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7

Quality of Life of Abused Older Women: Moderating Influence of Coping Mechanisms

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Introduction

In 2002, the World Health Organization (WHO) brought global attention to elder abuse and the need for prevention in issuing the Toronto Declaration (World Health Organization 2002a). With the rise in proportion of people aged 60 and over, but also the spectacular demographic projections for people aged 80 years and older (globally the number of persons aged 80 and over is expected to triple by 2050), *how* we age and *how well* we age is of great concern (United Nations 2015). Furthermore, there will be a growing need to protect the most

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vulnerable older people from harm (World Health Organization 2002b). For the development of policies and interventions, more insight into this complex phenomenon is required. To our knowledge, little is known about how abused older people cope, and there is a gap in research regarding the influence of coping on the quality of life of abused older people. Therefore, the current chapter examines the effect of abuse on the quality of life of older women, and more specifically, the moderating effect of coping on the relationship between abuse and quality of life.

Abuse and Violence Against Older Women: A Significant Challenge

Literature defines elder abuse in various ways (United Nations 2013; Mysyuk et al. 2012). Despite the evident complexity and uncertainty, the WHO chose to adopt the definition proposed by the UK's Action on Elder Abuse (1995, p. 11):

> Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.

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This definition highlights the importance of a relationship with the perpetrator: only harm to an older person occurring with an expectation of trust, e.g. spouse, (grand) children, other family members, caregivers, and so forth, is considered as elder abuse. This definition also includes both intentional and unintentional harm. Furthermore, the literature distinguishes different categories of elder abuse. Even though possible variations in these categories exist when taking cultural contexts into account, the categories most used in research are physical, psychological, sexual, and financial abuse, and somewhat less applied are neglect and violation of personal rights (De Donder et al. 2011; World Health Organization 2002a).

The development of awareness, prevention, and intervention programmes requires knowledge about the prevalence of abuse against older people. Due to differences in study designs, measurement instruments, definitions, categories, and inclusion and exclusion criteria, research has found broadly varying prevalence rates of elder abuse across Europe, from 0.8 to 29.3% (De Donder et al. 2011). While any person could become a victim of abuse, a well-established body of literature demonstrates that gender is an important indicator of elder abuse. In most studies, women are more often victims of abuse than men. Women not only report more repeated and severe victimization before the age of 65 (Ansara and Hindin 2010), but also after the age of 65 women are more often found to have a higher risk than men of being victims of domestic violence and abuse (Görgen et al. 2009; O'Keeffe et al. 2007). Nevertheless, research on elder abuse has traditionally been viewed as "gender neutral", leading to inadequate responses (Nerenberg 2002, p. 1). As long ago as 2002, Nerenberg emphasized the need for a broad gender-based analysis to gain an understanding of how the economic and social status of women and older people contribute to elder abuse, yet Brownell (2014) found very little progress more than 10 years later.

A recent meta-analysis of 50 different prevalence studies of elder abuse among older women living in the community (globally) calculated a pooled one-year prevalence estimate of 14.1% (95% CI [11.0, 18.0]) (Yon et al. 2017). A multinational project, the European Prevalence study on Abuse and Violence against Older Women

(AVOW) tried to provide an answer to these varying prevalence rates (Lang et al. 2014). Conducted in five European countries (Austria, Belgium, Finland, Lithuania, and Portugal) using the same questionnaire, the AVOW study provided an important contribution to the research on elder abuse (including 6 dimensions: physical, psychological, financial and sexual abuse, neglect, and violation of personal rights by demonstrating comparable prevalence rates across the different countries. They concluded that 30.1% of the older women reported at least one form of mistreatment in the last 12 months (Lang et al. 2014).

