Spiritualized Therapy Helps Sex Abuse Survivors

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

A program that integrates cognitive therapy with spiritual awareness and healing has proved beneficial to female survivors of childhood sexual abuse, significantly decreasing symptom scores in all patients in a small pilot study.

The 8-week program of manualized, individual sessions offers the kind of experience many abuse survivors never encounter though they may spend years in therapy—a way to explore how sexual abuse has shaped their spirituality and how that spirituality has shaped their mental and emotional health.

The link between spirituality and health has long been recognized, said Nichole Murray-Swank, Ph.D., who created the program. Just as positive spirituality is associated with better mental health, negative spirituality is associated with poorer mental health. Many abuse survivors carry extremely negative spiritual images; these very persistent thought patterns can impede healing, said Dr. Murray-Swank, a clinical psychologist at Loyola College in Maryland, Columbia.

At the core of these images is the survivor's belief that she is utterly worthless, irredeemably damaged, and undeserving of love or happiness, Dr. Murray-Swank said. These feelings form the basis of crippling shame, sexual dysfunction, poor body image, anger, and emotional isolation. They can also exacerbate depression and posttraumatic stress disorder.

Dr. Murray-Swank's pilot program, "Solace for the Soul: A Journey Towards Wholeness," asks clients to work through these thoughts and images. The program is nondenominational, although it is theistic, she said in an interview. In Ohio, where the pilot study was conducted, most clients subscribed to a monotheistic, paternal image of God. But the program does not specify this image. "By 'theistic,' we mean that it describes a creative force, whether people understand that to be nature, or energy, or a deity," Dr. Murray-Swank said.

Each session focuses on a specific aspect of spirituality and its relationship to childhood sexual abuse: feelings of abandonment by God and associated anger; connecting with the spiritual; letting go of shame; seeing the body as a beautiful creation; and seeing sexuality as a sacred, life-affirming way of connecting to others.

Dr. Murray-Swank's first group consisted of four adult women who had experienced long-standing sexual abuse—including penetration—by their father or stepfather, beginning in prepubescence. The women were referred from mental health agencies after they learned about the program and expressed an interest in joining. All of them had serious, chronic mental illness: one had bipolar disorder; one had borderline personality disorder and depression; and two had chronic, serious depression. All had severe PTSD.

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DR. MURRAY-SWANK

The women filled out five questionnaires at baseline, after session 4, at the end of the intervention, and at 1 or 2 months' follow-up (Brief Symptom Inventory, Trauma Symptom Checklist-40, Brief Measure of Religious Coping, God Image Scale, and Religious Concepts Survey). They also kept daily symptom logs measuring psychological and spiritual distress, positive and negative coping, self-worth, sexual problems, trauma symptoms, and body image.

By the last measurement, all of the patients experienced decreases in the Brief Symptom Inventory, with the most symptomatic patient making the largest improvement (dropping from 80 to 15 on the scale). One patient dropped from 55 to 35, one from 45 to 34, and the last from 15 to almost 0. The largest improvements were seen in depression and anxiety symptoms.

Dr. Murray-Swank said the work was challenging to all the women. The most difficult sessions were those that concerned sexuality and body image. "When I asked them to write positive things about their body, some were unable to give even one answer."

Some of the women experienced intermittent increases in their sexual symptom scores during the sessions. This wasn't a surprise, Dr. Murray-Swank said. "It's not fun doing these things. Healing is difficult, and it might even be more painful during the process."

Additional research is ongoing and may find a permanent home, the Center for the Study of Spirituality, Trauma, Loss, and Violence to be located at Loyola College in Maryland and focus on the importance of spirituality in healing, clinical programs, and provide education and training.

While acknowledging that these brief interventions cannot completely heal survivors of sexual abuse, she does think they can be an important adjunct to other therapy. ■

Emotional Abuse Increases Risk of Mental Illness, Substance Abuse

BY JOYCE FRIEDEN
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SCOTTSDALE, ARIZ. — People who are emotionally and physically abused by their intimate partners develop more mental illness and substance abuse than those who are only physically abused, Susan Ditter, M.D., said at the annual meeting of the American Academy of Psychiatry and the Law.

