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Vulnerability, family violence and institutionalization: narratives for elderly and professionals in social welcome center

Vulnerabilidade, violência familiar e institucionalização: narrativas de idosos e profissionais em centro de acolhimento social

Vulnerabilidad, violencia familiar e institucionalización: narrativas para personas mayores y profesionales en centro de bienvenida social

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ABSTRACT

Objective: To know the institutionalization process and the functional clinical condition of elderly people who suffered family violence, from the perspective of the elderly and professionals.

Methods: Qualitative, which used oral history as a data collection technique. Held in a long-term institution for the elderly, using a semi-structured interview script. The participants were three nursing technicians, two nursing assistants, five caregivers for the elderly and eight elderly. Thematic analysis was performed with the aid of the MAXQDA® software.

Results: Three categories were identified: The condition of vulnerability and the care needs of the elderly, indicating welcoming as an intervention; Suffering and denial of conditions of vulnerability; and Situations of family violence and the positive aspects of reception.

Conclusions: Long-term institutions are considered important spaces for comprehensive and humanized care, as well as essential for the protection of elderly victims of family violence.

Keywords: Aged. Elder abuse. Homes for the aged.

RESUMO

Objetivo: Conhecer o processo de institucionalização e a condição clínica funcional de idosos que sofreram violência familiar, na perspectiva dos idosos e dos profissionais.

Métodos: Estudo qualitativo, que utilizou a história oral como técnica de coleta de dados. Realizado em instituição de longa permanência para idosos, utilizando roteiro de entrevista semiestruturada. Os participantes foram três técnicos de enfermagem, dois auxiliares de enfermagem, cinco cuidadores de idosos e oito idosos. A análise temática foi realizada com o auxílio do *software* MAXQDA®.

Resultados: Identificaram-se três categorias: A condição de vulnerabilidade e as necessidades de cuidado dos idosos indicando como intervenção o acolhimento; O sofrimento e a negação das condições de vulnerabilidade; e Situações de violência familiar e os aspectos positivos do acolhimento.

Conclusões: Consideram-se as instituições de longa permanência importantes espaços para o cuidado integral e humanizado, assim como essenciais na proteção de idosos vítimas de violência familiar.

Palavras-chave: Idoso. Maus-tratos ao idoso. Instituição de longa permanência para idosos.

RESUMEN

Objetivo: Conocer el proceso de institucionalización y el estado clínico funcional de las personas mayores que sufrieron violencia familiar, desde la perspectiva de los adultos mayores y profesionales.

Métodos: Estudio cualitativo, que utilizó la historia oral como técnica de recolección de datos. Se lleva a cabo en un centro de atención a largo plazo para personas mayores, utilizando un guión de entrevista semiestructurada. Los participantes fueron tres técnicos de enfermería, dos auxiliares de enfermería, cinco cuidadores de ancianos y ocho ancianos. El análisis temático se realizó con la ayuda del software MAXQDA®.

Resultados: Se identificaron tres categorías: la condición de vulnerabilidad y las necesidades de atención de los ancianos, lo que indica la bienvenida como una intervención; Sufrimiento y negación de condiciones de vulnerabilidad; y Situaciones de violencia familiar y los aspectos positivos de la recepción.

Conclusiones: Las instituciones a largo plazo se consideran espacios importantes para la atención integral y humanizada, así como esenciales para la protección de las víctimas de la violencia familiar.

Palabras clave: Anciano. Maltrato al anciano. Hogares para ancianos.

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INTRODUCTION

In developing countries, population aging occurs in conjunction with serious social problems. The basic indicators of the Ministry of Health show this demographic transition in a very expressive way[1]. The 2020 estimate shows that the population aged 60 or over for the same year totals 30,197,052 million, representing 14.26% of the Brazilian population. There are currently 5.020.140 million elderly people living in southern Brazil, totaling 16.62% of the elderly population in this region, being the region with the highest growth of this age group in the country[1].

The social problems caused by the rapid population aging process are also associated with the increase in cases of violence[2]. Violence against the elderly is considered a serious social problem, a universal phenomenon that affects all social classes and has caused physical illness, mental illness and death[2–3].