Notwithstanding this high prevalence, a considerable amount of literature has been published on the impact of abuse on the lives of young people, but much less is known about the specific impact on the lives of older people (United Nations 2013). Existing evidence suggests the following consequences of elder abuse: (a) poorer physical and mental health (Fisher et al. 2010), (b) increased rates of disability (Schofield et al. 2013), (c) higher mortality rates (Baker et al. 2009; Schofield et al. 2013), and (d) hospitalization and placement in nursing homes (Dong 2012). Consistent with these findings, the AVOW study reported a significant decrease in the quality of life of older abused women compared to non-abused women (Lang et al. 2014). The extent to which abuse affects quality of life shows inter- and intra- individual differences; not all abused older people show the same decrease in quality of life. The severity of abuse, i.e. the occurrence of multiple forms and the frequency of abuse plays an important role. Women reporting several forms of abuse that occurred often had poorer quality of life than women reporting less severe abuse (Lang et al. 2014). In addition, the way that older people cope may also play an important role in these differences. With the same line of reasoning, in the past more attention has been devoted to the concept of resilience in violence against women research. For example, Labrocini (2012) demonstrated in a phenomenological study in Brazil that the resilience process began when the aggressor physically attempted to kill women victims or hurt and/or kill their children. This made them leave their state of immobility and triggered an existential movement, to search for help in social support networks, which appeared essential for their dealing with the situation.

Reducing Negative Effects of Abuse: Looking at Coping

Coping is defined as the way in which people manage stressful events, using certain cognitive and behavioural strategies (Comijs et al. 1999b; Folkman et al. 1987). The concept is broad and has a long and complex history, resulting in several distinctions, theories, and models (Carver and Connor-Smith 2010). Lazarus (1993), a key figure in the research on coping distinguished two main categories. First, problem-focused coping where people actively try to change the stressful event, for example, by evaluating the pros and cons of different behavioural options and by implementing steps to actively remove or diminish the effects of the stressful event (Carver and Connor-Smith 2010; Lazarus 1993). Second, emotion-focused coping, in which people try to reduce their emotional response(s) to the stressful event. This may be, for example, by self-soothing, seeking emotional support, expression of negative emotion, rumination, and so forth (Carver and Connor-Smith 2010; Lazarus 1993).

Another distinction very often used in such research is between engagement and disengagement coping (Carver and Connor-Smith 2010). Engagement coping deals directly with the stressful event by adopting problem-focused and/or emotion-focused coping responses. For example, an older man experiencing mobility problems uses a walking aid or seeks support to help with walking/mobility. In general, this form of coping is associated with reduced stress and engagement in healthier behaviour (Doron et al. 2014; Sorkin and Rook 2006). Disengagement coping refers to the flight from or avoidance of the stressful event and related emotions, mainly by emotion-focused responses like denial, behavioural disengagement, wishful thinking, substance abuse, and so forth (Carver and Connor-Smith 2010). The use of this type of coping increases distress, making it a maladaptive response (Carver and Connor-Smith 2010; Chung et al. 2004; Doron et al. 2014).

In connecting coping mechanisms with elder abuse, literature shows evidence for coping mechanisms as risk factors for the experience of

abuse (Comijs et al. 1999a; De Donder et al. 2016). As Comijs et al. (1999a) concluded: "The way people handle problems makes them more or less vulnerable to becoming victims of elder mistreatment (p. 48)". For example, behavioural disengagement was more used by abused women compared to non-abused older women, and older women experiencing the most severe abuse used emotional support less often compared to individuals with other severity levels of abuse (De Donder et al. 2016). Comijs et al. (1999a) also found evidence for avoidant coping to be a risk factor for elder abuse. Moreover, they reported that older abused people seldom used engagement coping strategies (Comijs et al. 1999a). Consistent with this finding, previous research focused mainly on the coping mechanisms used by older people as a risk factor for elder abuse. However, coping also plays an important role in the impact that stress has on the quality of life (Folkman et al. 1986). Several studies found a beneficial impact of certain coping mechanisms on the psychological health of people experiencing stressful events (Comijs et al. 1999b). This is not the stressful event itself, but the coping mechanisms used by the person particularly affects both health and quality of life (Folkman et al. 1987). Elder abuse can be considered as a stressful event; thereby bringing into question whether some coping mechanisms may moderate the negative impact abuse has on the quality of life.

