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Community reintegration for widows suffering religious minority violence: personalism as therapy[1]

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Abstract

Each year around the globe millions of people experience religiously motivated, traumatic violence. In the absence of assisted care those affected often suffer permanent psychological impairment, failing to reintegrate successfully into stable self-subsistent communities. We report here on the success of a personalistic therapy used to assist community recovery in a dispersed widow population suffering religiously motivated violence. In 2008, Orissa Hindu nationalists blamed local Christians for their leader's assassination; the subsequent retaliation led to murders, destruction of churches, schools, homes, and physical assaults. Subsequent recovery efforts were premised upon a psychotherapeutic restoration keyed to a personalistic, Catholic/Christian psychological framework (Vitz, 2011) as a necessary contingent for community reintegration and economic self-sufficiency. Assaultive trauma, personal valuation, interpersonal psychosocial functioning, agency, and sense of trust in committed care were monitored. Our results indicate, among others, that self-valuation generally paralleled growth in trust commitment, but the latter depended on the perception of the caregiver's commitment to faith values. Therefore, we propose an assault recovery model in which self-esteem and trust in committed care are constructed through the perception of a personalistic commitment grounded on faith values.

Keywords: Personalism, religious violence, therapy, faith values

1. Introduction

Each year millions of people around the world suffer assault trauma, including military combat, terrorist attacks, criminal activity, and physical violation. Increasingly prevalent is the experience of religiously motivated assault, particularly in intersectional regions such as Africa, the Middle East, Asia, and even Europe. Last year the PEW Forum recorded major religiously motivated incidents in more than 139 countries, with 124 in which governments themselves perpetrated violence (Grim, 2011). Reuters documented nearly 100 million Christians, for example, who were persecuted either through direct or indirect intimidation (Heneghan, 2013). Of these, nearly 100,000 lost their lives, a pattern that has reoccurred each year over the past decade. Large numbers of Muslims, Jews, and even Hindus and Buddhists have likewise suffered persecution.

While physical assault is the most easily seen form of violence, it is undeniable that trauma victims also suffer from substantive, adverse psychological consequences (Miller, 2002). The psychological impairment of trauma is often severe and may persist for years. Moreover, post traumatic circumstances, such as the loss of loved ones, or a host of nonspecific stressors, may exacerbate symptoms, complicating personal and or assisted recovery efforts (Samuels-Dennis, Ford-Gilboe, Wilk, Avison, & Ray, 2010).

Assaultive traumas include discrete and/or enduring offensive physical encounters that precipitate a state of intense fear, apprehension, loss of control, and/or powerlessness in the victim. The resulting psychological trauma may assume a variety of forms and take on numerous sequelae. Although physical injury or harm may accompany psychological trauma victims are often unhurt physically. The most widely used definition of psychological trauma, developed by the American Psychiatric Association

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Diagnostic and Statistical Manual of Mental Disorders V, is the direct experiencing or witnessing of life threatening events or violation of bodily integrity, and a subjective reaction of extreme fear, helplessness, or horror. By this definition, psychological trauma would include a range of events and experiences that may display widely varying specifics but have the common feature of exposure to the reality or threat of death or bodily violation thereby evoking emotional terror.

Given the acute and chronic character of the experienced trauma, with its plethora of cognitive symptoms, recovery efforts have explored a number of different approaches to assist in the recovery of victims as a prelude to social and economic self-sufficiency (Harney, Lebowitz, & Harvey, 1997). Due often to limited resources, recovery efforts seek to identify key psychological symptoms prevalent in the victim population, and to provide targeted therapy for the alleviation of the most acute symptoms. While targeted therapy and delimited constructs offer the practitioner a well defined scope and the opportunity to prioritize the redress of acute symptoms, focused intervention is unlikely to address the broad spectrum of behavioral outcomes which are invariably linked to assault trauma. Given the essentially interdependent character of the human psychological framework, and the perpetrator intent of fostering maximal psychological debilitation, consideration may need to be given to more global constructs operative in the psychological spectrum.

