

Current Psychopathology in Previously Assaulted Older Adults

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Older adult women age 55+ years ($N = 549$) were interviewed as part of a population-based epidemiological research study of lifetime experiences with physical and sexual assault and current mental health problems. Although overall rates of psychopathology were low, producing very small cells for comparison, women who reported experiencing physical assault an average of 28 years previously were more likely to present with past year substance abuse, depression, and avoidance and reexperiencing symptoms of posttraumatic stress disorder (PTSD) than those with no previous physical or sexual assault. Women who reported experiencing sexual assault an average of 50 years previously were more likely to present with autonomic arousal and avoidance symptoms of PTSD than those with no prior sexual assault. The aforementioned findings should be considered with caution however as sample cell sizes were minimal for all but the PTSD symptom subtypes. Mental health service implications for older adults are discussed.

Keywords: *older adults; elderly; victim; drug; substance abuse; depression; sexual assault*

Older adults appear relatively less affected by potentially traumatic events than similarly exposed younger adults (Bell, 1978; Bolin & Klenow, 1983; Goenjian, Najarian, Pynoos, & Steinberg, 1994; Kato, Asukai, Miyake,

Minakawa, & Nishiyama, 1996; Kilijanek & Drabek, 1979). Indeed, unspecified correlates of age (e.g., more refined coping mechanisms, wisdom, selective survival of the fittest) are protective factors with respect to post-traumatic symptomatology (Fontana & Rosenheck, 1994; Hyer, Summers, Braswell, & Boyd, 1995; Norris, 1992). However, the extent to which previously victimized older adults (i.e., individuals victimized when they did not possess the protective factors associated with advanced age) are more likely to present with emotional problems than similarly aged nonvictim peers remains unknown.

The present study examined the degree to which previously assaulted older adult women continue to experience emotional symptoms of depression, posttraumatic stress disorder (PTSD), and substance abuse relative to nonassaulted, similarly aged peers. We predicted that despite the passage of many years, women with self-reported histories of sexual or physical assault would continue to suffer from symptoms of these disorders at significantly higher rates than nonassaulted women.

Method

Participants

Participants were enrolled in the National Women's Study, a longitudinal research project in which a national household probability sample of 4,009 adult women were selected at random and interviewed by telephone (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Of the total sample, 2,009 were a national household probability sample of U.S. female adults (age 18 and older), and 2,000 were an oversample of women aged 18 to 34 years. Resnick et al. (1993) provided methodological and demographic characteristics of the original Wave I study sample, weighted by age and race to reflect national averages of these variables.

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To maximize sample size, only data from the Wave I interviews of women aged 55 and older ($N = 549$) are considered here. The mean age of participants was 67.0 years ($SD = 7.78$). With respect to ethnic/racial make-up, 88% of the sample was White, 6.7% was African American, 2.6% was of at least partial Hispanic origin, 2.0% was Native American, and approximately 3.5% endorsed membership in other ethnic groups or chose not to answer the question (note that the classification of “Hispanic” was not mutually exclusive of other ethnic groups).

Measures

The highly structured telephone interview was designed to collect information about several topics, including demographic characteristics, perceived health status, sexual and physical trauma, other trauma (e.g., accidents, disasters), and psychopathology. Demographic variables were measured using standard questions employed by the United States Census Bureau (U.S. Bureau of the Census, 1991) to categorize age, education, and race.

Sexual assault was determined by a positive response to any of the following queries: “Has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina;” or “Has anyone, male or female, ever made you have oral sex by using force or threat of harm? Just so there is no mistake, by oral sex we mean that a man or a boy put his penis in your mouth or someone, male or female, penetrated your vagina or anus with their mouth or tongue;” or “Has anyone ever made you have anal sex by using force or threat of harm? Just so there is no mistake, by anal sex we mean that a man or boy put his penis in your anus;” or “Has anyone, male or female, ever put fingers or objects in your vagina or anus against your will by using force or threats?;” or “Has anyone ever touched your breasts or pubic area or made you touch his penis by using force or threat of force?”

