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Older Women Survivors of Physical and Sexual Violence: A Systematic Review of the Quantitative Literature

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Abstract

Background: This systematic review synthesizes the quantitative empirical literature concerning older women survivors of physical and sexual assault.
Methods: A literature search was conducted using a range of scholarly databases. Information is presented here on the prevalence, correlates, and consequences of these types of interpersonal violence in older women. Additionally, age-related differences in prevalence, psychiatric distress, and characteristics of violence, including information on perpetrators, are reviewed.
Results: Overall, older women report lower lifetime and past year rates of physical and sexual assault and associated negative psychologic consequences compared to younger and middle-aged women. Additionally, older women who experienced interpersonal violence report greater psychiatric distress, including posttraumatic stress disorder (PTSD), than older women who have not experienced such events.
Conclusions: Some women who have been physically or sexually assaulted decades earlier in life continue to report significant levels of PTSD well into older adulthood. Gaps in the literature, including lack of information on ethnicity and culture, are presented, and future research directions are proposed.

Introduction

Understanding the prevalence and psychologic sequelae of interpersonal violence in older women is increasingly important, with the number and proportion of the older adult population in industrialized countries rapidly increasing and with women aged ≥65 a fast-growing segment.[1] In particular, in the United States, the advancing age of the Baby Boomer generation is projected to more than double the number of older women in the next 40 years.[2] Because of the political, legal, and economic circumstances in which the current cohort of older women came of age, some may have histories of interpersonal trauma but not recognize deleterious effects or disclose these experiences to healthcare providers. Additionally, healthcare providers may not recognize trauma and related distress in older women. These factors may have negative implications for treatment and recovery, including the design of inadequate treatment plans and administration of inappropriate psychotherapy, medication, or other medical intervention.[3]

This systematic review synthesizes the quantitative empirical literature on older women survivors of physical and sexual assault. Data are presented concerning the prevalence of these types of interpersonal violence, their correlates, and potential psychologic and physical health consequences. Differences between older and younger survivors in terms of trauma prevalence and associated distress as well as characteristics of violence are discussed. Gaps in the literature and future research directions are discussed.

Materials and Methods

A systematic literature search was conducted using MEDLINE/PubMed, PsychINFO, CINAHL, Dissertation Abstracts International, and Gender-Watch based on the following search terms: (interpersonal violence, assault, spouse abuse, partner violence, abuse, domestic violence, or battered woman) and (women or female) and (older, geriatric, elderly, or aged). The search was limited to empirical studies carried out from January 1980 through December 2009. Of note, the terms "elder abuse" and "older interpersonal violence survivor" were sometimes used interchangeably in the literature. Although the distinction between the two terms is often not clear, the task of differentiating them was beyond the scope of this review. Findings of elder abuse reported to Adult Protective Services or reports of abuse of those residing

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in institutionalized settings are not discussed here. Similarly, although no definition is universally accepted, the term "interpersonal violence" has been used to describe a range of acts, including physical, sexual, and psychologic abuse. The Centers for Disease Control and Prevention (CDC) has recommended that psychologic abuse be considered a type of violence only when there has also been prior actual or threatened physical or sexual violence.[4] As a result, acts outside of this governmental suggestion are not discussed here. Although every effort was made to include only data relevant to physical and sexual assault, in a few instances this was not possible. For example, certain studies included forms of psychologic abuse as well as physical and sexual assault and did not disaggregate reports in their articles. This discrepancy is noted in the article where appropriate. In addition, age 65 was selected as the threshold for older adult status, as many substantial life changes typically occur at or around this threshold (e.g., retirement, Social Security eligibility).

Thus, inclusion criteria for this review were (1) women, (2) 65 and older, (3) community dwelling, (4) experienced physical or sexual assault or unspecified violence, and (5) study findings were reported by age. A master-level graduate student (S.D.) and a licensed clinical psychologist (J.M.C.) independently screened the titles and abstracts of the studies produced by keyword searches. Additional studies were also located by hand-searching relevant references in the retrieved literature. In cases of disagreement, consensus was sought by consultation with another doctoral-level psychologist (C.O.).

