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 pilot study.

The 8-week program of manualized, individual sessions offers the kind of experience many abuse survivors never encounter through 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 Nicole 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. Any abuse can cause thoughts and images of spiritual abuse to pop into awareness; 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.

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 in the Maryland, abbreviated version). They also filled daily symptom logs measuring psychological and spiritual distress, positive and negative coping, self-worth, sexual problems, trauma symptoms, and body image.

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

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BY JOYCE FRIEDEN
Associate Editor, Practice Trends

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 coexists 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, 4.7) 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 attraction to the former partner. In another study, victims of even severe intimate partner violence reported psychological humiliation as their worst battering experience.

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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 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. 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 in the Maryland, abbreviated version). They also filled daily symptom logs measuring psychological and spiritual distress, positive and negative coping, self-worth, sexual problems, trauma symptoms, and body image.

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