inSocialWork Podcast Series

Episode 43 - Dr. Sharon Bowland: I Believe, But Will It Help?: Spirituality and Recovery from Interpersonal Trauma (part 1 of 2)

[00:00:08] Welcome to living proof a podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. Were glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to tell you about a new feature of living proof. In addition to listening subscribing to and sharing podcast you can now rate and write a review of each episode of living proof to rate or write a review of a podcast. Just go to our Web site at www.socialwork.buffalo.edu forward slash podcast and click on. Create your own review button. We look forward to hearing from you. Religion Spirituality the church from are refuge a guide pro-life their core meaning. But what about those who have experienced interpersonal violence such as physical abuse sexual abuse domestic violence or abuse and childhood to forgive and forget to walk away from your faith or spirituality a source of resilience. Today's guest took a look at the issue but the Sharon Boewland is a licensed clinical social worker and assistant professor at the Raymond Kent School of Social Work at the University of Louisville. Her research interests include violence against women spirituality religion and mental health and translation a research into practice. In this first of two podcast Dr. Bowland discusses her study on the effects of a spiritually based intervention on recovery among older women who have experienced interpersonal wilens. In today's episode Dr. Bowland discusses the quantitative results of hermit's method study.

[00:02:08] Dr. Elaine Rinfrette licensed clinical social worker and adjunct professor at the University at Buffalo School of Social Work spoke with dateable and by telephone this morning I'm happy to introduce Dr. Sharon Bowland from the University of Louisville who is going to talk about her study and the evaluation of spiritual intervention with older adults survivors of interpersonal trauma. Thank you for agreeing to do this podcast Dr. Bowland. I'm happy to be here. Well I think the first thing I want to know is how did you become interested in working with older women survivors who have a history of interpersonal trauma and their spirituality. Well before I went back to get my doctorate in 2002 I was in clinical practice for many years I worked at several kinds of agencies I've worked it up sexual abuse treatment center I worked at a pastoral counseling center. I worked in private practice. I worked at a couple of other community mental health centers. And repeatedly I found that I needed to have a lot of knowledge about trauma survivors and how to work with trauma because there were so many people presenting themselves for treatment that had a history of childhood abuse sexual abuse domestic violence sexual assault. So this became a clinical focus for me and for many years I also ran a lot of groups for survivors. Adults are molested as children. A Mac and a hand. So it's kind of a long term 25 year journey for me.

[00:03:40] And in the process of that many times people would talk about their spirituality as something that was challenging for them perhaps they had had experiences within the congregation that were really supportive or conversely really negative they had experienced pastors telling them priests pastors telling them that they needed to forgive the person who'd harmed them. I found that there were a lot of problematic responses and also that spirituality became a real source of support and meaning for people as they were trying to recover from experiences of interpersonal trauma defining interpersonal trauma here as experiences of child abuse that could be physical abuse sexual abuse emotional abuse and then adult trauma such as intimate partner violence domestic violence and sexual assault. So kind of the range of experiences that people have and many times women that came to my office were victims of survivors of multiple types of trauma over the course of their lives. And in working with women 45 and older women who were past childbearing years and who were in relationships I found that many of them had lived in chronically abusive relationships or that they again had experienced multiple trauma. This was something of interest to me and I was

also interested in how spirituality again was a source of resilience for women a place of a kind of protective factor a place of resilience that seemed to support them in their recovery or they could be in conflict with their religious beliefs their religious practices their traditions may not have given them the resources perhaps that they needed to move forward in their lives. So it's interesting that our clinical paths are in parallel and that I also experienced some of the things that you found in your clinical practice. So I'm wondering when you worked with older adult survivors how did they define spirituality.

[00:05:53] Well I had actually done some work with women in my study around this to find out how they were defining spirituality. My attempts to try to talk to people just on the street or to interview people about it. It was hard for people to talk about it. If you asked them the question. But the themes emerged in the therapeutic encounter or they emerged in the group encounter with my research. People would spontaneously talk about how they experience their spirituality. My thinking is that a lot of older women are involved in some kind of congregation that they tend to be more traditional in their religious practices. And I think the younger generation feels more permission to pursue alternative kinds of ways of being connected to community. But but older adults seem to be interested in pursuing continuing to be in congregations that they grew up in or that they began with in early adulthood. So let me just ask you to be sure I understand when you're talking about older adult women about what age range are you talking about. Well the women in my study were 55 and older. I'm thinking about women 45 to 50 and older women who have moved beyond the childbearing years and I make that delineation because I think a lot of the research on violence against women is really focused on women of childbearing years. And so there's a real dearth of research on older women and older women's issues and we don't really know what happens so much to women who are beyond the age of 45. WILKI and Venton did some research using the National Violence Against Women data. This is a national survey.

