Medical News & Perspectives

Sexual Harassment and Assault Associated With Poorer Midlife Health in Women

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Between 2012 and 2015, years before the Time's Up and Me Too movements galvanized countless women to come forward with accounts of sexual harassment and assault, researchers at the University of Pittsburgh asked a group of midlife female study participants if they had ever experienced these traumas.

The questions might have seemed out of place to some: The researchers, led by Rebecca Thurston, PhD, were investigating the association between menopausal symptoms—specifically hot flashes—and early signs of atherosclerosis, or hardening of the arteries, a risk factor for cardiovascular disease. Why ask about harassment and assault in a study about heart health?

To Thurston, a professor of psychiatry, psychology, and epidemiology, including the questions made sense. Thurston has long been interested in how gender-based power inequities influence women's health. Sexual harassment in the workplace and sexual assault are an "expression of this power dynamic," she said.

Audio

Thurston heads the Women's Biobehavioral Health Laboratory at Pitt, where one line of research is devoted to psychosocial factors in women's cardiovascular disease. She knew that traumatic events such as sexual harassment and assault are potent stressors, and she suspected that they could have some bearing on women's cardiac health.

A post hoc analysis of the study of midlife women recently published in *JAMA Internal Medicine* suggests that she was right. Women who reported a history of sexual harassment or sexual assault had poorer specific physical and mental health outcomes than those who didn't.

Unlike previous studies that have looked at similar associations, this one considered both sexual harassment and sexual assault and included objective measures of physical health rather than relying exclusively on self-reported outcomes.

Thurston acknowledged that the study can't prove causality. But the data do suggest that there could be long-lasting health effects of these experiences. The participants weren't asked when the traumas occurred, but for most women who are sexually assaulted, the first incident occurs in late adolescence or early adulthood, Thurston said. Younger women are also more likely to be sexually harassed than older women.

Thurston spoke with *JAMA* about the findings, how these exposures may influence health, and what physicians can do to help. The following is an edited version of that conversation.

JAMA: Why did you decide to study the association of sexual harassment and sexual assault with women's health?

DR THURSTON: Given that we take a biosocial perspective, we were thinking about key social and interpersonal experiences that are important to health outcomes in women. Sexual harassment and sexual assault are very prevalent in the population for women but relatively understudied when we think about their implications for women's physical health.

JAMA: Lay out the study design for us.

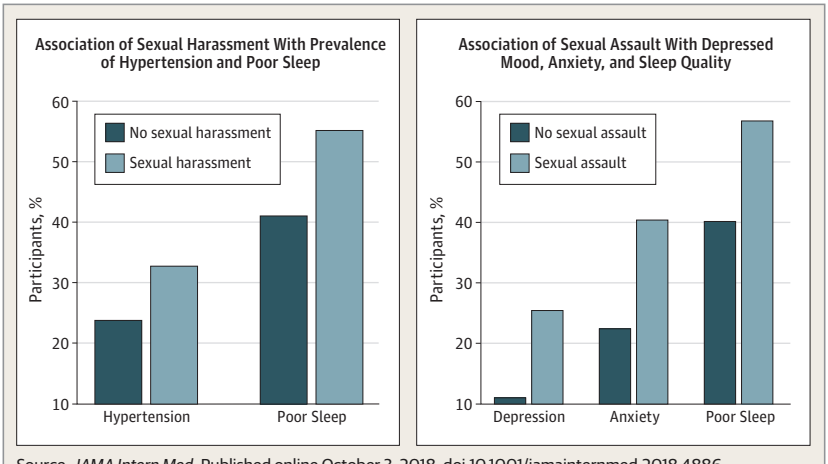
DR THURSTON: We recruited 304 midlife women between the ages of 40 and 60 [who] were nonsmoking and free of cardiovascular disease. The women came in for a brief screening interview. We did a workup of their blood pressure, their height, their weight, their medical history. And they filled out a battery of questionnaires, which included the questionnaire that inquired about sexual harassment and assault, as well as mood, anxiety, and sleep.

JAMA: How did you assess sexual harassment and assault?

DR THURSTON: We asked whether they had experienced workplace sexual harassment, and they self-defined what that constituted. We also asked whether they had experienced unwanted sexual contact. We said by sexual contact, we mean any contact between someone else and your private parts or between you and someone else's private parts. There are other kinds of sexual assault, like flashing, that were not assessed here.

JAMA: What did you learn?

DR THURSTON: We found that 19% of the women reported a history of workplace sexual harassment and 22% reported a history of sexual assault, with relatively mini-



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mal overlap between those 2 groups. They were not the same women. We found that women with a history of sexual harassment had approximately 2-fold odds of hypertension relative to the women who did not have a history of sexual harassment, as well as approximately 2-fold odds of poor sleep that fell within the clinically significant ranges for sleep problems, such as insomnia. Women with a history of sexual assault had almost 3-fold odds of depressive symptoms and 2-fold odds of anxiety and poor sleep.

JAMA: What does this suggest?
DR THURSTON: It suggests that sexual harassment and sexual assault have implications for women's physical health and mental health.

JAMA: What factors did you adjust for?
DR THURSTON: We considered a range of covariants, things like age, race, ethnicity, economic status, medication use. We also considered things like physical activity and alcohol use, but those did not play any role in these associations, so they didn't make it into the final models.