The most common reasons for exclusion of studies were participants' age was ≤ 64, study did not present results according to age categories, study was not published in English, or study was primarily qualitative in nature. Qualitative studies were excluded from this review, as this type of methodology is held to less standardized means of reporting and is, therefore, potentially difficult to synthesize.[5] Qualitative studies were selectively used in this review as supplementary sources to elaborate on themes that emerged in the review of the quantitative literature. A list of studies that did not meet criteria is available from the first author (J.M.C.).

For each publication, data concerning author(s), year, country, sample size, participant age, assault characteristics, and association between assault and mental and physical health were extracted. It was often not stated when the violence women were reporting was by known perpetrators or strangers. For the purposes of this review, whenever possible, it is noted whether studies are referencing stranger or known assailant assaults. The final literature search consisted of 163 articles from which 105 were excluded, leaving 58 articles for review.

Results

Prevalence

Trauma in older women is most frequently discussed in the context of interpersonal violence. However, the definitions of violence (e.g., physical, sexual, and psychologic abuse, stalking, controlling behavior, financial abuse) vary widely and thus affect prevalence estimates across studies. Additionally, estimates also depend on the sampling method (e.g., random, community, clinical samples) and specific age groups examined (e.g., 55+, 60+, 65+).

As part of a population-based investigation of 549 women over the age of 55, lifetime prevalence of physical assault was 6% and of sexual assault was 8%.[6] Similarly, in a subsample of women aged ≥ 60 selected from a population-based study, the lifetime prevalence of interpersonal violence was 8%, and the past-year prevalence was 0.8%.[7] A 1% prevalence of past year domestic violence was found in women and men ≥ 55 ($n = 3622$).[8]

The prevalence of interpersonal trauma is higher in clinical vs. community samples. In a random sample of 370 women aged ≥ 65 selected from a large healthcare system, 27% reported lifetime experience of interpersonal violence (i.e., physical, sexual, emotional), whereas the past-year prevalence was 2%.[9] Indeed, the majority of women with a history of interpersonal violence reported more than one episode, and many reported multiple episodes over their lifetime (e.g., 18% reported >20 episodes of physical assault); the average duration ranged from 3 years to 10 years.[9]

In a study of 842 women aged ≥ 60 identified from primary care clinics, nearly half had experienced at least one type of abuse (i.e., physical, sexual, emotional, control, threat) since turning 55.[10] Women aged 60–64 reported a significantly higher percentage of abuse, repeated abuse, and multiple types of abuse than women ≥ 65.[10] The highest prevalence of trauma was found in an examination of 1245 postmenopausal women aged 50–70 enrolled in a nontrauma-related multisite clinical trial; 59% reported exposure to some type of abuse over their lifetime.[11] This high number may be due to the inclusion of verbal abuse.

In sum, prevalence estimates of interpersonal violence in older women range from 6% to 59% over the lifetime, from 6% to 18% since turning 50, and from 0.8% to 11% in the past year. Across all three time periods, other types of abuse, especially those identified as emotional, were the most frequently reported. However, the prevalence of physical and sexual assault may be underestimated in this population.

Correlates and consequences

Although the association between interpersonal violence and subsequent psychiatric and physical health is well established in younger and middle-aged women,[12] much less is known about the correlates and consequences of this type of trauma in older women. Older women who reported a history of physical or sexual assault were more likely than their nonassaulted counterparts to have substance abuse, depression, and posttraumatic stress disorder (PTSD) symptomology.[6,13] More specifically, sexual assault history was related to PTSD arousal and avoidance symptoms, and physical assault history predicted PTSD reexperiencing, alcohol abuse, and depression.[6] Additionally, whereas older women who experienced assault at some point in their lifetime were more likely to report PTSD and depression symptoms, those who had recent trauma reported more PTSD symptomology but not depression.[6] Furthermore, older women who suffered abuse of any kind were nearly twice as likely to experience depression and anxiety compared to older women without such a history.[10] Similarly, in a convenience sample, older women with a history of two or more interpersonal traumas had higher depressive symptoms and emotional distress than those without any or only one traumatic experience.[14]

In a subsample from a larger intervention study, 33 older women aged 54–83, who reported experiencing childhood

abuse, intimate partner violence (IPV), or both, were assessed to discern the challenges of measuring traumatic stress and PTSD (the Posttraumatic Diagnostic Scale [PDS][15]) in this population.[16] PTSD symptoms varied widely among the women, with 7 reporting mild symptoms, 9 reporting moderate symptoms, 14 reporting moderate to severe symptoms, and 3 reporting severe symptoms. Although the women endorsed signs and symptoms of PTSD, they also frequently noted symptoms of isolation, feelings of humiliation and shame, low self-esteem, and substance abuse problems.[16]