[00:07:38] 8000 people survey and they discovered that older women actually had higher rates of current abuse and that they had more mental health issues than people younger than them. So what we began to see here is the possibility of cumulative effects based on a lifetime of different types of events. What would you say are the more common types of trauma related experiences for this population. Well I would say that again I think we don't know very much about this population. But for instance there was a study done by fall that she basically found that 72 percent of a community's sample of women now she had a small sample. Hundred women had experienced some type of violence or abuse. I think a lot of women are living in chronically abusive relationships with partners that they did not leave and that turned out to be true. In my study the sample there 30 percent of the women were in relationships that they had over a long period of time and at some point those relationships may have been physically abusive. Currently they were emotionally abusive or psychologically abusive. I didn't work with anyone in my study who was in an acute need of services. But what I found is many of these women from that earlier cohort time period did not leave those relationships. They stayed in them whereas women who are younger tend to leave relationships so I think there's a lot of the abuse that happens in marriages in relationships with older women and their partners. I'm interested in how you recruited this sample.

[00:09:11] Well the sample was a community sample and I originally started by putting out flyers in the community and some of my colleagues were concerned that I wouldn't get anyone for the project because older women are less likely to seek psychological help particularly on taboo topics like trauma which sometimes people avoid talking about. So I was concerned they were concerned. I went to the Life Long Learning Institute which is older adult educational program through Washington University. I had flyers that I posted on the Alzheimer's Association Web site thinking that there might be some caregivers out there who had had a history of abuse and might be interested in talking about it. I had some response from those sites and certainly from some of the flyers that I've handed out to people in the community. But the main source of recruitment turned

out to be through volunteer list at Washington University Hospital. They posted the study on a poster and moved it around the hospital that's one way that they advertised some of the research is being done. And there was a volunteer list of thousands and thousands of people who said Call me if there's some research I may be interested in participating. So I sent flyers and make phone calls a problem to over 2000 people to find women who are interested in participating in the study of course what I was doing was trying to find women who had had these kinds of life experiences. Plus women who were in spiritual distress women who had spiritual issues or struggles that they were trying to come to terms with who were open to talking about their spirituality. In this case I decided to recruit people who were a Christian background. We did some hard thinking about how do we limit this group to Christians. Do we mix the group in terms of faith backgrounds.

[00:11:09] We decided that the best way to go was to have the group be homogenous at least somewhat homogenous. I think Christianity has a quite a range of different types of Christians but at least people would relate to some of the New Testament scriptures. Whereas it would be more difficult for for instance Jewish women to relate to New Testament scriptures and if that became something people were talking about in some kind of way that would be harder so that we decided to go with that kind of homogeneity in the group. And so women weren't necessarily may currently practicing Christian but they had had some experience in the Christian tradition. And we also decided against having people in the study who were in therapy. That was challenging. I turned away a number of people who were in therapy and who wanted to be in the study but couldn't qualify because of that exclusion criteria other criteria were finding people who could participate in an 11 week group. A lot of research shows interventions that go for six weeks as a new researcher. It was really clear that there's a reason for that because it's hard to get people to make a commitment for 11 weeks. However the women in this study did that and followed through with that. I said 11 or 12 week group because I think someone who has worked with a lot of groups it takes about 11 or 12 weeks to really go through a cycle of kind of stages of group development. And so you want to allow for that. So there was a theoretical reason why a kind of experimental reason why I thought that kind of model would work.

[00:12:46] And the intervention that I found which I gratefully been able to use was created by someone who also had similar experiences. That's Roger fallot. He's collaborator and he's in Washington D.C. and Roger works with trauma and does research in the area of trauma that he developed he was working with Maxine Harris. They developed a model called trem trauma recovery and empowerment model. And that was a 33 session model that's been published basically using cognitive restructuring and skill building and psycho education to help survivors recover from experiences of trauma. So in addition to working with a case manager at the Community Connections agency in Washington D.C. survivors also participate in the trem groups and the population at that agency which is a Lutheran Social Service Agency is largely women who are on the streets they may be homeless. They have drug addictions. They're recovering from high rates of violence in their lives. So this is a population with a lot of difficulty with severe mental illness. So very much in need of anything they can get the people at that agency and I think about 85 percent of the survivors there were African-American asked the administration there to specifically focus on spiritual issues in recovery. And they developed an 11 session group. And it's that group that 11 session group that I tested in my research project that's the model similar to the trend model in cognitive restructuring psycho education and skill building. Were you the first one to use an 11 session model they had used it a couple of times and the agency that they had not done research with it.

