Psychological Distress in Victims of Elder Mistreatment: The Effects of Social Support and Coping

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The objective of the study was to examine psychological distress in victims of elder mistreatment and to determine whether social support, coping style, mastery, and perceived self-efficacy favorably influence the psychological health of these victims. The study sample consisted of 77 subjects who reported recent chronic verbal aggression, physical aggression, or financial mistreatment, and a control group of 147 subjects who had not been mistreated. All participants were elderly persons who were over 65 years of age and living independently in the community. Social support, coping style, mastery, and perceived self-efficacy were measured by means of a standardized home interview. Psychological distress was measured by means of the General Health Questionnaire (GHQ-12). Victims of elder mistreatment had significantly higher levels of psychological distress than nonvictims. Social support showed a favorable effect on the level of psychological distress in victims, but not in nonvictims; victims who received more social support showed less psychological distress. A lower sense of mastery, a negative perception of self-efficacy, and a passive reaction pattern were associated with higher levels of psychological distress in victims as well as in nonvictims. The beneficial role of social support, locus of control, and perceived self-efficacy on the level of psychological distress could be of importance in the development of future intervention programs.

Previous research on mistreatment of elderly adults has focused mainly on the prevalence and risk factors. In several community-based studies, between 3% and 6% of elderly people (over 65 years of age) reported that they had been victims of physical aggression, financial or material mistreatment, neglect, or chronic verbal aggression from relatives or other people with whom they had a personal or professional relationship (Comijs, Pot, Smit, & Jonker, 1998a; Kurrle, Sadler, & Cameron, 1992; Ogg & Bennett, 1992; Pillemer & Finkelhor, 1988; Pillemer & Suitor, 1992; Podnieks, Pillemer, Nicholson, Shillington, & Frizell, 1990; Pot, van Dijck, Jonker, & Deeg, 1996). In cross-sectional studies among victims, depressive symptoms were found to be risk indicators of elder mistreatment (e.g., Comijs, Pot, Smit, & Jonker, 1998b; Podnieks et al., 1990). However, the direction of this association is unclear, because stressful events are also known to have inverse effects on the psychological health of individuals (Lazarus & Folkman, 1984). Elder mistreatment in any form can be considered a stressful event and therefore could be the cause of psychological distress in the victims.

The impact of stressful events on psychological health is dependent on the coping mechanism of an individual (Lazarus & Folkman, 1984). Coping refers to the cognitive and behavioral strategies that are used to manage stressful situations and regulate negative emotions (Lazarus & Folkman, 1984). It includes coping styles such as problem solving, or managing affect, and it includes various coping resources as intervening variables (Nurius, Rutter, & Berliner, 1992), that is, social support, mastery, and perceived self-efficacy. It has been found that coping resources have a beneficial influence on the psychological health of people who are experiencing chronic stress (e.g., people who are chronically ill). Chronically ill people who received more social support (Berkman & Syme, 1979; Penninx, van Tilburg, Deeg, Kriegsman, Boeke, & van Eijk, 1997), and higher levels of mastery (Roberts, Dunkle, & Haug, 1994; Penninx et al., 1997), and a more positive perception of self-efficacy (Bandura, 1986), had fewer depressive symptoms than those with lower levels of these coping resources. Coping style and personal coping resources have a direct effect on the psychological health of an individual (direct-effect model), and may moderate the negative influence of stress on psychological health (stress-buffering model; Cohen & Wills, 1985). According to the direct-effect model, coping style and personal coping resources have a direct, beneficial effect on psychological health, irrespective of the presence of stress (Broadhead et al., 1993; Lazarus & Folkman, 1984; Pearlin & Schooler, 1978). The stress-buffering model assumes that coping style and personal coping resources moderate the negative influence of stress on psychological health (Cobb, 1976; Cohen & Syme, 1985). The direct-effect model and the stress-buffering model are not mutually exclusive; a modified buffering model can include both direct effects and buffering effects (Aneshensel & Stone, 1982; Cohen & Wills, 1985).