Physical assault was determined by a positive response to either of the following queries: “Another type of stressful event women sometimes experience is being physically attacked by another person. Has anyone—including family members or friends—ever attacked you with a gun, knife, or some other weapon, regardless of when it happened or whether you ever reported it or not?” or “Has anyone—including family members and friends—ever attacked you without a weapon, but with the intent to kill or seriously injure you?” Women who responded affirmatively to either of these two questions were classified as having experienced a physical

assault. Such assaults would be defined as aggravated assault under the criminal statutes of most jurisdictions in the United States.

PTSD and depression (major depressive disorder) were measured via structured interview according to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R*; American Psychiatric Association, 1987) criteria. Specifically, each *DSM* criterion was operationalized in the form of a yes/no question, and *DSM* diagnostic algorithms were used to derive diagnoses. PTSD was measured for the past 6 months, whereas depression was measured for the past month. Because very few older adults met full criteria for PTSD, this disorder was examined in terms of its *DSM-IV*-defined symptom sets of avoidance (three symptoms), reexperiencing (one symptom), and hyperarousal (two symptoms).

Current substance abuse was determined using criteria for alcohol and drug abuse that approximated the *DSM-IV* (American Psychiatric Association, 1994) diagnostic criteria. Drug abuse referred to pathological use of illicit substances including marijuana, cocaine, heroin, PCP, and so on over the past 12 months.

Procedure

Following selection of households, a telephone call was placed to the randomly generated number. In households with more than one adult woman, the most recent birthday method was used to select one woman for interview. Female interviewers collected all data using a computer-assisted telephone interview (CATI) procedure in which each question appeared on a computer screen and was read verbatim to respondents (see Resnick et al., 2003, for details).

Results

Data are presented in Table 1 in terms of prevalence rates and odds ratios. Univariate odds ratios were determined through chi-square analysis using the SPSS statistical package (Version 12) for Windows. For all analyses, an alpha level of .05 was chosen a priori.

Approximately 5.5% ($N = 30$) reported being physically assaulted, and 7.8% ($N = 43$) reported being sexually assaulted at some time in their lives (these were not mutually exclusive categories, and $n = 483$ reported neither sexual nor physical victimization). The average age of physical assault victims at the time of assessment was 65.8 years ($SD = 9.1$ years), the average

Table 1
Univariate Odds Ratios and Prevalence of Study
Variables by Victimization

	Prior Physical Assault		No Assault		Chi-Square	OR	CI
	%	<i>n</i>	%	<i>n</i>			
	Alcohol abuse	8.7	2	0.4			
Drug abuse	4.3	1	0.2	1	9.56	21.91	1.33 – 361.93
Major depression	8.7	2	1.4	7	6.60	6.48	1.27 – 33.09
PTSD arousal	26.1	6	19.5	94	0.61	1.46	0.56 – 3.81
PTSD avoidance	39.1	9	13.7	66	11.28	4.06	1.69 – 9.76
PTSD Reexperiencing	39.1	9	8.9	43	21.76	6.58	2.69 – 16.08

	Prior Sexual Assault		No Assault		Chi-Square	OR	CI
	%	<i>n</i>	%	<i>n</i>			
	Alcohol abuse	2.8	1	0.4			
Drug abuse	0	0	0.2	1	0.08	0.93	0.91 – 0.95
Major depression	5.6	2	1.4	7	3.32	4.00	0.80 – 20.00
PTSD arousal	33.3	12	19.5	94	3.97	2.07	1.00 – 4.29
PTSD avoidance	38.9	14	13.7	66	16.35	4.02	1.96 – 8.25
PTSD Reexperiencing	16.7	6	8.9	43	2.36	2.05	0.81 – 5.19

Note: OR = odds ratio; CI = 95% confidence interval; PTSD = posttraumatic stress disorder. Due to missing data for some variables, subsample size might vary slightly from the overall total of physical and sexual assault victims. Please note that for all but the PTSD symptom subtypes, *N*s are very small and may lead to unstable odds ratios.

age of sexual assault victims was 64.8 years (*SD* = 8.0 years), and the average age of nonvictims was 67.2 years (*SD* = 7.7 years). Among physical assault victims, assaults took place an average of 27.8 years ago (*SD* = 17.59 years; range = 5 to 78 years). Among sexual assault victims, an average of 49.7 years had elapsed since the crime (*SD* = 11.7 years, range = 22 to 74 years).