The concept of violence is understood as the intentional use of physical force or power, in threat or in practice, against oneself, another person or against a group, which results or may result in suffering, psychological damage, deprivation or death[2–3]. The specific forms of manifestation of violence against the elderly can be described as: Intra-family or family, Structural and Institutional[3]

When violence occurs in the family environment, it is defined and understood as actions or omissions that harm the well-being, physical and psychological integrity of the elderly. It can be performed inside or outside the home, by any family member who is in a relationship involving power with the attacked person or even people with an intimate relationship, even if not related by blood[2]. The family can bring both positive aspects, in order to assist in the development of individuals, and negative aspects, through the dispute for power, promoting inequalities and discrimination. There may be a need for intervention and, in not so rare cases, the institutionalization of the elderly as a way of protecting them[4–5].

In Brazil, many studies have been focused on the elderly population, but there is a small number of investigations directed at institutionalized elderly people, even less studies that relate institutionalization to violence[6]. Elderly people who suffer family violence usually have characteristics that evolve with the aging process, among them, the clinical-functional vulnerability stands out[6].

Clinical-functional vulnerability comprises organic changes that can compromise the main dimensions of functionality, resulting in locomotor deficit, mood disorders, cognition and communication, directly affecting the autonomy and independence of the elderly person to perform basic and instrumental activities of life. daily life, also affecting their quality of life[7].

The elderly become more susceptible to violence as they need more physical care or show an increase in the degree of dependence. In this sense, clinical-functional vulnerability can negatively influence family relationships[8]. The vulnerability of the elderly, a weakened family life, as well as unprepared and unattended caregivers make the environment in which the elderly person is extremely hostile[9].

Therefore, knowing the expectations and adaptation of elderly people who have been institutionalized in situations of violence or neglect can contribute to the planning and implementation of unique care strategies for the elderly, in the perspective of better care practices, taking into account their needs and needs. limitations[10]. In this context, the following is questioned: How does the institutionalization process take place in the face of conditions of clinical-functional vulnerability of elderly people who have experienced family violence? Thus, the present study aims to understand the institutionalization process and the functional clinical condition of elderly people who have experienced family violence, from the perspective of the elderly and professionals.

METHOD

This is a qualitative study, based on oral history as a data collection technique. Qualitative research has reliable characteristics, such as a natural environment for the search of its data source[11]. Oral history as a data collection technique places the subject in a prominent place, since it is based on speech, uses memory as a primary source for understanding society and the past, valuing the experiences and what has to be said about them[12].

The study took place in a municipality located in the Southern Region of Brazil, where 13.6% of this population is elderly[1]. The study scenario was a governmental institution for elderly (ILPI) victims of violence. The guarantee of assistance to those attended occurs through the Department of Social Assistance and Citizenship (SASC), together with the Special High Complexity Protection Network, which coordinates the implementation of policies to protect and defend the rights of this population in the municipality.

The institution is capable of receiving 18 people, respecting its capacity, with nine female and nine male vacancies. At the time of the research, two vacancies were filled by non-elderly individuals with special needs.

The institution has 28 statutory city civil servants, two of whom are college-educated professionals, seven are mid-level technicians and six are caregivers for the elderly.

These 15 civil servants provided direct assistance to the elderly. The other 13 servers are responsible for maintaining the unit. Of the civil servants who work directly in the care of the elderly, two had been admitted to the institution less than 6 months ago, two were on vacation and one, on medical leave during the data collection period, so they did not participate in the research.

Of the 16 elderly people admitted to the unit, one elderly person was hospitalized during the data collection period and seven elderly people presented cognitive impairment according to the results of the Mini Mental State Examination (MMSE), and did not participate in the research because they did not meet the inclusion criteria.

Of the total of 18 participants, 10 were professionals: three nursing technicians, two nursing assistants, five caregivers for the elderly. Eight participants were elderly victims of family violence.

The inclusion criterion for the participation of the elderly in the research was: being welcomed at the ILPI motivated by family violence. For the professionals, they were: to provide direct assistance to the elderly person and to work in the service for more than 6 months. The exclusion criteria for the elderly were: presenting cognitive status impairment, assessed based on the application of the MMSE, being hospitalized during the period of data collection, presenting orofacial apraxia or any other condition that prevented understanding during the interview. As for the civil servants, exclusion criteria were: being absent from their work activities due to vacation or leave during the data collection period. Therefore, it was an intentional sample.

For data collection, the instrument used underwent apparent and content validation by three doctors who are experts in the subject. The evaluation was carried out using an adequacy instrument for the interview script, containing two parts: the first comprised of the evaluator's identification; the second part with instructions on the objectives, place and participants of the research to support the evaluation process, and the questions for analysis of aspects of the script, considering its form, sequence and scope.