In this paper we explore a therapeutic approach premised on the Catholic/Christian model of the human person (Vitz, 2011) for a widow population suffering religiously motivated trauma. According to this anthropology the human person is constituted in the image of God, thereby possessing an intrinsic value, and called to live in loving communion with Him and other persons. He is multidimensional, with capacities operationally functional at the cognitive/rational, sensory/perceptual, and biological levels. These dimensions include four principal domains: the interpersonal, rational, volitional, and bodily. We propose that violent trauma negatively impacts these domains, thereby generating adverse psychological symptoms. Accordingly, a major premise guiding the therapy reported here was a perceived weakening of the victims' psychological constitution in these areas. Recovery efforts employed a personalistic therapy whose experiential features were intended to redress the integrity of these domains through a restructuring of integral self worth, interpersonal communion, and volitional freedom.

To our knowledge this study constitutes the first to examine the recovery process based on a personalistic therapy aimed at global psychological constructs for victims of terror. The restoration of trust, interpersonal support networks, and self initiated economic activity observed in this study testify to the future value of contextualizing care within a comprehensive framework that values the personal dignity of the traumatized victims.

2. Methodology

2.1 Participant

A group of about 80 widows, drawn from a population of 55,000 affected village Christians from the Indian state of Orissa, participated in the study. Orissa Christians comprise less than 2 % of the local population, the majority religion that of about 80% Hindu nationals. A majority of the remaining population consists of Muslim adherents. The Catholic Church exercises the dominant organizational influence amongst Christians, with local ministries directed from its diocesan center at Kandhamal. A number of Catholic religious orders and institutes, with international affiliation, including the Divine Word Missionaries, Vincentian Fathers, Sisters of St Joseph of Annency, and the Daughters of Charity also minister to Christians living there in collaboration with diocesan personnel. Sisters of St Joseph of Annency, a French religious order devoted to care of Christians in underserved regions, assisted in the administration of therapy and the data collection for the study. Religious order members participating in the care of the widows were graduates of professionally administered sociology programs.

Reporting data were obtained after the widows had made significant recovery, roughly three months after the onset of microeconomic initiatives (below). Data were based on a questionnaire format with answers provided by widows, and by sisters' recollections of conversations with widows, at each of the following phases of the study: 1) the initial period of assessment and onset of care, 2) an intermediate period in which a majority of widows (>50%) demonstrated improved participation in community social structures, and 3) a final interval in which a majority of widows (>50%) initiated participation in community micro economic assistance programs. Measuring instruments were modified to accommodate the transition in recording time.

2.2 Procedures/Visits and Therapy

Following an onsite psychological evaluation sisters established proximate quarters for easy access and frequent visitation. Widows were visited daily. Each visit combined 1) a period of personal validation, that included listening, recollection, and

prayer, and 2) a period of living assistance, in which medical, educational, or physical assistance was provided. With increase in trust the period of validation was extended to include counseling related to the terrorist events. After the widows had improved significantly visitations were undertaken twice weekly.

2.3 Measures

Anxiety/Fearfulness. Symptoms of fear included verbal and emotional distress as well as physical symptoms accompanying recollection of trauma including unsteadiness, shortness of breath, unusual body sensations, and the like. Symptoms were readily observed at the onset of care and detailed over the course of recovery.

Severe anxiety/PTSD symptoms. Traumatic stress syndrome (PTSD) and trauma anxiety were assessed using a modified CAPS -1 instrument (Blake, et al., 1995). Seventeen items from the instrument were included. Intensity and frequency of occurrence were separately monitored and scored on a Likert scale from 0 to 4.

Interpersonal and psychosocial functioning. A modified Adolescent to Adult Personality Functioning Assessment(ADAPFA) instrument was used to assess psychosocial functioning (Naughton, Oppenheim, & Hill, 1996). Three social parameters were assessed: 1) family and friends, 2) community, and 3) non-specific social contacts, such as those involving strangers. Ratings were obtained independently for frequency and severity and scored on a Likert scale. Items included 1) feelings of estrangement or detachment from others, 2) restricted range of affect, 3) exaggerated irritability with others, 4) significant restriction of social functioning, and 5) emotional unresponsivity.

Personal volition. Personal agency was assessed using a modified Pearlin and Schooler Mastery scale (Smith et al., 2000) and included a) basic needs, b) establishing social contacts, and c) negotiating participation in community structures. Items were scored and summated as above.

Trust in relations. Assessment of trust had three dimensions: perception of 1) the sincerity of the intentions of the caregivers, 2) the capacity to effectively assist recovery, and 3) the caregiver's commitment to values that affected the sincerity of their intentions. Scaling ranged from a value of 0 (do not trust) to a value of 3 (exceptional reliability). Five items were scored: 1) Sincerity of expression, 2) sacrificial commitment of time and safety, 3) capability of providing assistance, 4) willingness to overcome significant difficulties to help, 5) perception of the caregiver's commitment to personal religious values.