No known research has been carried out to examine the effects of social support and coping on psychological health in the context of elder mistreatment being the stressful event.

The present study examined psychological distress in elderly victims of mistreatment. The study population consisted of elderly people who were victims of chronic verbal aggression, physical aggression, or financial mistreatment during the year prior to the interview, and a reference group of elderly people who had not been mistreated (nonvictims). The main research questions were: (1) Do victims of elder mistreatment suffer from more psychological distress than nonvictims? (2) Do certain aspects of social support, coping style, mastery, and perceived self-efficacy either directly or via buffer effects influence psychological distress in victims of elder mistreatment?

METHODS

Sample
Participants were selected from respondents in the Amsterdam Study of the Elderly (AMSTEL). AMSTEL is a...
that are advantageous when interviewing elderly people; the scale is short and contains very few questions about somatic functioning. Its concurrent validity with a standardized psychiatric interview (Present State Examination) was found to be good (r=0.68 – 0.80; Koeter & Ormel, 1991). Examples of items included in the GHQ-12 are: “Have you recently had difficulty in concentrating?” or “Have you recently been sleeping badly because you have been worrying?” Each question was rated on a 4-point scale, ranging from 1=very much worse than usual to 4=very much better than usual, with higher scores indicating more psychological distress. The internal reliability of the scale was good (Cronbach’s α=.87).

Social support was measured by means of a Dutch self-report inventory of social support (ISB, Inventarisatielijst Sociale Betrokkenheid; Dam-Baggen, Huiskes, & Kraaimaat, 1986). The scale consists of 10 statements concerning social support received during the 6 months preceding the interview, such as, “I discuss my personal problems with others.” The responses were rated on a 4-point scale, ranging from 1=almost never to 4=often, with higher scores indicating more social support. These 10 items are considered as a total measure (Cronbach’s α=.83), but they also comprise three subscales: potential emotional support (4 items; Cronbach’s α=.83), actual emotional support (3 items; Cronbach’s α=.61), and mutual visiting (2 items; Cronbach’s α=.63). The size of the social network was assessed by means of two questions concerning the number of regular visitors and the number of good and trustworthy friends and relatives.

Coping style was measured by means of the Dutch coping questionnaire, the Utrechtse Copingslijst (UCL; Schreurs & van de Willige, 1988). The UCL measures coping style as a stable personality trait and consists of 47 questions in which respondents are asked how often they react in a certain manner (e.g., “try to relax”) when faced with problems. Each answer is rated on a 4-point scale, ranging from 1=seldom or never to 4=very often. Higher scores indicate stronger characteristics, measured on a subsequent scale. The questionnaire comprises seven subscales: active problem solving (7 items; Cronbach’s α=.79), palliative reaction (8 items; Cronbach’s α=.71), avoidance (8 items; Cronbach’s α=.73), seeking social support (6 items; Cronbach’s α=.71), passive reaction pattern (7 items; Cronbach’s α=.66), and expression of emotions (3 items; Cronbach’s α=.60). The subscale “expression of emotions” was not included in the analyses because of its low internal reliability (Cronbach’s α=.33).

Mastery was defined as the extent to which a person has the feeling of being in control of his or her own life. Mastery was measured by means of an abbreviated and translated Dutch version of the Pearlman Mastery Scale (Pearlin & Schooler, 1978). The questionnaire consists of five statements (Cronbach’s α=.63), such as “I can’t seem to be able to solve some of my problems at all,” with response categories ranging from 0=total disagreement to 4=total agreement. Higher scores on the scale indicate a greater sense of mastery.