After the assessment, all suggestions were incorporated into the instrument with the corrected version being analyzed within a research group constituted of student and teacher participants, for use in the fieldwork. The questions were refined in order to ensure clarity and meet the proposed objectives, also minimizing the risk of discomfort to the participants.

Oral history techniques were applied in the thematic modality. These techniques place the subject in a prominent place, starting with reports and memory as the primary source. They are used to understand society, life stories, remarkable events and the past, emphasizing the experiences and what there is to be said about them[13].

Data collection took place in two stages. Initially, documentary collections were performed from medical and personal, social and institutional records, such as: reason and situation of the elderly at the time of reception, bond and frequency of family visits, daily care and routines, activities and entertainment.

The second stage took place from the interviews of the elderly and professionals of the institution. Participants were personally invited by the principal researcher. At the time of the invitation, each participant was informed about the research objective, the subject under study and the risks related to the research as moments of discomfort since feelings would be exposed, and memories and life trajectories explored. The interviews were carried out by the main researcher, according to the availability of the participants, at the institution itself in a reserved, quiet environment, without interruptions. The interview audio was recorded for later transcription and analysis.

The dialogues between the interviewer and the elderly were guided by a script of questions containing the following questions: Tell me what your life was like and if you needed any care before residing at the ILPI. How was your relationship with your family throughout your life? How did you find out about or be referred to the institution. How does it feel to live in this institution. What changes have occurred in your life after coming to live here? Would you like to talk more about something that was not asked in this interview?

For professionals, the question script was: How is the acceptance and evolution of the elderly in the institutionalization process? Knowing the stories of the elderly here, in general, what do you think about the conduct of institutionalizing as a solution to cases of violence? After welcoming, what results do you identify in relation to the violence that the elderly suffered? Would you like to talk more about something that was not asked in this interview?

Then, the thematic analysis[11] was carried out, based on the MAXQDA® software , version 2018, which provided easy coding and allowed the interrelation between data, codes and derivatives with a methodological approach.

The thematic analysis of the data derived from the documents and interviews took place, according to Minayo[11], following the steps pre-analysis, exploration of the material or coding and treatment of the results obtained/interpretation. In the pre-analysis, the organization of the material involved the initial systematization of ideas, through reading. In the second phase, the material was coded, enabling interpretations and inferences. The third phase consisted of

the treatment of results, inference and interpretation. It was the moment of intuition, reflective and critical analysis[11].

The validation of the inferences was carried out voluntarily, by means of an invitation to the participants, with one member of each category as its minimum criterion. Two professionals and two elderly participated in this validation process, one elderly participant of each sex, considering that family violence can be experienced and interpreted differently in both sexes. The inferences in the analysis process for the professionals and the elderly were read, and they confirmed or adapted the statements.

Finally, the analysis of the medical records of the elderly allowed the visualization of the family, environmental and social context in which the elderly were inserted, facilitating the understanding of the meanings of the speeches about the conditions of vulnerability that the residents were exposed to, and the relationship of this reality with the institutionalization process.

The categories emerged from the results of the participants' narratives. Thus, three were established, in order to better visualize the clinical-functional vulnerability of elderly victims of family violence and their institutionalization.

The study complied with the current resolutions regarding research with human beings, was authorized by the person in charge of the institution, as well as by the Standing Committee for Ethics in Research involving Human Beings, of the State University of Maringá, with Opinion No. 3.384.162 and CAAE nº 08167419.7.0000.0104. All participants signed the Informed Consent Term and, to guarantee confidentiality and anonymity, the statements were identified by the letters: TE - for Nursing Technician, AE - for Nursing Assistant, CI - for Elderly Caregiver and ID - for Elderly, followed by numbering.

RESULTS AND DISCUSSION

Among the participating professionals (n = 10), all were female, aged between 31 and 63 years old. As for the function developed, two were nursing assistants; three, nursing technicians; and five, caregivers for the elderly. All professionals had more than 11 years of education, two caregivers had a higher level in social work. The working time of the professionals was from one to 16 years, with an average of six years.

Among the elderly participants (n = 8), four were female and four were male, all aged between 60 and 85 years. Three elderly people were single; two, widowers; two, divorced; and one, separated. All were institutionalized motivated by situations of violence and family and social risk. The elderly had pre-existing diseases such as: Chronic Obstructive Pulmonary Disease (COPD), hypertension, diabetes, hypothyroidism, neurodegenerative diseases, vascular, psychiatric and emotional diseases. Regarding the conditions of dependency, one elderly person had a degree of dependence I, there were four elderly people with a degree of dependence II, and three elderly people had a degree of dependence III.