To answer this question, the stress-buffering hypothesis building on theorists such as Cassel (1976) and Cobb (1976) might be useful (in Cohen and Wills 1985). According to this hypothesis, perceived availability of social support protects or buffers people in a stressful situation from the negative effects this stress has on physical and psychological health. The main model of the buffer hypothesis defines social support as the degree to which a person is integrated in the community where it is directly, stressful event or not, associated with an increase in health (Cohen and Wills 1985). The first study to examine this stress-buffering model in the context of elder abuse was conducted by Comijs et al. (1999b). The authors made a distinction between social support as (a) an interpersonal resource, measured as the perceived availability of social support and the size of the participant's social network and (b) as a coping mechanism; measured as how often participants sought help or

shared their problems with others to cope with stressful situations. The study confirmed the stress-buffering hypothesis among abused older people. They found a moderating effect of social support as an interpersonal resource on the level of psychological stress for abused older people, while non-abused older people did not benefit from this support. However, the study did not find evidence for the coping mechanism as a protective factor (Comijs et al. 1999b). Cisler et al. (2012) replicated perceived social support as protective factor for psychological health in abused older people. Luo and Waite (2011) developed a conceptual model for elder abuse including psychosocial resources and deficits, linking this with psychological well-being. They also found evidence for the stress-buffering hypothesis. The experience of abuse negatively affected psychological well-being, and perceived emotional support protected the abused older people against this pathogenic effect. In addition to the stress-buffering hypothesis abused individuals reported a stronger relationship between abuse and well-being in the presence of psychosocial deficits like social isolation (Luo and Waite 2011). Until then, the stress-buffering hypothesis did not acknowledge a possible exacerbating effect of the negative association between stress and health (Luo and Waite 2011).

The European AVOW Study: Trying to Unravel the Moderating Role of Coping

The main research question in this chapter is whether coping can buffer or exacerbate the relationship between abuse and quality of life? This may further encourage the development of intervention strategies to minimize the negative impact of abuse on abused elders' quality of life. Based on data from the AVOW study, the following hypotheses will be examined:

a. Abuse has a negative impact on the quality of life of older women.
b. Engagement coping (i.e. active coping and emotional support) buffers the negative impact of abuse on the quality of life of older women.

c. Behavioural disengagement exacerbates the negative impact of abuse on the quality of life of older women.
d. Additionally, it will be possible to distinguish if the effect of coping on QOL is a general effect for both abused and non-abused women or merely a buffer effect when older people experience a severe amount of abuse.

The current chapter uses data from the AVOW study (Luoma et al. 2011), which was funded by the EU Daphne III programme regarding violence against women and children. The study took place between 2009 and 2011 and was based on collaboration between five European countries: Austria, Belgium, Finland, Lithuania, and Portugal. By focusing on community-dwelling women aged 60 years and above, the study aimed to provide comparable multinational information about the prevalence of abuse against older women in the last 12 months. In total, 2880 older women participated in the study (Austria: $n = 593$, Belgium: $n = 426$, Finland: $n = 678$, Lithuania: $n = 515$, Portugal: $n = 649$).

All participants filled in a structured survey. The three most important variables we measured were: quality of life, coping, and elder abuse. For the measurement of quality of life, the EUROHIS-QOL 8-item index was used (Schmidt et al. 2006) for which a good cross-cultural field study performance, and good convergent and discriminative validity have been reported. The scale questioned the respondent's satisfaction with several aspects of life, like health, performing daily activities, perceptions about themselves, personal relationships, and conditions of their living environment. All these different items were summed into one quality of life score (ranging between 1= low QOL and 5 = high QOL). For the coping mechanisms, the survey distinguished three different styles of coping (Carver 1997): active coping, using emotional support, and behavioural disengagement. The survey consisted of 34 different items of elder abuse (classified into the 6 types of elder abuse). Severity of elder abuse was determined by combining information about the density (number of items of abuse) and intensity (the frequency of abuse) of the reported abuse and categorized in four distinct levels: (a) no abuse at all, (b) low level 1: a single item of abuse that seldom occurred, (c) medium level 2: a single item of abuse that occurred often, or multiple items of abuse that seldom occurred, and (d) most severe level 3: multiple items of abuse that occurred often.