Perceived self-efficacy refers to the conviction of being able to successfully realize the behavior that is required to achieve the desired outcomes (Bandura, 1977). Global beliefs of self-efficacy were measured by means of the translated, short (Dutch) version of the General Self-Efficacy Scale (Bosscher & Smit, 1998; Sherer et al., 1982). The scale consists of 12 items (Cronbach’s α=.67), such as, “When I set important goals for...
myself, I rarely achieve them," with response categories ranging from 0=total agreement to 4=total disagreement. A higher score on the scale indicates a more positive perception of self-efficacy.

**Analyses**

Analyses of covariance (ANCOVA), adjusted for age and gender, were applied to determine whether there were differences in the level of psychological distress between victims of chronic verbal aggression, physical aggression, and financial mistreatment. Subsequently, t tests and chi-square analyses were performed to determine the characteristics of victims and nonvictims. Within both the victim and the nonvictim groups, the associations between the continuous GHQ score and each social support and coping variable separately were examined by means of linear regression analyses. All regression analyses were controlled for age and gender, as they were associated with the GHQ scores. The distribution of the GHQ score was skewed (kurtosis=1.2, skewness=1.24). When using the logarithmic GHQ score, the distribution became more normal (kurtosis=90, skewness=70). Because the residuals in the linear regression analyses of the new variable fitted better with the assumptions underlying the linear regression analyses, the transformed GHQ score was included in the regression analyses. A direct effect of social support or coping on psychological distress is considered to be present if these variables are significantly associated with psychological distress in both groups (victims and nonvictims). In order to determine possible buffer effects, multivariate regression analyses were performed, in which Emotional Support × Coping interaction terms were entered. In order to avoid multicollinearity between the first-order terms and the product terms, the product terms were formed by multiplying the centered (deviation from the mean) scores of the predictors of interest (Cronbach, 1987). A buffer effect is considered to be present if the association between the social support or coping variable and psychological distress differs between victims and nonvictims, and this association is stronger for the victims than for the nonvictims.

**Results**

**Characteristics of the Sample**

In 1994, the mean age of the respondents was 77.0 years (SD 5.2), ranging from 69 to 89 years. Of the 77 victims, 41 (53.2%) reported chronic verbal aggression, 9 (11.7%) reported physical aggression, 33 (29.9%) reported financial mistreatment, and 4 (5.2%) respondents were victims of more than one type of elder mistreatment. No significant differences in GHQ scores were found between these three groups of victims of mistreatment, F(2,74)=0.32, p=.73. Therefore, the victims were classed as one group for further analyses. Table 1 shows the characteristics of the sample population and the study variables. Due to the matching procedure, no differences were found with regard to age, gender, socioeconomic status, living conditions, or subjective health between victims of elder mistreatment and nonvictims. In total, 57% of the respondents were female, and 63% had a low economic status. Half of the respondents lived alone, whereas 45% lived with a partner. Most respondents reported good physical health (67%). The victims of elder mistreatment achieved significantly higher GHQ scores (M=25.2, SD=6.7), indicating higher levels of psychological distress than the non-victims (M=22.8, SD=5.2). With regard to social support, the victims of elder mistreatment had lower scores on social support (complete scale), they reported less potential emotional support, and they also reported having fewer good friends than nonvictims. Compared to nonvictims, the victims had lower scores on mastery and perceived self-efficacy. Finally, the coping style of victims was found to be more avoidant and passive than the coping style of nonvictims.

**Social Support**

Table 2 presents the results of the multiple regression analyses applied to the transformed GHQ score on coping and social support variables for victims and nonvictims, after adjustment for age and gender. For victims, all social support variables demonstrated a negative association with psychological distress, indicating that victims of elder mistreatment who receive less social support report higher levels of psychological distress (see Table 2). Significant associations were found for the co-
Table 2. Standardized Regression of Psychological Distress (transformed GHQ score) on Each Social Support and Coping Variable Separately (Controlled for Gender and Age) for Victims and Nonvictims