[00:14:32] So Dr. Valot graciously agreed for me to do the research with it in another setting. So that's how I came to connect with that I know about Dr. ballot's work because he was very interested in trauma recovery and in spirituality as a part of recovery some trauma and also working with women and men who have mental illness. So again people that are really struggling and have

major major mental health and psychological issues. That was a great opportunity for that opportunity. Yes yes it was. I guess I saw immediately the value of what he was doing because in a sense the model is it's very elegant and it's simple. And that is that the person facilitating the group moves into a kind of psycho educational place at the beginning at the group by sharing information about a topic that might be anger or it might be spiritual coping but using kind of research what do we know about these topics five or 10 minute lecture and then people talk about their experiences of anger or their experiences with spiritual coping and then perhaps discuss things from their religious background that either help a person cope with anger or may make it harder to deal with your anger. For instance in the groups a lot of messages that came forth were about how one is supposed to be angry. Could that be a problem in trauma recovery. Well yes because we understand that part of the process is becoming angry. There is a place for self righteous anger and that that if you're reading a scripture for instance or holding onto a scripture that says turn the other cheek. That that could become problematic. It may in a sense.

[00:16:26] BLOCK Your capacity to feel ok about being angry. I'm wondering also you had literally hundreds of potential participants but for various reasons some were not able to participate so how many did you finally wind up with in your sample. I wound up with 43 people and I would say that a number of people said oh again you know I spoke to probably close to 2000 people that people said always my spirituality has been very important in my recovery and I've worked through my struggles and I'm in a good place with it. Some people said I don't have any kind of spiritual connection at all. But many people said yes I I have a spiritual connection and I'm I have worked through these issues. So there were people that had found some kind of solace in their spiritual life found it to be a Kenyan recovery. So that was very interesting just the spontaneous kind of response. As I was going through the interviews with people where the types of trauma that the participants in your study had similar to what you described already or were they different or what types of trauma did they have. Well I was looking at. Of course there were traumas that we didn't measure one person's father committed suicide. And while she didn't witness that it was extremely traumatic parents who were kind of emotionally abusive even to their adult children. So there were things that we didn't necessarily look at we asked people specifically about their emotional abuse their childhood physical or sexual abuse their sexual assault or their domestic violence. So we did include emotional abuse in there but these were the specific things we were looking at in this study.

[00:18:08] Basically in looking at the whole sample of 43 98 percent 42 out of 43 reported multiple types of interpersonal trauma. So more than one type of category and 100 percent reported emotional abuse in some form. Most of the time it began in childhood. Seventy percent had childhood physical or sexual abuse 49 almost 50 percent had experienced a sexual assault or attempted assault. And 77 percent of the sample had experienced domestic violence. So the rates of interpersonal trauma were extremely high. It was shocking to me this was not a clinical population. Now I can say that many of the women had been in therapy at some point in their lives. They had been in some kind of psychotherapy. But another interesting finding from the study is that not many people talked about their abuse while they were in there. Again when we think about the timing of this it might have been a time before we were talking much about abuse and violence. A lot of times we didn't start doing that really till the 70s or 80s really the 80s. And prior to that if you were having marital trouble or family trouble the focus might not have been at all on any kind of trauma or traumatic experience. That was their experience. They reported they didn't talk about it. The other thing thinking about distress and spiritual distress because again we asked them Are you in a spiritual distress. Yes or no in relation to these particular types of what we consider to be distress. Do you have difficulty forgiving yourself. Well 91 percent of the sample 39 women said yes. Difficulty forgiving others.

[00:19:53] 84 percent said yes feeling alienated from spiritual self. 65 percent said yes feeling alienated from religious communities. Sixty three percent said yes feeling abandoned by God.