The Impact of Abuse on QOL

Table 7.1 shows the results for abuse and quality of life of the older women in the survey. The majority of the respondents 1891 women (69.9%) reported no abuse and 812 (30.1%) reported having been abused in the last year. This 30.1% is the general total and comprised a variety of levels. 7.4% older women experienced level 1 abuse, meaning that they experienced one item of abuse, only 1–6 times in the past month. 16.1% older women experienced level 2 abuse (1 item of abuse at least monthly or several items of abuse each 1–6 times in the past month). 6.5% older women experienced the most severe level of abuse. These women experienced several items of abuse, each at least monthly.

In line with our expectations, the results of the analyses indicate that the quality of life of older women who had experienced abuse in the last year was significantly lower than women who reported no abuse. Older women who experienced abuse scored on average 3.46, while older women who did not experience abuse in the past 12 months scored 3.80 on the quality of life scale.

Table 7.1 Mean quality of life for abused and non-abused older women

	$\%_{Total}$	Quality of life Mean (Standard Deviation)
Sample ($n = 2880$)	100	3.70 (0.69)
Total abuse		
No abuse	69.9	3.80 (0.67)
Abuse	30.1	3.46 (0.70)
Severity of abuse		
No abuse	69.9	3.80 (0.67)
Level 1	7.4	3.69 (0.57)
Level 2	16.1	3.48 (0.69)
Level 3	6.5	3.15 (0.75)

Note $\%_{Total}$ = valid percentage of total sample
Quality of life score: Min = 1, Max = 5

With regard to the severity of abuse, the quality of life scores also differed significantly between the levels of severity. Quality of life decreased from level 1 (*Mean* = 3.69), to level 2 (*Mean* = 3.48), to level 3 (*Mean* = 3.15). From this data, for us, it is apparent that the more severe the levels of abuse reported, the lower the quality of life.

The Impact of Coping on QOL

Active Coping Older people who actively cope with difficult or stressful situations are those people who often take action to try to make the situation better. They concentrate their efforts on doing something about the situation they are in. In general, Table 7.2 shows that this type of older person reported a better quality of life than older people who did not cope actively.

Pairwise comparisons showed the following, more detailed results: this relation between active coping and quality of life was more clearly present for older adults who experienced level 2 or level 3 abuse. For example, older women who experienced level 3 abuse, but often coped

Table 7.2 Mean QOL score of older women with different levels of severity abuse for each of the three coping mechanisms

	QOL among no abuse	QOL among Level 1 abuse	QOL among Level 2 abuse	QOL among Level 3 abuse
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Active coping				
Seldom	3.72 (0.72)	3.68 (0.56)	3.20 (0.84)	2.84 (0.81)
Sometimes	3.64 (0.68)	3.64 (0.56)	3.40 (0.61)	3.00 (0.64)
Often	4.00 (0.58)	3.71 (0.59)	3.74 (0.60)	3.53 (0.66)
Emotional support				
Seldom	3.77 (0.71)	3.71 (0.53)	3.36 (0.74)	3.13 (0.70)
Sometimes	3.72 (0.67)	3.63 (0.62)	3.48 (0.68)	3.17 (0.81)
Often	3.93 (0.60)	3.74 (0.46)	3.70 (0.55)	3.16 (0.68)
Behavioural disengagement				
Seldom	3.82 (0.67)	3.71 (0.57)	3.57 (0.64)	3.27 (0.72)
Sometimes	3.62 (0.66)	3.55 (0.47)	3.33 (0.69)	2.84 (0.66)
Often	3.60 (0.65)	3.17 (0.74)	3.23 (0.82)	3.07 (0.75)

Quality of life score: Min = 1, Max = 5

actively reported a score of 3.53 on quality of life. Older women who experienced the same severity of abuse, but only seldom coped actively reported only 2.84 on the quality of life scale.