"Emotional abuse is not well studied, [but] it precedes and predicts physical aggression in marriage," said Dr. Ditter, a forensic psychiatry fellow at the University of Virginia, Charlottesville. "It can occur without physical abuse, but the converse is rare."

She and her colleagues looked at data from the National Violence Against Women Survey, a random-digit-dial phone survey of households nationwide. The survey, conducted from November 1995 to May 1996, included responses from 8,000 men and 8,000 women, all aged 18 years and older. All respondents were either currently married, formerly married, or in a cohabiting heterosexual relationship.

Dr. Ditter and her associates distinguished between two subtypes of emotional abuse: verbal abuse, which involves verbal attacks and degrading behaviors, and power-and-control abuse, in which the victim is isolated and forced into traditional sex roles. They found that 25% of men and 27% of women had experienced verbal abuse, while 12% of men and 20% of women had experienced power-and-control abuse.

The risk of emotional abuse increased in low income, less educated, uninsured, unemployed, divorced, or single people, Dr. Ditter said. Widowed men were at higher risk for emotional abuse than widowed women.

The researchers also found that those who had experienced emotional abuse along with other types of intimate partner violence had more depression, serious mental illness, illicit drug use, and antidepressant treatment than those who experienced the violence without emotional abuse.

Overall, men were more likely to experience only emotional abuse than were women, while women experienced more power-and-control abuse along with other types of partner violence. Men who experienced only verbal abuse were much more likely to carry a gun for protection (adjusted relative risk, 4.77) than were women in that category (aRR, 0.22), Dr. Ditter said.

There were several limitations in the study, according to Dr. Ditter. She noted that it was a cross-sectional survey, so causation could not be assessed. In addition, the emotional abuse measures were not widely standardized for reliability and validity, and there were limited measures for mental health history and treatment.

Other studies support the harmfulness of emotional abuse. One study found that 6 months after leaving their partners, all of the 25 emotional abuse subjects studied had three sequelae of "battered woman's syndrome," including trauma symptoms, low self-esteem, and a paradoxical attachment to the former partner. In another study, victims of even severe intimate partner violence reported psychological humiliation as their worst battering experience. ■

Patterns and Location of Bruises Can Suggest Physical Abuse

Bruises that occur in nonmobile infants, those over soft tissue areas, and those that carry the imprint of the implement used or multiple bruises of uniform shape could be signs of physical abuse.

That is the key conclusion from the first-ever systematic attempt to answer the question "what patterns of bruising in childhood are diagnostic or suggestive of abuse?"

For the study, Sabine Maguire, M.B., and associates at Cardiff (Wales) University examined 23 studies on the topic that were published in the medical literature from 1951 to 2004 (Arch. Dis. Child. 2005;90:182-6).

They ranked the study by design and definition of abuse used and excluded review articles, expert opinion, single-case reports, and studies that failed to define abuse and addressed medical conditions that predispose children to bruising.

The investigators found that bruises in nonabused children tend to be 10-15 mm in size, sustained over bony prominences, and located on the front of the body, typically the result of a fall. The prevalence of bruising in babies who are not independently mobile is less than 1%. "Around 17% of infants who are crawling or cruising have bruises, whereas the majority of preschool and school-age children have accidental bruises," they wrote.

They listed the following patterns of bruising that suggest physical abuse: bruising in children who are not independently mobile; bruising in babies; bruises that are seen away from bony prominences; bruises to the face, back, abdomen, arms, buttocks, ears, and hands; multiple bruises in clusters; multiple bruises of uniform shape; and bruises that carry the imprint of the implement used or a ligature.

"When interpreting the significance of any bruising, it is essential to evaluate the full clinical and social picture and note the developmental level of the child," they said. "All bruising must be interpreted in the context of the explanation given."

In a related study, the same investigators searched the medical literature to determine if it is possible to tell the age of a bruise in a child (Arch. Dis. Child. 2005;90:187-9). Dr. Maguire and associates identified 167 studies but only used three in their assessment. It was concluded that it is not currently possible to "accurately age a bruise from clinical assessment. Any clinician who offers a definitive estimate of the age of a bruise with the naked eye is doing so without adequate published evidence."

—Doug Brunk