About 50 percent of the sample said yes failed. Community support. In other words someone said I'm having a lot of difficulty and so they approach their pastor their priest or someone in their congregation to try and talk about their abuse and try to get support for that. So that's failed community support. Forty four percent said yes they had experienced some type of failed community support. And then lastly 37 percent said they felt punished by God. So this again is the same sample and you could see that there are different types of spiritual distress that reported. And certainly there are other types of distress that this is that these are the types that we were looking at in the study and they're quite high. And again I recruited people who were who thought they had the spiritual some kind of spiritual struggle going on and who clearly felt they had some continuation of previous symptoms or difficulties related to previous abuse. So these were women who thought they could benefit from talking about their spirituality in a group with other women talk about their experiences within their religious faith or felt that they were willing to talk about their abuse at least at some level the focus of the intervention by the way isn't really talking about your abuse.

[00:21:23] It's much more focused on again this kind of elegant sense of talking about places that you struggled kind of the consequences of abuse like anger or depression and then talking about places that you've struggled in terms of your spiritual life and then talking about resources that might build off of that or move beyond this kind of conflict into some place of peace or acceptance or finding something something that you can hold onto in your religious faith or in your or your personal practice that would be helpful. You know it's interesting when you say that many of these women even though they've been in therapy had never talked about the issue of abuse and that talking about those kinds of topics is relatively new. And I also think from experience and I don't know if you agree that until recently clinicians weren't very comfortable asking clients about their trauma histories or their spirituality histories and that without that kind of permission. These women certainly weren't going to own up to any of those problems so that I think that they stand to reason that at least some of them would be interested in this opportunity to do so. Well I had been in a child sexual abuse treatment center and working with families and children in the late 70s early 80s. This particular treatment center was in Illinois was the first treatment center in the state of Illinois. And I was really aware that these topics were totally taboo. Prior to that in the 80s I think brought about a change of some kind with that. I do think that women were looking for an opportunity. In fact they said people said repeatedly this is the first time I had an opportunity to do this. One woman came from 60 miles away. She was living in a rural area and said I can't talk about this in my small town.

[00:23:16] I need a safe place and so I can I'm coming here to do that. And she would travel every week the 60 miles to get to talk about this in the group and had never told anyone at around town what had happened. So but other women too said I haven't had a chance to talk about this. And particularly they said I've never would have talked about this in my congregation. There's never been an opportunity to talk about my spirituality to talk about how my spirituality might be helpful in my some of the challenges I've faced in my life that this was bringing you together. Two things in their lives that they hadn't seen anyone else attend to and yet creating a sense of community and in the process of that seemed meaningful for a number of women. I'm sure it did. Could you say a little bit about what you measured in your study and how you did that. Sure. We really didn't know how this intervention would work if it would work what it might be effective in reducing symptoms. What kinds of symptoms that might reduce. I think part of it is is that there just isn't much research out there on spirituality particularly not randomised control trials in terms of an intervention with looking at a connection between mental health and spirituality. There's a lot of talk about it. There's certainly cross-sectional studies that show some kind of correlation. For instance Heckman and fallot again my colleague Dr. fallot found that in a sample of trauma survivors negative variances were correlated with global distress depression. And certainly that there's some kind of correlation that holds up there.

[00:25:04] We've found that being a part of a congregation may be protective against mortality and we're not sure exactly whether attending a religious congregation or religious services means there could be a lot of things in that that really are kind of the mechanisms that make that correlation happen. But what we're trying to tease apart what is it about spirituality and particularly the struggles around defining spirituality has been challenging. So in this study we were looking at depression. We were looking at anxiety and PTSD post-traumatic stress disorder. And the reason that we were doing that is that those are the types of outcome measures that that people look at when they're looking at trauma and people experiencing trauma. When I look across a lot of different studies those are those are very common kinds of measures outcomes symptom outcome measures so that we call those trauma laded symptoms. I looked at somatic symptoms and spiritual distress. When we had a measure of spiritual distress that we put together using several subscale from other measures and spiritual well-being. And then the other thing was religious coping. So the measures were the geriatric depression scale the back anxiety inventory the the PTSD scale the post-traumatic the diagnostic scale the health Gaile was the ph. Q 15 spirit of the stress was measured by putting together some questions on forgiveness. Some questions on interpersonal religious discontent from the are cope with the scale on kind of your relationship in a congregation with clergy and with the congregation and then on the spiritual assessment inventory which was looked at your relationship with God and your spiritual maturity.