Altogether, these results indicate that active coping buffered the negative impact of abuse on quality of life. And, there was a statistically significant interaction between active coping and abuse severity, indicating that the effect of active coping on the relationship of abuse and quality of life is larger among more severe abused women: older women who reported the most severe abuse benefited the most from active coping.

Emotional support Older women who cope through seeking emotional support are women who when facing difficulties or stressful situations are often trying to get advice or help from other people about what to do. However, the results show no influence of emotional support. First, there was no significant main effect of emotional support on quality of life, indicating that older abused women who often used emotional support did not report a significantly higher QOL than those who used emotional support seldom or sometimes. Second, emotional support did not buffer the negative impact of abuse on QOL (see Table 7.2). This (non)-effect of emotional support on the relation abuse—QOL also did not differ significantly for the severity levels of abuse. So, seeking emotional support as coping mechanism was not important, not even for the severe levels of abuse.

Behavioural disengagement Older women, who often use behavioural disengagement as a coping mechanism, are women who often give up trying to deal with difficulties or problems. This is sometimes also called "an avoidant strategy" as people are often actually not trying to cope. The findings of the AVOW study show a significant main effect of behavioural disengagement on quality of life (see Table 7.2). Older women who seldom used behavioural disengagement showed a significantly higher mean QOL than those who used it sometimes. For example, older women who experienced level 2 abuse and often used behavioural disengagement as coping strategy experienced on average 3.23 on the quality of life scale. However, if they only seldom used

behavioural disengagement as coping strategy, they scored 3.57, which is significantly higher.

So, together these results indicate that using behavioural disengagement as coping strategy increased the negative impact of abuse on quality of life. However, there was no statistically significant interaction between behavioural disengagement and abuse severity, indicating that the effect of behavioural disengagement on the relation between abuses—QOL was not dependent on the different severity levels of abuse.

Discussion

The aim of this chapter was to examine the influence of coping mechanisms on the relationship between abuse and quality of life in older women. We were interested to see if different coping mechanisms could buffer or exacerbate the impact that abuse has on their quality of life. First, we examined the impact of abuse on the quality of life of older women. Second, we explored the influence of engagement and disengagement coping on the quality of life of abused and non-abused older women. Then, we examined whether the impact of these coping mechanisms on the relation between abuse—quality of life was stronger or weaker for the different severity levels of abuse.

The results confirmed the negative impact of elder abuse (Dong et al. 2013; Lang et al. 2014; Schofield et al. 2013). Older women who reported abuse in the last year showed statistically significant lower quality of life than women who did not report abuse. Moreover, the more severe the reported abuse, the lower the reported quality of life.

Several reports have shown the importance of coping in the lives of children and adults (Doron et al. 2014; Folkman et al. 1986). Our results confirmed a mediating role of coping in the lives of older women: a clear influence of coping on the quality of life of both abused and non-abused older women was found. Confirming our hypothesis, active coping showed a beneficial effect on quality of life. Namely, older women who coped actively more often reported a higher quality of life than those who coped actively either seldom or sometimes. This finding

was in line with existing literature where active coping or problem-focused coping was associated with reduced distress and more healthy behaviour (Doron et al. 2014; Sorkin and Rook 2006). Zink et al. (2006, p. 648), for example, concluded that "*coping with predominantly emotional abuse or the threat of physical abuse, some victims and/or survivors created fulfilling lives; others simply survived*".

Second, we found that older women who often used emotional support did not report significantly higher quality of life than those who sometimes or seldom used emotional support. This differed from the results obtained by Krause (2004) where emotional support showed a clear beneficial effect on the life satisfaction of older people who experienced trauma. A possible explanation for this inconsistency is the way that we operationalized emotional support as a coping mechanism. In our study, we focused on how often older women used emotional support in general; we did not specify the amount nor type of emotional support during the periods of abuse. It is conceivable that emotional support plays a more important role during the period of stress/abuse than afterwards (Krause 2004). Moreover, the study by Comijs et al. (1999b) showed no beneficial effect of seeking social support as a coping mechanism but did find a beneficial effect when social support was operationalized as the amount of social support the participants received in the last six months.

