dependence), as well as information on energy conservation and the recommendation of auxiliary devices; in addition to helping the old person to rescue old leisure interests, identifying new areas of potential skills in domestic tasks, strengthening the family unit and increasing their self-esteem. Intervention in the family and caregiver structure, providing information on available community support resources (transportation and recreation services for old people, friendly visitors and geriatric daycare centers), alleviating the day-to-day responsibilities of caregivers. Community education on violence against old people.
Mildenberger e Wessman, 1986[23]	Recognition of warning signs for violence: physical (bruises on the chest, shoulders, back, arms or legs; cigarette burns; rope/chain marks resulting from physical restrictions; lacerations on the face; head injuries, absence of hair or scalp hemorrhage); psychological (behavior changes, being scared or upset, avoiding talking about the family); interruption of physical therapy treatment; family prevents the old person from remaining alone during visits; financial (the old person reports loss of money or valuables); negligence (physical deterioration, malnutrition, weight loss, neglected or broken teeth, broken glasses, poor hygiene, repeatedly used clothing); violation of rights (caregivers impose unrealistic restrictions on decision making by the old person, on physical mobilizations and opportunities for socialization). Interventions include family counseling and specific training for dependent old people caregivers; use of community support services (day care, home nursing service, accessible transport, financial assistance - allowing caregiver stress relief), social and health education. In suspected cases, the action will depend on the type of abuse and physical danger to the old person. If it threatens life, professionals must know local protection agencies to report.
Tomita, 1982[24]	Functional assessment: assess activities of daily living (ability to self-care and prepare meals, use transport, shopping) and walking condition; observation of trauma or bruising, consistent with the patient's condition of dependence. Request a description of a typical day and your expectations about yourself and your caregiver. Physical examination: if there is an injury resulting from an accident, document the circumstances and record in sketches and graphics of the upper body and extremities; examine effects of over/under-medication, nutrition, hygiene and personal care. Assessment of burns, physical injuries to the head, bruises (bilaterally on the arm, clusters on the upper body), presence of bruises and injuries at different stages of resolution, fractures, falls, contractures, poor muscle tone and evidence of physical restriction; walking condition (if disabled it may suggest sexual aggression). Observation if the bruises presented on a hospital admission disappear during hospitalization (in this case, suspecting violence). Interview with the caregiver: age and sources of income of the caregiver, responsibilities inside and outside the home, expectations of the caregiver in relation to the patient and their difficulties experienced in caring for the old person; assessment of the caregiver's ability to withstand the stress of care and the support systems available to the caregiver. Educational plan: self-care education for the patient; inform the caregiver about the aging process. Therapeutic plan: instruction in self-care techniques to reduce dependence on caregivers; helping the patient with alternative arrangements, changing his life situation (using day centers, congregating housing or nursing homes).

It is observed that physical therapy interventions aimed at the old person in situations of violence involved: health education, measures on caregiver stress, community resources, screening/triage, evaluation, identification, therapeutic/rehabilitation plan and reporting.

Educational interventions involved the education of the old person, the caregiver and the community/society. The most reported, in half of the studies, were those aimed at the old people population: guidance on places of shelter, protection, counseling and assistance from professionals; provision of educational material; activities to prevent violence, maintain activities and socialize; providing information on legal and protection provisions for old people; rights and self-care education[17,18,20,24].

In three of the studies, educational activities with the caregiver were described as follows: specific training for the caregiver of dependent old people, including safe positioning/transfers, hygiene care and skin inspection; and information to the caregiver about the aging and health-disease processes[21,23,24]. Community education was also an intervention reported in two of the studies[22,23].

The assessment of caregiver stress was an intervention addressed in four studies, which reinforce the assessment of support systems available to families, the difficulties experienced in caring for old people and the caregiver's ability to withstand the stress of care. These studies report that the physiotherapist can suggest ways to reduce caregiver stress and burden, providing information on community support services[21-24].

Community resources were described in three papers. Among these resources, we can mention: friendly visitors, geriatric daycare, transportation and recreation services for old people, and financial aid[22-24].

Regarding screening/triage, three studies reported the importance of tracking potential sources of violence, and this strategy can be incorporated into the assessment protocol and the routine of care[18-20].