[00:27:02] So these were things that we looked at particularly in that dimension your relationship with God your relationship with the congregation and forgiveness. Those were three dimensions. We looked at in terms of distress and spiritual well-being as a scale that's been been used a lot in spiritual spirituality research. So we thought we'd look into see if there were any kinds of changes in the spiritual well-being in the course of the study religious coping as a newer measure. It's been developed to look at negative and positive aspects of coping we can think of coping as a positive event in terms of what you might say to yourself appraisals if you will to get through difficult times. One kind of appraisal might be something like God is my friend God is my partner. So a sense of a collaboration between you and God or sense that God is working for good in the world. These are types of appraisals and attributions that we call positive coping positive spiritual coping positive religious coping. There are other kinds of appraisals that are more negative things like God is punishing me. We still have a relationship with God. But it's more negative. God is abandoning me. God doesn't care about me and the world and what's going on in the world. Those are appraisals that may help you get through in a certain kind of way but may also. So we call it coping but it's it's really more like spiritual distress or spiritual issues spiritual struggle. So you're having a sense of abandonment you're having a Spens sense of kind of the negativity of God coming through in your life.

[00:28:42] This was something again that fallot and Heckmann found were significant in their work with trauma survivors and that with larger studies that they did that correlation between the negative ways of coping and higher rates of mental health issues. So those are the measures we looked at so we were looking at a number of different outcomes. We didn't pick any one target as a target outcome is something we thought specifically we were just doing this more and a more exploratory way just because of that. One of the things we did to control over all the testing was we conducted a Minova as a way to kind of control for all the tests that we were doing so we did that one test to control for that. The measures hold up in terms of the Chron backs alphas. They were all acceptable on all the measures. And so from that perspective it appeared that we were measuring they were holding together they were correlated. So that worked out okay. I didn't have any dropouts in the experimental or control groups during the initial condition of the assignment. So in mice in the way that I set this up I had some people who were in the control group 22 and then 21 and that in the treatment group. Then when they finished the study the people in the control group went into a delayed treatment group. So in the end I had about 36 people who went through the the whole the treatment itself the quantitative findings are based on the 43 people that were in the initial control

and treatment conditions. There were a couple of women who didn't complete eight sessions which we describe as the kind of the baseline for being called a treatment completer.

[00:30:27] But there are post tests were included in the testing and some were looking from pre to post test and then we did a three month follow up. What happened in the outcomes was this is that there were significant drops in depression post-traumatic stress and anxiety for the treatment group but not for the control group. What I can also say is that to begin with there were not any significant differences as they were randomized into treatment and control there were no significant differences between the groups at pretest so they were essentially equivalent and at post-test the treatment group had dropped significantly on all three of the mental health outcomes and they had dropped on the spiritual distress scale and on the our Cope religious coping had increased and spiritual distress a spiritual spiritual being had increased. Those were all positive kinds of outcomes of the study. Additionally the physical health outcomes had also improved. There was a two point drop in the somatic symptoms two points meaning there were two fewer somatic symptoms and post-test. I can't say that it was statistically significant. I can't say that it's clinically meaningful to say two point drop but that means but I can't say that it moved people from a mild symptom level to a 2 below the mild central symptom level. So it actually put them into a different category because 10 to 15 was mild symptoms. There was a shift in positive ways for women in the study. Would you talk a little bit about any limitations you had in your study. Yeah there were definitely imitations in the study I had as a P.I. I recruited women I did a phone screening.

[00:32:18] I did the clinical interview and I did the intervention. I did have co-facilitator and all of the the six groups that I ran I did not do the testing I hired doctoral students to do the testing so I did not participate in the testing but that is a limitation it's wearing many different hats and there's some question as to whether women could be biased based on my participation in their awareness of me in terms of they might want to see a positive outcome. So essentially they could have skewed the results by putting in answers that weren't realistic for their circumstances. However I did look at all the tests and there was one woman who had lost a job during the time that she was in the group and her scores went down. And another woman who had a major mental health crisis particularly related to her housing during the study and her scores went down. So there were indicators that women were being honest in terms of their experiences and the group effect sizes were medium to large depending on the outcome probably have the largest effect size for depression and for spiritual well-being. Those were probably the most you've been listening to Dr. Sharon Bowland and discuss her research on spirituality and recovery from her personal life. Let's look for a second part of this podcast in which Dr. Bowland discusses findings with a qualitative portion of her study. Thanks for listening and join us again next time for more lectures and conversations on social work practice and research. Hi I'm Nancy Smyth professor and dean at the University of Buffalo School of Social Work. Thanks for listening to our podcast.

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