<table>
<thead>
<tr>
<th></th>
<th>Victims n=77</th>
<th>Nonvictims n=1147</th>
<th>Difference (based on interaction terms)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support, complete scale (few - much)</td>
<td>-.32**</td>
<td>.00</td>
<td>.01</td>
</tr>
<tr>
<td>Potential emotional support (few - much)</td>
<td>-.26*</td>
<td>-.03</td>
<td>.05</td>
</tr>
<tr>
<td>Actual emotional support (few - much)</td>
<td>-.19</td>
<td>.11</td>
<td>.01</td>
</tr>
<tr>
<td>Mutual visiting (few - many)</td>
<td>-.34**</td>
<td>-.06</td>
<td>.04</td>
</tr>
<tr>
<td>Number of visitors (few - many)</td>
<td>-.22</td>
<td>.03</td>
<td>.11</td>
</tr>
<tr>
<td>Number of good friends (few - many)</td>
<td>-.25*</td>
<td>.06</td>
<td>.03</td>
</tr>
<tr>
<td>Mastery (low - high)</td>
<td>-.48**</td>
<td>-.42**</td>
<td>.49</td>
</tr>
<tr>
<td>Perceived self efficacy (low - high)</td>
<td>-.27*</td>
<td>-.17*</td>
<td>.61</td>
</tr>
<tr>
<td>Coping style</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active problem-solving (low - high)</td>
<td>-.17</td>
<td>.05</td>
<td>.17</td>
</tr>
<tr>
<td>Palliative reaction (low - high)</td>
<td>.04</td>
<td>.08</td>
<td>.58</td>
</tr>
<tr>
<td>Avoidance (low - high)</td>
<td>.04</td>
<td>.00</td>
<td>.88</td>
</tr>
<tr>
<td>Seeking social support (low - high)</td>
<td>-.08</td>
<td>.03</td>
<td>.60</td>
</tr>
<tr>
<td>Passive reaction (low - high)</td>
<td>.55**</td>
<td>.51**</td>
<td>.66</td>
</tr>
<tr>
<td>Reassurance (low - high)</td>
<td>.00</td>
<td>.03</td>
<td>.45</td>
</tr>
</tbody>
</table>

*p value for difference in the effect on transformed GHQ score between victims and nonvictims, as tested by significance of the interaction term between Mistreatment × Social support/coping in the regression analyses of the total population.

* p<.05; ** p<.01.

Figure 1. Levels of psychological distress (mean GHQ score adjusted for age and sex) for victims and nonvictims with low social support (score < 19), moderate social support (score 20-24), and high social support (score > 25).

Figure 1 shows the GHQ scores for victims and nonvictims with low social support (score≤19), moderate social support (score 20-24), and high social support (score≥25). No such association in nonvictims, F(2,144)=0.15, p=.86. This suggests a buffer effect of social support, as a favorable effect of social support was only present among victims of elder mistreatment. Significant interaction terms further confirmed buffer effects for the subscales potential emotional support, actual emotional support, mutual visiting, and number of good friends. To check the robustness of the interaction between social support and mistreatment, regression analyses were performed, also including the coping resources of mastery and perceived self-efficacy. In this model, adjusted for coping resources, the interaction term ISB (complete scale) × mistreatment was still significant (β=-.12, p<.05).

Coping
Table 2 shows that mastery is negatively associated with psychological distress in both victims and nonvictims, indicating that for both groups a higher sense of mastery is associated with less psychological distress. No buffer effects of mastery on psychological distress were found, indicating that the association between mastery and psychological distress is the same for victims and nonvictims.

A direct effect of perceived self-efficacy on psychological distress was also found. Higher scores on this scale were negatively associated with GHQ scores in both victims and nonvictims, indicating that a positive perception of self-efficacy is associated with less psychological distress, irrespective of victimization.

Very few associations were found between the UCL scores (coping behavior) and psychological distress. Just one direct effect was found for a passive reaction pattern on psychological distress, indicating that for both victims and nonvictims a passive reaction pattern is associated with more psychological distress. When
tested with the interaction terms Mistreatment $\times$ Coping variables, no difference was found between victims and nonvictims in the association between coping style and psychological distress.