The general assessment included observation of the patient, family and patient-caregiver interaction. In seven studies, the general signs of VAOP, which may also indicate probable psychological violence, were: confusion; disorientation; fear of strangers and the environment; frequent unexplained crying; sudden changes in behavior; depression; low self-esteem; longing for attention; nervousness; rage; aggressiveness; non-adherence to the physical therapy treatment program; tendency to isolation; fear or suspicion of certain people at home; ambivalence of feeling towards the caregiver; and hesitation to talk about the caregiver[17-21,23,24].

The importance of assessing family behavior has been reported in three studies, and included as signs: family impatience; refusal to leave the old person alone; family members answering questions instead of the old person; not allowing the old person to make decisions; and unreasonable expectations on the part of the family, such as wanting the old person to walk, when they no longer want that goal[17,18,23].

In four studies, there were reports of the observation of signs and symptoms of neglect against old people, listed as: poor care or deteriorating health; malnutrition; dehydration; poor body hygiene; neglected teeth; use of dirty and/or inappropriate clothing for the climate; absent auxiliary devices; unexplained apathy or fatigue; over/under-medication, with possible sedation; multiple contractures or pressure ulcers[17,20,21,23].

Half of the studies (n=4) recommended documenting unusual skin injuries, contusions, bruises, fractures and injuries resulting from accidents. This documentation takes place through the description of the lesions, recording on maps/body models and photographs[17,18,20,24].

Assessment of the neuro-musculoskeletal system and/or functional assessment has been reported in two studies. Functional assessment should involve activities of daily living (self-care skills, preparing meals, using transport, shopping) and observing whether the occurrence of trauma is consistent with the patient's condition of dependence[17,24]. In one study, there is a report of the need to screen for physical and biomechanical disorders[21].

The identification of cases, reported in seven of the studies, can be done during the evaluation and/or physical therapy, by recognizing the following

warning signs: injuries to the face, head and neck; irregular hair loss; broken glasses; dental fractures; cuts; perforations; burns, which may be in glove and sock shape; inconsistent sites of unusual skin wounds or injuries; grouped bruises or contusions, in a regular or central pattern (head, neck, breasts, abdomen, back and genitalia/groin); bruises/injuries/fractures at different stages of resolution; falls; bad muscle tone; and evidence of physical restraint (rope/chain marks)[17-21,23,24].

In four studies, interventions that make up a therapeutic and rehabilitation plan were described: therapeutic exercises to maintain functional independence and good shape; rehabilitation of functional activities and self-care skills; in addition to energy conservation measures and recommendations for auxiliary devices[17,21,22,24].

Finally, the complaint was an intervention reported in six articles[17-21,23]. Complaints are mandatory according to current local legislation. In two studies, the physiotherapist's report to his supervisor or a social worker was included as an intervention prior to the complaint[18,19].

DISCUSSION

Many countries have endeavored to strengthen policies to protect and support old people in situations of violence, yet the United States stands out for the development of programs that are being implemented to provide victims with multidisciplinary social and health support[25]. This reality portrays the origin of the studies included in this review, in which the unanimity of North American studies with this theme is observed.

The first publication about VAOP, approached by physiotherapists, took place in 1986[23]. After this production, a few reflective texts were produced in an incipient attempt to debate the role of the physiotherapist in this area.

In 2011, Aveiro et al.[13] contributed to the discussion about the participation of the physiotherapist in health promotion, disease prevention and recovery of the main health problems of old people, including VAOP. Only in 2020, a case study was published reporting physical therapy interventions performed on an institutionalized old person, victim of urban violence[26]. Thus, the scarcity of publications reflects the timid involvement of physiotherapists in this context, suggesting misunderstanding and/or ignorance of this problem on the part of these professionals.

The Secretariat for Human Rights of the Republic of Brazil (SDHRB)[2] recommends that health professionals specialize and act in all types of VAOP. However, the physiotherapists who identify these situations understand them as a matter of psychological management and/or social assistance, not perceiving themselves as protagonists of relevant interventions in these situations. Ribeiro and Barter[27] evidenced this distance, reporting that physical therapists did not consider themselves responsible for listening, support, care and guidance to old people with a history of violence. On the contrary, these professionals assumed that they should only act on physical injuries and transfer the responsibility for the situation of violence to other professionals (such as psychologists and social workers).