Older adult women who reported physical assault histories were more likely to present with all forms of psychopathology than women who reported no prior physical or sexual assault, particularly with respect to alcohol abuse, depression, and avoidance and reexperiencing symptoms of PTSD. By contrast, women who reported a previous sexual assault were

more likely to present with PTSD hyperarousal and avoidance symptoms than women with no prior assault history. Note that the number of individuals endorsing either victimization or psychopathology were quite low, and power to detect group differences in sexual assault victims was likely limited.

Discussion

Our findings support with those of past researchers (Bachman, Dillaway, & Lachs, 1998; Bachman & Saltzman, 1995; Muram, Miller, & Cutler, 1992; Norris, 1992) indicating relatively low overall reported rates of sexual and physical assault in older women. However, consistent with study hypotheses, older women who reported a history of interpersonal violence were at increased risk for some mental health problems compared to their nonassaulted peers, despite the protective factor of age and the passage of time. These data are also consistent with a large literature indicating increased risk of mental health problems in victims of interpersonal violence, including younger adults (e.g., Resnick et al., 1993) and adolescents (Fisher, Kramer, Hoven, & Greenwald, 1997; Kilpatrick et al., 2003). However, for analyses other than PTSD symptom subtypes, sample sizes were extremely small and conclusions should be made with caution. A cursory comparison of psychological outcomes among physically and sexually victimized participants suggests that at least initially, older women who are physically assaulted are more likely to suffer negative emotional sequelae than those who are sexually assaulted. However, other factors, such as the recency of assault, likely influenced symptom presentation. Indeed, physical assaults tended to occur more recently than did sexual assaults in this sample. Even after many years have elapsed since the event, both assault groups continued to report significant levels of PTSD symptomatology (albeit, not at diagnostic levels). It is also possible that participants did not report all instances of interpersonal violence that did in fact occur. Older adults tend to report fewer lifetime assaults than do younger adults, perhaps due to cohort effects (e.g., less violence in older generations) but also perhaps because the assaults occurred long ago and may have been forgotten or were diminished in perceived relevance or significance (Norris, 1992).

Regardless of differences in mental health problems across assault modalities, results of this study suggest that some older adult women who experienced interpersonal violence decades earlier continue to present with psychopathology and may benefit from trauma-focused treatment that addresses varied symptom presentations. Several psychosocial interventions

are effective in reducing psychopathology among interpersonally victimized adults (e.g., Foa et al., 1999; Meichenbaum, 1985; Ouimette & Brown, 2003; Resick, Nishith, Weaver, Astin, & Feuer, 2002), but substantive statements regarding effectiveness of these treatments among older adults await well-controlled outcome research. Bartels et al. (2002) reviewed evidence-based treatments for older (but not necessarily traumatized) adults with depression (see also Floyd, Scogin, McKendree-Smith, Floyd, & Rokke, 2004) and alcohol abuse problems and highlighted the strong treatment effects generated by cognitive-behavioral treatments. Less is known about the effectiveness of psychosocial treatments for anxiety and drug abuse among older adults. In the absence of empirically supported treatments to guide psychosocial treatment of mental health problems, clinicians should consider using treatment packages validated in younger samples that are modified to adequately address issues that may distinguish older from younger adult patients, such as age-related variances in symptom presentation, comorbid mental and/or physical problems, issues related to cognitive functioning, and attitudes toward mental health care.

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