JAMA: How do the findings on self-reported incidents compare with national statistics?
DR THURSTON: They were lower. We know from national statistics that around 36% of women report a history of sexual assault, so it's really quite high. For sexual harassment, the estimates are much more variable and depend a lot on whether you're talking about workplace sexual harassment or all sexual harassment, and how you define that sexual harassment. So we're a little murkier there in terms of national statistics, but probably what we [saw] was a bit lower.

The reasons for that are probably many. We recruited a relatively low-risk sample when it comes to behavioral and physical health. We had women who were nonsmokers, did not have clinical cardiovascular disease, were not taking antidepressants, and were not using medications such as [calcium] channel blockers, β-blockers, and insulin. We also asked specifically about workplace sexual harassment and contact sexual assault. So for those reasons, our estimates were probably a bit lower. Also, we know that [women] don't love reporting these experiences, so there's a tendency to underreport.

JAMA: Were you surprised at all by your findings?
DR THURSTON: I was surprised by the range and pervasiveness of the outcomes across bodily systems that we saw related to harassment and assault. I also was somewhat surprised that we saw a divergence with sexual harassment related somewhat more to the physical health indices and sexual assault more related to mental health and sleep. But what I was not surprised about is that we did see these relationships broadly, because we know that stress and stressful experiences are important to mental health and physical health. We're taking it a step further here and looking at female predominant stressors.

JAMA: How does being sexually harassed or sexually assaulted potentially affect a woman's long-term health?
DR THURSTON: There's a deep literature linking stress and health. Number one, we tend to think about health behaviors: smoking, physical activity, substance abuse, dietary factors. We didn't have any smokers in the study [but] we looked at all the other health behaviors pretty carefully, and they did not explain these associations. We also think about more direct physiologic mechanisms, [like] autonomic nervous system dysregulation. For example, the balance between the sympathetic and parasympathetic branches of the autonomic nervous system are important for blood pressure and hypertension and can be disrupted when it comes to situations of chronic stress. The HPA [hypothalamic pituitary adrenal] axis dysregulation is also important. And we have some data linking stressful experiences and traumatic experiences to vascular endothelial dysfunction. These are just a few of the many potential mechanisms that can link stress to physical health outcomes, particularly hypertension.

When it comes to mental health outcomes, I think we can all agree that these experiences are stressful, and they likely have implications for mental health and psychological functioning. We're probably seeing a lifetime effect of these experiences.

JAMA: Most of the women in your study were white and well-educated. Do you think these associations are true for other groups of women?
DR THURSTON: We had a decent representation of minority women—about a third. Most of the nonwhite women in this study were African American, so we can't really generalize beyond those 2 groups. I would suspect it's the same [for other groups]. These are oftentimes universal experiences for women, sadly, and it would make sense to me that the psychological impacts and physical impacts, or at least correlates, are probably similar.

JAMA: Men can also be sexually harassed and sexually assaulted. Do you think there could be health effects for men?
DR THURSTON: Absolutely. Sexual harassment and sexual assaults do occur in men. The best we know, they are not as prevalent, but it does happen. And, likely, if you match the invasiveness of the experience [to those of women], you probably will see important health impacts.

JAMA: What do you want women who have experienced sexual harassment or sexual assault to know about how it could potentially affect their health?
DR THURSTON: First, know how to recognize when you're being harassed. Unfortunately, we've normalized many of these experiences, and we try to tell women you're the problem for thinking that there's a problem. It's important for women to listen to themselves. Number 2 is that these are toxic experiences. If you're in a relationship or a workplace that has harassment and assault happening, the best thing to do—if you can—is to either report the situation or get out of the situation.

Now, all of that is easier said than done. Oftentimes for women who are in harassing workplaces, for example, it's not so easy to get out. Money is really quite important, and I don't want to ignore that. And we saw in our own sample that the women who were more financially strained were more likely to report a history of sexual harassment. But getting help as best you can is important—not simply putting up with it and tolerating it. These are challenging situations to address.

JAMA: What can physicians do to support the health of women who may have experienced these events in their past?

DR THURSTON: Physicians have an important role to play. Number 1 is [knowing] the prevalence of these problems and just how common they are. Number 2 is [knowing] their implications for health. When you're thinking about health [it's important] to have a sense of a woman's sexual assault history. It's also the recognition that the woman may not report these experiences to the provider, even when asked. It really takes a lot of trust for people to come forward with these experiences, so it may mean developing a relationship over time, and not assuming that if you get a "no," that [it's] not happening.

So, to address that, have educational materials available and provide patients with materials to know where to go if it's happening to them, regardless of disclosure. Partner with local agencies and support services to be able to refer people to appropriate care once they report a history of sexual assault or current sexual assault. And, ideally, have behavioral health care providers or victim services advocates on-site. That really reduces the tendency to lose people between referral and treatment. And then, finally, follow-up with people and maintain that ongoing relationship.

JAMA: Women and men are increasingly coming forward to talk about workplace sexual harassment and sexual assault. What do you want us to remember when we hear these accounts?

DR THURSTON: Remember that overreporting is rare. Underreporting is typically the rule. So, when people are reporting it, take it really seriously. Most likely you can trust their word for it. And understand that these experiences are important for their mental and physical health, not only at the time, but years down the road. The imperative is to try to help people to get out of these situations and receive appropriate care. ■

Note: Source references are available online through embedded hyperlinks in the article text.