Spiritualized Therapy Helps Sex Abuse Survivors

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

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-dig it dial phone survey of households nationwide. The survey, conducted from 1995 to May 1996, included responses from 8,000 men and 8,000 women, all aged 18 years and older, who 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, unmarried, 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 other antidepres sants than those who experienced the violence without emotional abuse.

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 had three sequelae of “abandoned woman’s syndrome,” including trauma symptoms, low self-esteem, and a paradoxical att atchment to the former partner.

In another study, victims of even severe intimate partner violence reported psychological humiliation as their worst battering experience.

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, seri ous depression. All had severe PTSD.

The women filled out five questionnaires at baseline, after session 4, at the end of the intervention, and 2 months later. They conducted from November 30, 2004, to April 1, 2005, by workshop participants.

The program was manualized, individual sessions are 1 hour each, and the total group conducted from November 30, 2004, to April 1, 2005, was 8 weeks.

Each session focuses on a specific aspect of spirituality and its relationship to childhood sexual abuse.

Dr. MURRAY-SWANK

Each session focused on a specific aspect of spirituality and its relationship to childhood sexual abuse.

B RUES that occur in nonmo bile infants, those whose soft tissue, 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 reviews, articles, expert opinion, single-case reports, and studies that failed to define abuse and addressed medical conditions that may 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; bruising in babies 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, either by examining the naked eye is doing so without adequate published evidence.”

—Doug Brunk