Reinforcing this perception, this study also evaluated, as a distant practice, the consolidation of the safety net for cases of old people victims of violence. The professionals considered the rehabilitation services as an isolated, discontinuous and punctual action, demonstrating the lack of engagement in this issue.[27].

Regarding educational interventions, the literature recognizes that the best way to prevent VAOP is knowledge. Many old people are unaware of their rights or do not even recognize themselves as victims, nor their ways of prevention and defense in these situations[28,29].

In addition, some studies also report that the role of caregiver is often assumed by family members, often unprepared, causing care to occur in an intuitive and mistaken way, which can cause situations of neglect[30]. Therefore, many cases of VAOP could be avoided with educational interventions aimed at family members and caregivers.

SDHRB[2] highlights the importance of producing awareness campaigns on aging and valuing old people,

aimed at the entire Brazilian society. For Hirst et al.[31], education is a fundamental preventive strategy, so public awareness campaigns and educational initiatives are essential to avoid situations of violence for old people. In this way, education is a powerful tool for preventing this violence and physiotherapists can contribute with necessary clarifications for old people, family/caregivers and community.

Measures focused on caregiver stress were also reported, as this condition acts as a risk factor for situations of violence[32]. Caregivers are predisposed to stress, mental fatigue, difficulty concentrating, memory loss, apathy, emotional indifference, anxiety attacks and depression[33].

Pillemer et al.[1] affirm that the potential for the beginning of violence can be reduced by interventions to support the caregiver, as well as Lopes et al.[30] describe factors related to VAOP: absence of formal and informal support, and of public policies or support for families providing care.

Caregiver interventions are therefore a promising approach to prevention, and it is also necessary to assess the support systems available to caregivers. SDHRB[2] highlights the need to support families with social facilities such as: Community Centers, Day Centers, Collective Residences and Support Services for Family Caregivers. It is worth mentioning that these community environments favor new relational dynamics and strengthening the autonomy and protagonism of the old person, favoring their access to protection networks and services[34].

It is known that the caregiver burden increases the greater the functional dependence of the old person[30]. Furthermore, studies have linked impairment of functional capacity to the risk of violence, as well as signs of violence in this population[35-37]. Maia et al.[38] they also reported that the old person who suffers some type of violence is in a situation of functional dependence. That is, old people who need assistance for activities of daily living can trigger stressful situations in the caregiver and increase the chance of suffering some type of violence.

In this scenario, the physiotherapist is committed to the universality and comprehensiveness of care, with interventions aimed at the functional independence of the old person, promoting relief from the caregiver's stress and thereby preventing situations of violence. Thus, these interventions consist of preventive actions against violence, as well as contributing to improving the quality of life of the old person, their family and caregiver.

To detect abuse situations early, it is necessary to recognize the warning signs of all types of violence, which includes general signs in the behavior of the old person, as well as visible physical signs. The warning signs described in this article corroborate literary findings from other reviews, guidelines and government publications[39-41].

The physiotherapist, having a focus on physical interventions, can pay attention to physical signs of violence. However, due to the physiotherapist-patient relationship that develops during therapy, this professional must be aware of psychological, behavioral changes and the old person-family/caregiver interaction, which may indicate psychological violence. Thus, through a situation of violence, the old person may present changes in the emotional state[29,39,41], that corroborate the general signs and likely psychological violence presented in this review.

PNSPI[11] establishes that management instruments must be implemented to face the difficulties faced by the old person, and one of these instruments includes functional assessment. From it, depending on the functional condition of that person, actions will be established such as: rehabilitation for the recovery of maximum functional autonomy, prevention of functional decline and/or recovery of health.

Thus, it is pertinent to use therapeutic exercises aimed at the rehabilitation of functional activities, making it possible to promote quality of life for the old person and to act in the prevention of situations of violence.

Among these exercises, strength and multicomponents (strength training combined with balance, aerobic and stretching exercises) stand out as good strategies to improve functionality in old people[42].