Although research on the association between interpersonal trauma and physical health in older women is equivocal, the majority have found that this type of trauma is related to poor physical health.[10,14] For example, older women who experienced interpersonal violence had poorer self-reported physical health and higher medication use than older women without trauma.[10,14] In addition, older women with sexual assault exposure had increased rates of physician-diagnosed arthritis and breast cancer than those without assault histories, and those who reported multiple assaults experienced a dose effect, doubling or tripling the likelihood of experiencing these diseases.[17]

IPV may have cognitive consequences that impact women many years later. For example, in a sample of 40 older women (average age 76) with probable Alzheimer's disease referred to a memory disorder clinic, 17.5% ($n=7$) reported spousal abuse with head trauma (i.e., being struck in the head five or more times and losing consciousness on two or more of those occasions).[18] Most women reported that the abuse took place roughly 30 years earlier. Of the 7 women with reported (and corroborated by at least one family member) spousal abuse with head trauma, only 4 mentioned the abuse at the first clinic visit. The other 3 women had to be repeatedly probed before acknowledging the abuse and reported feeling too embarrassed or scared to talk about it earlier. Although this study was retrospective and in need of replication, these results may indicate that the odds of cognitive impairment/dementia for women experiencing spousal abuse with head trauma may be four times as high as those not abused.

In a study of older women recruited from family practices in Northern Italy, those who reported a history of interpersonal violence (i.e., physical, sexual, psychologic, or economic) endorsed having poorer health and greater use of pills (type not specified) than older women without a history of violence.[19] Additionally, older women who experienced abuse after turning 55 were 3.6 times more likely to report negative physical health conditions, including chronic pain, compared to their nonabused counterparts.[10] In particular, past-year abuse was associated with increased physical injuries, such as sprains or broken bones.[10] Only one study found that after controlling for demographic variables, the relationship between domestic violence and physical health disappeared.[20]

Older and younger survivors

The most consistently reported difference between older and younger survivors of interpersonal violence is a lower rate of reported victimization in older women.[6,13,21–24] In a nationally representative sample of women, those ≥55 years reported less lifetime exposure to physical and sexual assaults (6% and 8%, respectively) relative to those aged 18–34 (13% and 21%).[13] In the National Crime Victimization Survey, women ≥55 reported the lowest rates of interpersonal violence (2%), and the highest rate was reported by those 25–54 years (62%), followed by those 12–24 years (36%).[25]

These lower rates may be due in part to reporting differences. Older women appear to delay disclosing traumatic histories to their psychotherapists. More specifically, although no older woman disclosed a trauma history at the time of outpatient admission to a mental health center, about 85% disclosed histories of childhood abuse, domestic violence in their marriages, or both during the course of psychotherapy.[26] The understanding and use of particular words may also affect reporting of violence for this current cohort of older women. For example, 40% of older women did not accurately label sexual assault that occurred during a date likely because the current lexicon "date rape" did not exist to them.[27]The belief that rape applies only to women who are attacked by a stranger may also impact their perception of this type of violence.[28]

That older women report lower lifetime and past-year frequencies of physical and sexual assault as compared to younger and middle-aged women is consistent with the broader literature on the lower prevalence of traumatic events across the life span.[29] These findings, however, run contrary to the assumption that trauma accumulates over one's lifetime.[29] Possible additional explanations for lower prevalence rates of trauma and associated distress in older women include limited remembrance, diminished perceived relevance or significance of trauma over time, recovery or development of better coping mechanisms across the life span, and resilient women living longer ("survival of the fittest").[29]

Older women with lifetime histories of interpersonal violence also appear to have a lower prevalence and proportionate risk of PTSD and depressive symptoms relative to younger and middle-aged women,[13] although differences in posttrauma pathology between these groups may vary when assaults are more recent. For example, the effect of sexual assault on depression 1 year after the attack was examined in 115 women aged 15–71 referred to a rape crisis center.[30] Similar to younger women, older women demonstrated a significant drop in depressive symptoms 4 months after the assault. However, at 12-months postassault, rates of depressive symptoms correlated with age, indicating a marked link between older age and the chronic course of depression after sexual assault.