As expected, disengagement coping showed a negative effect on the quality of life of older women. Often using the coping mechanism behavioural disengagement resulted in a lower mean quality of life than sometimes or seldom using this mechanism. This result was in line with the existing association in literature between disengagement coping and increased distress and unhealthy behaviour (Chung et al. 2004; Doron et al. 2014).

In sum, the results above confirm our hypotheses of the positive influence of engagement coping mechanisms and the negative influence of disengagement coping mechanisms on the quality of life of abused and non-abused older women.

Responding to the stress-buffering hypothesis, our last research question, the findings illustrate mixed evidence. None of the coping mechanisms studied here showed exclusive evidence for the stress-buffering

hypothesis, which would expect a beneficial/harmful effect of coping in abused older women but not in non-abused older women. However, the effect of active coping on the relation between abuse—quality of life was dependent on the severity of abuse. The beneficial impact of active coping was greater for those older women who reported the most severe level of abuse: when they often coped actively they showed a comparable mean QOL with those women reporting a less severe level of abuse. This suggests that the buffering effect of active coping is especially important for those women who experience the most severe levels of abuse.

This study was unable to demonstrate a buffer/exacerbating effect of using emotional support and behavioural disengagement on the relation abuse—quality of life. Consistent with the research of Comijs et al. (1999b), emotional support did not support the stress-buffering hypothesis. However, the study of Krause (2004) found clear evidence for emotional support as a buffer for the effects of trauma on life satisfaction. As mentioned before, a possible explanation lies in the operationalization of the concepts. The role of emotional support and the existing inconsistencies should be further examined.

This study showed some limitations, which could be of interest for future studies. First of all, because of the quantitative analyses of group-scores, individual differences could be overlooked. Second, the measurement instrument used in the AVOW study was developed to obtain prevalence figures for abuse in community-dwelling older women. Therefore, the number of items regarding coping mechanisms was quite limited. Future research should focus more on specific measurement instruments for coping mechanisms to replicate our results. Related to this limitation, the items measured coping as a stable personality trait. Comijs et al. (1999a) already raised the issue that this might not be specific enough to measure how abused older people cope. Third, this work did not analyse for types of abuse (such as physical, psychological, ...). It is plausible that different types of abuse influence the way that coping influences quality of life of older people.

In spite of the limitations discussed above, the current chapter is relevant in providing preliminary insights into the relation between coping and quality of life in abused and non-abused older women. Health and care workers, service providers, and policymakers may want to give

more attention to how older women cope with stressful events since it has a great impact on their quality of life. The findings of our study might have potential practical importance for (a) the development of interventions to minimize the negative impact of abuse on the quality of life of older women and (b) to enhance the quality of life of older women in general. Our results suggest that interventions should focus on the promotion of engagement coping mechanisms (especially active coping) and on the prevention of disengagement coping mechanisms. Besides existing recommendations about enhancing social networks, organizing social support groups, providing adequate information about elder abuse and training of professionals, our study suggests interventions to empower women in general and especially abused older women by giving attention to their coping mechanisms would be useful to develop in future (Comijs et al. 1999a; Luo and Waite 2011).

Conclusion

In conclusion, this work suggests that how older people manage stressful events influences their quality of life. It demonstrates a positive effect of engagement coping and a negative effect of disengagement coping on quality of life. For both abused and non-abused older women active coping, using emotional support, and behavioural disengagement showed a direct influence on quality of life. In addition, active coping moderated the negative impact of abuse on the quality of life, especially for those women reporting the most severe abuse. These findings are important not only for the development of interventions to minimize the negative impact of abuse on the lives of older people, but also for the enhancement of older people's quality of life in general. Professionals working with older women who experience abuse could usefully explore coping mechanisms used by individuals and promote the use of more adaptive approaches in order to increase quality of life for older people. For a better understanding of the relationship between coping and quality of life in older people, more research on specific coping mechanisms used by older women and their adaptive dynamics is needed.

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