In addition, the combination of individual and collective physical therapy interventions aimed at assisting old people who are victims of violence can improve cognitive, social, physical-functional capacities and quality of life in general.[26].

Some studies have already shown optimistic results with the inclusion of rehabilitation services for old people, victims of violence. Physiotherapists showed positive results acting in the rehabilitation of patients, such as the resumption of locomotion, guidance to families, return to the community and social reintegration[27].

The resumption of locomotion and social reintegration can be favored by the use of assistive walking devices, as well as other Assistive Technologies (AT), such as prostheses and orthoses. The assessment, prescription, adequacy and training of AT are strategies used to minimize motor dysfunction and reduced mobility, allowing greater autonomy, delaying or rehabilitating functional disabilities, and thus improving the quality of life of old people[43].

Regarding complaints, in Brazil, the Old People Statute[44] warns of the obligation of public and private services to report suspected or confirmed cases of VAOP to the competent authorities, and establishes as an administrative infraction the lack of this communication by the health professional.

In the ethical sphere, physiotherapists are responsible for the Code of Ethics and Deontology of the Federal Council of Physiotherapy and Occupational Therapy, which establishes that "the physiotherapist must communicate to the immediate head of the institution in which he works or to the competent authority, a fact that he is aware of, typified as a crime, misdemeanor or ethical infraction"[45].

Thus, it appears that the notification of the situation of violence is compulsory to the physiotherapist, and its communication to the immediate boss is an intervention based on ethical conduct, making its omission an administrative infraction.

However, Oliveira et al.[9] describe that the main difficulty pointed out by professionals in communicating VAOP cases is the failure to recognize this situation. Professionals admit that better training is necessary in order to identify and prevent this health issue[46]. In the study by Saliga et al.[19], physiotherapists reported lack of training/information about VAOP, reinforcing the conception of this professional's distance from the problem in question.

The present study has limitations inherent to scope reviews, as it includes several studies, not being concerned with the quality or level of evidence. In addition, this review mostly identified reflective and editorial texts, published more than 15 years ago, demonstrating the scientific fragility with which this content has been approached.

In addition, most studies emphasized the identification of signs and symptoms, and the assessment of the old person in the context of violence, to the detriment of more specific concrete physiotherapeutic interventions. Furthermore, in some studies, different professional categories were addressed, covering interventions common to other professionals, limiting the recognition of the physiotherapist's actions.

CONCLUSION

This review provided a summary of the physical therapy interventions aimed at the old person in situations of violence, which involved: health education, measures of caregiver stress, community resources, screening/triage, assessment, identification, therapeutic plan/rehabilitation and reporting.

These interventions are in line with health policies aimed at the old person, including the National Policy for the Old Person, the Statute for the Old Person, the National Health Policy for the Old Person and the National Policy for Reducing Morbidity and Mortality from Accidents and Violence. These policies converge so that health care for old people is guaranteed at different levels of care, protecting them from any type of violence.

Despite this, the scarcity of updated observational and experimental studies, published on this topic, was identified. Thus, it is observed that some questions still need to be answered: how is the physiotherapist

acting in situations of violence against old people (VAOP)? What would be the specific actions of the physical therapist in these situations? Which actions are multiprofessional? How effective are these interventions in this problem? How should the protocol for physiotherapeutic assistance be faced with VAOP?

Considering that many important actions in coping with VAOP, mainly at the levels of prevention and promotion, are shared with other health professionals, it is suggested that future reviews be carried out that include interdisciplinary approaches aimed at this problem, enabling the identification of updated studies and portray proven interventions.

On the other hand, physiotherapists contribute with specific and significant actions for this problem, especially with regard to the therapeutic and rehabilitation plan, and which constitute the differential of these professionals in the context of VAOP, needing to be disseminated among researchers and professionals of the practice.

Based on this and future reviews, it is suggested to conduct methodological research for the elaboration and validation of care protocols, both specific to the physiotherapist and multiprofessional. These protocols could support a qualified professional practice with a focus on comprehensive care for old people who are victims of violence, contributing to the implementation of existing public health policies and improving the quality of life and health of this population.

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