The following categories emerged from the thematic analysis: The condition of vulnerability and the care needs of the elderly indicate welcoming at the ILPI as an intervention; Suffering and denial of the conditions of vulnerability and family violence and Situations of family violence and the positive aspects of institutionalizing the elderly.

The condition of vulnerability and the care needs of the elderly indicate welcoming at the ILPI as an intervention

In this category, the elderly recognized their condition of vulnerability and their care needs, as well as the importance of the welcoming process at the ILPI in the context in which they were inserted. The high social and health risk in which the elderly lived before the reception and the impossibilities to perform basic and instrumental activities of daily living are also observed during the documentary analysis. Thus, the clinical-functional vulnerability proved to be a strong factor for the institutionalization of those welcomed until now. During the data collection process, the participants' desire to live with more quality was evidenced, receiving care, company and respect.

> *I needed care. Someone who would help me with everyday things. I felt very dizzy, barely walked, had to take showers seated, made food as much as I could, but I didn't eat [...] everything changed in my life after I came to live here.* (ID-01)

> *In fact, I knew that I could no longer take care of myself [...] I couldn't do mostly anything anymore, I lived as I did [...] I lived in the hospital, after I was discharged I couldn't live alone.* (ID-4)

> *I lived alone, I knew I needed help with everyday tasks, taking a shower and going to the doctor, for example. I couldn't take that life anymore, it was very lonely.* (ID-05)

The impossibility of performing basic and instrumental activities is strongly related to the presence of clinical-functional vulnerability, associated with the health conditions of this elderly person. Thus, it is important to implement programs in order to minimize vulnerability and its risks[10,14]. The condition of vulnerability encompasses biological, psychological, social and cognitive factors, requiring a comprehensive assessment of the elderly, associated with social and health care[2,15].

It is known that the condition of clinical vulnerability can lead to hospitalization, institutionalization and even death[14]. This context can make the elderly dependent on special care and, therefore, they must be considered a priority group in public social and health policies, in order to minimize its consequences and aggravations[10,15].

Although the elderly maintain a preserved cognitive system, the high degree of vulnerability and, consequently, dependence, is usually part of the context of the elderly welcomed in the research scenario. The narratives below bring stories of abandonment and loneliness that surround this context.

> *I came to live here at the home because I lived alone and already used a wheelchair. I couldn't take care of myself. I needed help to bathe myself, make food, shop. I depended on the help of a neighbor for everything.* (ID-02)

> *I had a lot of medication to take, but I always had a friend or neighbor around to help me look for it and buy it [...] before I used to bathe myself, cook food, wash my clothes and clean the house [...] , but then it became difficult, impossible*. (ID-03)

> *I was always alone when I had seizures and when I needed help from my brothers, I realized that my sisters-in-law did not like it. I was afraid of being alone, I felt I was a burden for them.* (ID-6)

> *I believe that, depending on the stage in which some elderly people arrive here, if they were not here, they would have already died. So, institutionalization for those we welcome means the continuation of life. In my opinion, we almost resuscitate these elderly people [...] the person arrives here and flourishes!* (CI-03)

Elderly people living in the ILPI, despite having family members, accept to live in the institution due to the loneliness experienced and the health conditions that increase the needs for care and companionship. The current place where we live represents a refuge, protection, it means a space of representations, stories and memories, because the main reason for institutionalization is usually the need for care, arising from social problems[4,14].

It is also known that institutionalization can have negative effects for the elderly[14]. The presence of symptoms of depression, decreased levels of physical activity or leisure and loss of functional independence, potentiate functional decline[16]. However, it has already been shown that specialized and humanized care has potentially positive benefits for the elderly[10,17–18].

Suffering and denial of conditions of vulnerability and family violence

The vulnerability of the elderly is related to adverse outcomes, such as functional dependence, risk of institutionalization, hospitalization or death, in face of biological, social, cognitive, psychological and family arrangements[3,10]. However, the narratives show that, even living in subhuman conditions, the elderly became resistant to recognizing, or even denying their condition of vulnerability and their experiences in relation to the violence and abandonment suffered. In the midst of this scenario, the elderly are resistant to institutionalization. They often recognize the reason and the importance of institutionalization for maintaining their health, but they tend to justify this process in a way that does not expose their vulnerability, even with an understanding of this context.