The characteristics of interpersonal violence also appear to have some differences between younger and older women. Older women with a lifetime history of sexual assault reported less vaginal, oral, anal, and digital forms of rape and were less likely to report being physically assaulted with or without a weapon than younger women.[31] Older women who had more recent assaults were more likely to sustain genital or other injury and more frequently required medical treatment than younger women.[21,32] Additionally, most assailants of recent single incident violence in older women were strangers, and the majority of assaults took place in their homes.[21] There appears to be a difference in beliefs about violence between older and younger women. For example, older women report a higher degree of belief in rape myths.[33]

Perpetrators of interpersonal violence against younger women appear to share certain similarities with perpetrators of violence against older women, namely, that most are

spouses or current partners.[25] A current spouse was the most likely perpetrator of violence against older women (62%), followed by a former spouse (12%) and current or former partner (26%).[25] Using data from 2072 women aged ≥55 seeking help at domestic violence centers, over half of white and Hispanic women were abused by their spouses, whereas the majority of African Americans were abused by relatives and spouses equally.[34]

One study indicated that older and younger women present different problems to domestic violence services.[35] Namely, younger women reported physical abuse as their primary presenting problems (64%), followed by emotional abuse (34%) and sexual abuse (2%), whereas older women most commonly presented with emotional abuse (50%), physical abuse (49%), and sexual abuse (<1%). Older women were also more likely than younger women to report physical and sexual assault to the police.[36]

Another study indicated some similarities between survivors. Namely, women aged 15–87 presenting at a hospital-based sexual assault care center in Ontario were compared in regard to assault characteristics and service delivery.[23] Younger, middle-aged, and older women did not report any differences in the type or severity of coercion or number and range of injuries. In addition, women did not differ across age groups in regard to likelihood of using ambulatory services, undergoing physical examination, or collecting forensic evidence. Middle-aged and older women were more likely to have psychiatric problems, such as depression, schizophrenia, and bipolar disorder, than younger women. However, information on whether these difficulties predated or were a consequence of the assault was not provided.

Gaps in literature

There is generally a dearth of information on interpersonal violence in older women of color and those from nonindustrialized countries. The population of older minorities in the United States will more than double by the year 2030, particularly among Hispanics and Asians.[37] Addressing the unique needs of older women trauma survivors from minority populations is thus an important line of future investigation. In a large-scale survey of postmenopausal women, 17% who reported past-year abuse were ethnic minorities.[38] More specifically, older African Americans were 2.8 times more likely than whites to report physical abuse both at the time of initial survey and at the 3-year follow-up. Further supporting this disparity, the National Crime Victimization Survey provides the estimate that 6/1000 as opposed to 3/1000 older African American women compared to older white or other ethnic women experienced physical and sexual assaults/abuse and robbery in the past year.[39]

It is estimated that the number of older women immigrants, who likely manifest a range of trauma histories, in the United States is increasing.[40] In a small sample of middle-aged and older Cambodian refugee women, many reported unexplained somatic problems, severe depression, war zone-related nightmares, and intrusive trauma-related thoughts.[41] Using a subset of a larger telephone survey in Southern California, Shibusawa and Yick[42] examined the experiences and perceptions of IPV in older Chinese immigrants aged 50–86. Whereas 7% of women reported experiencing minor violence (e.g., pushing, shoving, having something thrown at them, or slapped) by their intimate partner in the past 12 months, none reported severe physical violence (e.g., biting, kicking, being burned). Lifetime prevalence was 14% for minor violence and 4% for severe violence. Clearly, older immigrant trauma survivor populations are in need of associated mental health assessment and service as well as inclusion and focus in future research investigations.

Treatment and assessment

Assessment of trauma and potential negative consequences are typically not included in routine intake processes in mental or medical health settings. Indeed, only 3% of older women were questioned by a healthcare provider about violence.[9] Although specific measures of interpersonal violence in older women are lacking, there are psychometrically sound measures of trauma and related stress for use in older adults.[43] Although providers working with older adults may consider using established instruments used with younger women,[44] it is important to recognize that these may fail to adequately capture trauma in older women.[16] Because of unique issues in older adults, such as a lack of normative language to accurately convey their experience, comorbid or complicating medical conditions, and reluctance in reporting, providers may consider a more thorough and ongoing discussion about clients' trauma histories.