**DISCUSSION**

This study examined psychological distress in victims of elder mistreatment and the possible beneficial effects of social support, coping style, mastery, and perceived self-efficacy on the psychological health of these victims. The results showed that victims of elder mistreatment had higher levels of psychological distress than nonvictims in the control group. In victims, social support had a favorable, moderating effect on the level of psychological distress. No effect of social support on psychological distress was found for nonvictims. This buffer effect of social support on psychological distress indicates that victims of elder mistreatment benefit more from the support they receive than nonvictims. Social support may have various functions for the victims of elder mistreatment. First, it helps to distract their attention from problems and provide some relaxation. Second, social support might be functional in providing help or advice on how to stop or deal with the mistreatment. However, seeking social support as a coping mechanism (UCL subscale) was not associated with psychological health in victims of elder mistreatment. This is in concordance with the earlier findings, that is, that most victims (91%) do not ask friends or relatives for help (Comijs et al., 1998a). Further research is needed to provide an explanation for the beneficial role of social support in victims of elder mistreatment.

Low feelings of mastery and a negative perception of self-efficacy were directly associated with higher levels of psychological distress in victims as well as nonvictims. No support was found for a buffer effect of mastery and perceived self-efficacy on the psychological health of victims of elder mistreatment. This suggests that the influence of these aspects of coping on psychological health is relatively independent of the mistreatment and that, in general, a more positive perception of the ability to cope with events reduces psychological distress. These findings are in line with the earlier findings that aspects of coping were related to psychological distress, independent of the presence of a chronic illness (Penninx et al., 1998).

With regard to coping style, it was found for both victims and nonvictims that a passive reaction is associated with higher levels of psychological distress. No associations with psychological distress were found for other aspects of coping style. The reason for this might be the use in the present study of a coping scale that measures coping as a stable personality trait; it is possible that this is not specific enough to measure the extent to which victims are able to deal with their mistreatment. The instrument was not sensitive to the impact of the appraisal tent to which victims are able to deal with their mistreatment. It is possible that this is not specific enough to measure the coping scale that measures coping as a stable personality trait; therefore, caution is advised in generalizing the associations that were found to victims of severe abuse. However, it can be expected that the impact of severe abuse on psychological distress is even more serious. Second, because the findings are based on cross-sectional data, it is not appropriate to draw causal inferences on the basis of these data. Longitudinal data are needed to determine the psychological consequences of elder mistreatment over time, in order to examine the influence of social support and coping on the course of psychological distress after a victim is mistreated. Third, in this study the influence of the perpetrator who was inflicting the mistreatment was not taken into account. It is possible that the characteristics of the perpetrator have an effect on study outcomes. Because the groups of perpetrators identified in our study were too small to warrant analyses, future studies are necessary to address this issue further.

In spite of the aforementioned limitations, the findings are considered to be relevant in providing insight into the psychological health of elderly victims of mistreatment. The findings demonstrate that elder mistreatment affects the psychological health of the victims. Elder mistreatment can easily be overlooked, and therefore deserves to receive extra attention from health care practitioners. If a situation involving elder mistreatment is identified, interventions to stop the mistreatment are not always possible or accepted (Biggs, Phillipson, & Kingston, 1995). The results of this study show that social support and positive feelings of mastery and self-efficacy are beneficial for the psychological health of victims of elder mistreatment. This suggests that if it is not possible to mitigate the cause of the mistreatment, interventions could focus on moderating the effects of the mistreatment on the psychological health of the victims by providing social support at home or organizing social support groups. This may give the victims a greater sense of emotional support, but could also help them to become more competent or self-efficacious in dealing with the mistreatment.

**ACKNOWLEDGMENTS**

This research was funded by the Dutch Ministry of Public Health, Welfare and Sports.

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Received July 9, 1998
Accepted February 4, 1999