> *I needed a lot of help from my neighbor, but I also did a lot on my own if I think about it. Actually I came to live here because the social worker came to my house, called me and I decided to come [...].* (ID-02)

> *I didn't need help, just someone to take me to the bank, because I didn't know Maringá well, but I made my own food. I came to live here because of my age. I had already worked, now it was time to stop. Because of that, I had nowhere to live.* (ID-05)

> *I made coffee, made my food, the people at home (they lived next door to the home) gave me food because they wanted to, but I cooked myself. I took my medication by myself, but other people who sought the medication and took me to the doctor were not from my family [...] in fact, I couldn't work, I didn't have anything to eat at home. I collected cardboard, I got a basic necessity basket*. (ID-08)

The denial of the vulnerability brings suffering with remembering their life stories and what brought them to institutional home. During the evaluation and analysis of documents and interviews, feelings of failure, rejection, loneliness and sadness were easily evident.

The perception of functional vulnerability and the situations of family violence experienced refer to life stories, marked by physical or mental suffering, as well as illnesses, the lack of financial resources, security, care and family support[15–16]. These narratives are filled with emotion and express suffering when reporting how the individual lived before institutional care and the recognition of the benefits acquired after institutionalization[15–16,19], which can be observed through the following statements:

With the time here, I understood that before, I drank because of loneliness. I had nothing else to do [...] I did not receive visitors, I had no contact with my children. Here, I don't feel like drinking, because I feel good. In fact, I don't really like to remember how I lived before. Here, even my children come to visit me sometimes [...] I thought that loneliness was living in an old age home, but for me it was better. (ID-01)

I had no help. I took care of all my brothers. I dedicated myself during my whole life to them, so much so that I didn't get married [...] and today there are other people who take care of me, thank God they exist (refers to the institution's team). (ID-04)

I realize that they understand the need for proper care, but sometimes they deny it, perhaps out of shame. On special days, such as birthdays, even with the party we have, we find them caught in their own thoughts and sad. Talking about the family also doesn't seem to me to be something they enjoy. They almost never speak about their families. (TE-01)

It is very easy to see how needy they are if you follow their everyday life. They want to draw attention. Few receive visits and they usually love the volunteers who visit the house, because they know they are the only visitors, no one else comes. I realize that no matter how good the institution is, it does not replace the presence of the family. The elderly suffer from family abandonment. (AE-02)

Remembering their life stories covers several factors that are directly associated with the culture and individual characteristics of the elderly, which generates different sensations and different intensities. This directly reflects on the feelings experienced and the acceptance or not of residing in an ILPI, as there are different ways of assessing the situations that arise throughout life. Some elderly people face institutionalization naturally, others accept it because there are no other options[10,14].

Situations of family violence and the positive aspects of institutionalizing the elderly

It is known that several factors are associated with situations of violence against the elderly. In this context, this research was marked by a strong factor that seems to contribute to the perpetuation of family violence, the clinical and functional vulnerability of the elderly.

When the family has an elderly person with a high degree of dependence under their care, they are susceptible to constant financial pressures, physical overload and reorganization in the family and family caregivers' routine. These factors can make the environment and coexistence hostile, triggering violent behavioral responses on the part of family caregivers, being potentiated by the complications of the elderly's physical, emotional and psychological health status[2,14]. In addition, several factors intrinsic to the elderly contribute to making it difficult for health professionals to identify violence[7,14].

Violence is directly related to power relations, as it involves the ability to impose your will on others, outside any organizational or institutional framework [14]. There are many factors associated with situations of violence. It is a biopsychosocial phenomenon, highly intertwined with the other's state of vulnerability[9,14].

Most of the times, it is the families that commit the violence and generally the most serious violence that came to be known here were inflicted on the most fragile elderly people, every type imaginable. The elderly demand a lot from the caregiver, but no one deserves violence. (CI-01)

We have a person here with special needs, totally "unconscious", that suffered sexual violence. We feel the person's pain. Here there are cases of aggression, both verbal and physical violence, false imprisonment. The family is responsible for most of the violence in the cases we see and we always notice that the elderly are defensless. (CI-02)

I notice that the elderly who arrive are highly dependent, usually Grade III. Families are not prepared or do not want this responsibility and end up assaulting these people, or simply not caring. (AE-01)

After I started working here, I saw some very bad situations against the elderly that took place before being taken to the institution. Abandonment situations, putting the elderly at risk, leaving them without food, without water. Sometimes the elderly suffer violence from the family such as physical and psychological aggressions. Violence is most often caused by families [...] (TE-02)

The feelings that institutionalization reflects in the elderly, in relation to the care needs, were observed in the interviews and documents analyzed when emphasizing the relationship between the clinical-functional vulnerability of the elderly and violence.