Self esteem. Measurement of self-esteem employed a modified Rosenberg self-esteem scale (Robins, Hendin, & Trzesniewski, 2001)

Statistical analyses. Item summated values for Likert scales were analyzed using SEM and normalized as a percentage of the maximum obtained value. Significance determinations employed the p test. Multiple regression analysis was used to obtain zero correlation coefficients for model structuring (Draper & Smith, 1966).

2.4 Model

The current study was undertaken to assess the efficacy of assisted trauma recovery as referenced to a holistic and

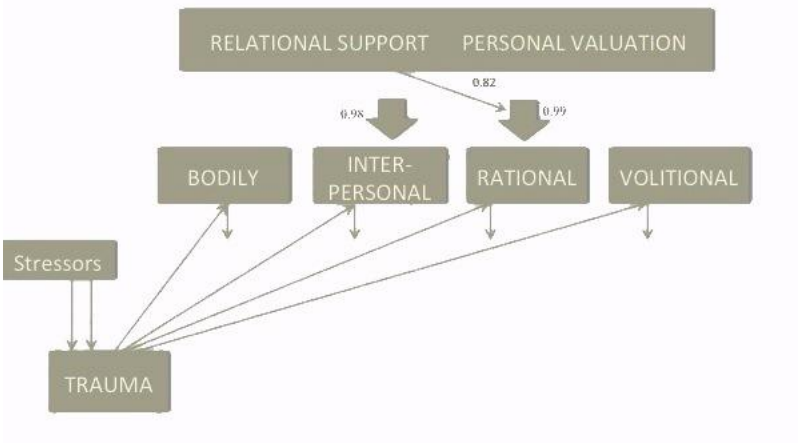

Figure 1. Catholic PP model for trauma and recovery

Figure 1. Catholic personalistic psychology model (Catholic PP model) showing trauma impact and recovery. Anthropological framework constructed from four principal domains. Assault trauma is shown having negative impact. Personalistic care is targeted to interpersonal and rational domains. Zero correlation coefficients are presented for interpersonal and rational/self-esteem pathways. Correlation coefficient for impact of relational support on rational domain is shown diagonally.

personalistic, Catholic/Christian psychological framework (Vitz, 2011). The model purposefully situates the victim within a comprehensive anthropological schema that identifies 1) the projected recovery level for each major domain, and 2) the extent of deviation from these projections. A critical theoretical reflection guiding therapy is that the experienced trauma, either directly or indirectly, negatively impacts integral well being, thereby distancing the victim from the respective recovery levels.

Complicating stressor variables are shown as accentuating the severity of impact. Four principal domains are depicted, reflecting the multiple, actualizable features of the human person: his volitional, rational, interpersonal, and bodily dimensions. Emphasis is given to the conception of the human person as situated within a web of relationships, especially those guided by self-giving and self-sacrificial relating. Negative symptoms (Table 1) are directed downward, below each domain.

Table 1. Domain designated negative psychiatric symptoms.

Symptoms	**Domain**
Intrusive trauma recollections	Rational
Distress at trauma reminders	Rational
Difficulty with sleep	Rational
Fearfulness	Rational
Recurrent dreams	Rational
Feelings of estrangement	Interpersonal
Restricted affect	Interpersonal
Diminished interest	Interpersonal
Exaggerated irritability	Interpersonal
Need help with decisions	Volitional
Hopelessness	Volitional
Unable to control emotions	Volitional
Unusual body sensations	Bodily

Trauma victims may move vertically, either downward, developing greater symptom severity, or upwards, for improved positive indices.

Recovery, depicted as vertical ascent, invariably requires external assistance. Trauma victims typically suffer a host of symptoms within each domain due to the perpetrator's intent to intimidate and render powerless the victim. Secondary symptoms, such as social strain, may also present, arising from the initial debilitation. Alleviation of any or all of these symptoms requires external assistance that for the most part is no longer available. Familial and community resources, for example, are regularly destroyed by the perpetrators in order to amplify the impact of the assault. With the emphasis on terror and the infliction of psychological harm perpetrators strike at the value of the individual as a person, and at the resources held most dear, the interpersonal support of family, friends, and belief community. In the wake of assault the victim is left isolated, devalued, and without the personal agency needed to mount self initiated recovery.