To date, there are no randomized controlled trials testing the efficacy of psychosocial interventions to alleviate the distress associated with trauma in older women. Case studies have indicated that various treatment modalities, including cognitive-behavioral therapy, relaxation training, psychodynamic psychotherapy, and guided imagery, have been successfully used with this population.[45–48] Other types of interventions that include a trauma processing component may also be helpful with older women; life review, a therapeutic technique where a structured narrative is created around one or more life themes (e.g., major events in one's life), appears to be a promising intervention to help older adults better cope with trauma-related memories.[49,50] Although clinicians must be aware of the potential for autonomic arousal in medically compromised older clients when using trauma-focused therapies,[51] this type of intervention should not be automatically ruled out with this population. Specific training in working with trauma-focused interventions, particularly with older adults, is recommended.

Working clinically with older women currently involved in violent relationships has specific challenges that may complicate treatment, such as limited financial resources and social support and medical difficulties.[52] Providers can establish primary goals of establishing safety plans and secondary goals that promote long-term recovery.[53] Additionally, because of historical perspectives and stigmas related to mental health treatment, psychoeducation about trauma and mental health treatment may be used in older women to help normalize experience and socialize one to psychologic treatment.[43]

Perspectives on mental healthcare and desired interventions may vary culturally and, thus, require special consideration. For example, older white women were less likely to seek legal services at domestic violence centers, and African American women sought less emotional support or housing than Hispanic or white women.[34] American Indian and

Hispanic older adult women reported higher levels of abuse than Caucasian or African American women, and Asian/Pacific Islanders reported lower levels of abuse than all other races.[54]

Future directions

More information is needed on the negative mental and physical health effects of physical and sexual assault experienced by older women. In particular, knowledge on the course of mental health symptoms and functioning across the life span after trauma would be instructive in understanding risk and resiliency. It would also be informative to determine if and how trauma interferes with women's capacity to successfully navigate normal cognitive and physical changes associated with aging.[55]

As the number of older women increases, healthcare professionals need to be made aware of the link between trauma and associated distress. Because older adults are less likely than younger adults to report psychologic distress, developing assessment tools that include more somatic indicators and take into account contextual differences (e.g., generational, cohort, cultural) in trauma and mental health descriptions will be necessary to ensure proper assessment and treatment.[13] The lack of empirically validated assessment tools for use with older women is thus an important area for future research. One measure that shows promise is the Family Violence Against Older Women Scale.[56] In one small investigation, it showed good construct validity and high test-retested reliability. The measure contains both abuse factors (i.e., physical, sexual, psychologic, financial abuse, neglect) within the context of intimate relationships and caregiving failures, where the older adult woman is in a mutually dependent abusive relationship (i.e., the older adult woman is dependent on a family member for care, who is in turn dependent on her for financial security).

Limited information exists about risk and protective factors for interpersonal violence against older women. Research on this topic is generally limited to qualitative studies (e.g., Zink et al.[57]), and has included small numbers of participants and typically only those from one or more subgroups (e.g., African Americans).[58] Thus, more research is needed to better understand the generalizability of these findings. Additionally, few studies in this review differentiated between acts of violence committed by intimates or known assailants vs. strangers. This also represents an area worthy of investigation, as the psychologic effects may be different. As previously noted, cultural diversity likely creates complexity in the presentation and experience of trauma sequelae and thus also is an important focus for future research endeavors.

Although qualitative studies were excluded from this review article, several investigations of this type[57–59] represent an important source of information on the impact of IPV and the self-identified needs of older women. Future directions may also include a systematic review of qualitative studies in this area.

Conclusions

Although interpersonal violence against older women is not a widespread phenomenon, it should not remain a hidden variable in their lives.[60] Despite lower reported rates of interpersonal trauma in older as opposed to younger women, the number of older women who have experienced interpersonal violence is not inconsequential. As Baby Boomers reach older adulthood, the number of older women who have experienced or acknowledge interpersonal trauma and associated psychologic difficulties will likely increase. Although many older women who had been physically or sexually assaulted decades earlier do not meet full diagnostic criteria for PTSD, the majority report significant symptoms.[6] Older women may also tend to have slightly different symptoms from those of younger women. This can complicate assessment and treatment. In particular, lack of acknowledgment or recognition of trauma-related distress likely interferes with diagnosis and may contribute to inappropriate services for older women survivors of physical and sexual assault.[3]

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