It is known that the elderly can demonstrate that they are happy to live in the institution, although they were often resistant to discomfort in the face of institutional rules, changes in routines, which are inherent to collective assistance[14,15]. In the context of this research, the positive feeling of being at the ILPI is directly related to the work of the team that valued

and invested in humanized and individualized care, which was facilitated by the reduced number of people taken in. The narratives of the professionals and the elderly were blunt.

> *I am very grateful to those who brought me to this home, she was very good to me. I don't think I would go very far living as I was (referring to her fragile condition, with a high need for care). Well, I'm happy, I feel accepted. I always say that I never expected to find a place like this.* (ID-01)

> *I don't suffer here. It can't get better than that. The people who work here are nice to me. We talk, we laugh, we talk nonsense. I like living here. I have all the help I need [...] I am no longer afraid of loneliness or not having help when I need it.* (ID-03)

> *Their lives change, their appearance, their health improves after we welcome them. They gain more autonomy and then, when the degree of dependence increases, for example, it is because nothing can be done. The elderly who live here live much better than before.* (CI-01)

> *They live much better here at the home, than before. They seem to be happy, they feel at ease. It is clear that they have moments of sadness and outrage like all people do. This happens with people of any age, living with family or friends.* (TE-02)

It is worth mentioning that the highest degree of dependence, as was the case with the elderly in this research, promotes the feeling of pleasure in the face of welcoming, favoring adaptation to the institutionalization process[14,19]. Yet, the fact that many elderly people in this condition of vulnerability do not have an active and intense public and social life, such as, for example, doing house work, going to the market, having romantic relationships, attending dances or social groups[14,19], it also facilitates the acceptance of the context of life at the ILPI. It is noteworthy that units with welcoming processes specialized in individuals who are victims of violence, neglect and abandonment, such as the location of this study, provide for rescuing social life, in addition to dignity, which in some situations may have been lost[7,14].

Another important factor observed is that the elderly were concerned about disturbing the family with their demands, a fact that comforted them when institutionalized, and which can also be related to the underreporting of cases of violence against the elderly[10]. These findings were contrary to a study, when it found that the elderly with relationship difficulties and conflicts with the family suffer from institutionalization[10].

Therefore, many interdisciplinary efforts, coming from the areas of health, education, social assistance and justice, are necessary in the intervention of the problem. In the organization of social assistance and health services, it is assumed that the results can contribute to public health policy and the quality of care for the elderly, whether institutionalized or not[6,14–15,20].

FINAL CONSIDERATIONS

The objective of the research was unveiled from the use of the oral history technique, since it allowed to understand how the institutionalization process takes place in a unit for elderly victims of violence.

The elderly cared for in the institution under study had a high degree of dependence when carrying out daily life activities, high need for care and attention to existing comorbidities, and presented conditions of clinical-functional vulnerability. Still, there are signs of abandonment or verbal, psychological and physical violence against the elderly, in the narratives of the participants. In this sense, institutionalization was considered, from the perspective of professionals and the elderly themselves, the promotion of safe and quality care to health, and basic daily needs, as well as the distance from the risks of violence.

When recalling life before the institutionalization process, some elderly people did not recognize their condition as vulnerable, or themselves as victims of violence. However, their speeches showed the experience of complex and negative feelings such as sadness, failure, loneliness and feelings of rejection, which were directly related to the limitations of self-care and the inability to perform daily living activities, resulting from functional decline and the presence of comorbidities. These circumstances were further aggravated by weaknesses in the family relationships to which they were subjected. In view of this context they lived in, the institutional welcome based on humanized care provided the elderly with positive experiences permeated by a feeling of protection and improvement in their quality of life.

The importance of the elderly having a team of professionals responsible for welcoming, preserving and encouraging autonomy and independence, seeking to meet the set of needs and ensuring comprehensive care once institutionalized was also noted. The role of the health team is highlighted for the importance and understanding of changes in the physical and mental state of institutionalized elderly.

There was also the sensitization of the researcher's view of resolutive assistance in which multidisciplinary analyzes

are needed, and collective strategies in public health and social assistance are necessary, in order to minimize the risks and damages in the life and health of this population.

The development of the research in a single scenario, as well as the reduced number of participants can result in limitations to the study. However, it is noteworthy that this institution is the only one in the region designed to serve elderly, victims of violence, in particular. In addition, the study can contribute to the formulation of new public policies that improve the adaptation of the elderly in the institutionalization process, enabling new protective actions for this population.

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