It is to this situation that a personalistic approach, premised on the unique value of each person, is especially suited. Hence, the initial aim of therapy is to restore these primary losses within a time frame that can project both consistency and commitment. This enables, also, the construction of an insulating barrier within which the victim can acquire trust and a sense of coherence (Herman, 1998). Figure 1 depicts the process as it is structured and implemented successively during the recovery stages. In recognition of the critical loss of family relationships after the assault it is critical that the victims experience the concern and empathy ordinarily transmitted by family bonds. Accordingly, a caring support system is structured to replace the web of interpersonal relations lost by the victim and in which she previously participated. Communication is facilitated by the common Christian belief of the sisters and of the victims in the love of Christ for each victim who has suffered. This understanding helps to underscore the perception of personal care and empathy.

The catholic personalistic model also highlights the important role of self-value and goodness in each person. The operative premise is that trauma is intended to diminish the value of the victim. Anxiety, thus, reflects personal devaluation. The support system attempts to reverse devaluation by emphasizing the personal worth of the victim in her identification with the suffering Christ. It is important that the caregivers project a sense of indefinite commitment to the victim's well-being and safety, through

assurances, if needed. In effect, the victim becomes aware of being sufficiently valued to warrant an indefinite investiture of the caregiver's care, assistance, and even defense.

Diagrammatically, support for interpersonal relations and self-valuation is shown as being provided from above, and of positively impacting the interpersonal and rational domains of the victim. The model assumes that intervention in these two domains will subsequently and positively impact the domains of bodily well being and of volition, an assumption subsequently confirmed in our analysis (Figure 1).

3. Findings

3.1 Trauma exposure

All widows were exposed directly or indirectly to severe trauma, affecting themselves, immediate family members, neighbors, or clergy (Table 2). All lost their husbands through murder and, in a majority of cases, directly witnessed the incident.

Most were physically assaulted, had one or more children who were, or witnessed physical assault on another community member. All witnessed direct destruction of churches and religious buildings, and in many cases witnessed the physical assault of catholic clergy or women religious. All lost their homes during the uprising. Most were exposed to community wide intimidation, such as slogans, roadblocks, and abusive language.

Post uprising incidents included an exodus to local forests for safety, with little or no provision for shelter and food except that of the natural setting. Widows lived in the forest setting for periods ranging from several weeks to several months before going to government organized refugee camps. Food and water were made available in the camps, but little provision was made for medical assistance. Widows were thus physically weak at the beginning of the period of assistance, two years after the uprising, and typically suffered a range of infections. All were occupants of the refugee camps at the time at which their psychiatric symptoms were first diagnosed.

Table 2. Summary of exposure to trauma incidents

Incident type	**Number**	**Witnessed**
Personal		
Murder of spouse	All	Direct and indirect
Witness to murder	> 50	Direct
Physically assaulted	> 50	Direct
Assault of child or family member	> 50	Direct
Destruction of home	All	Direct
Community/Religious		
Destruction of church	> 50	Direct
Destruction of school	> 50	Direct
Assault of community member	> 50	Direct
Assault of clergy or women religious	> 50	Direct

3.2 Assessments

Longitudinal studies of recovery are shown at three different time points in Figure 2 for the beginning, intermediate, and final stages of the recovery period. Item summated values for negative symptoms in the early period of recovery were significantly elevated. Widows were fearful, particularly of strangers, displayed significant anxiety, and experienced considerable difficulties with trauma recollections. Negative psychosocial variables were significantly elevated, as was volitional weakness. By contrast, self-esteem was significantly depressed. Moreover, trust variables were depressed for strangers, government rehabilitation efforts, and even of church mediated assistance.

Negative social symptoms, volitional weakness, and anxiety fell significantly in the final recovery stage (Figure 2A-C). Percentage changes for anxiety and volitional weakness were greater than those of psychosocial functioning. Notably, trauma

anxiety and volitional weakness remained high in the intermediate stage in contrast to the decline in psychosocial impairment. By contrast with negative symptoms, self-esteem and trust in the caregiver significantly increased between onset and final stages (Figure 2D-E). The increase in self-esteem closely followed the decline in anxiety symptoms, with no statistically significant difference observed between onset and intermediate stages. By contrast, trust in caregivers significantly increased between the onset of care and the intermediate stage of recovery and was directly correlated with the perception of the caregiver's fidelity to faith ideals. Trust in governmental efficacy and assistance remained consistently low throughout recovery.

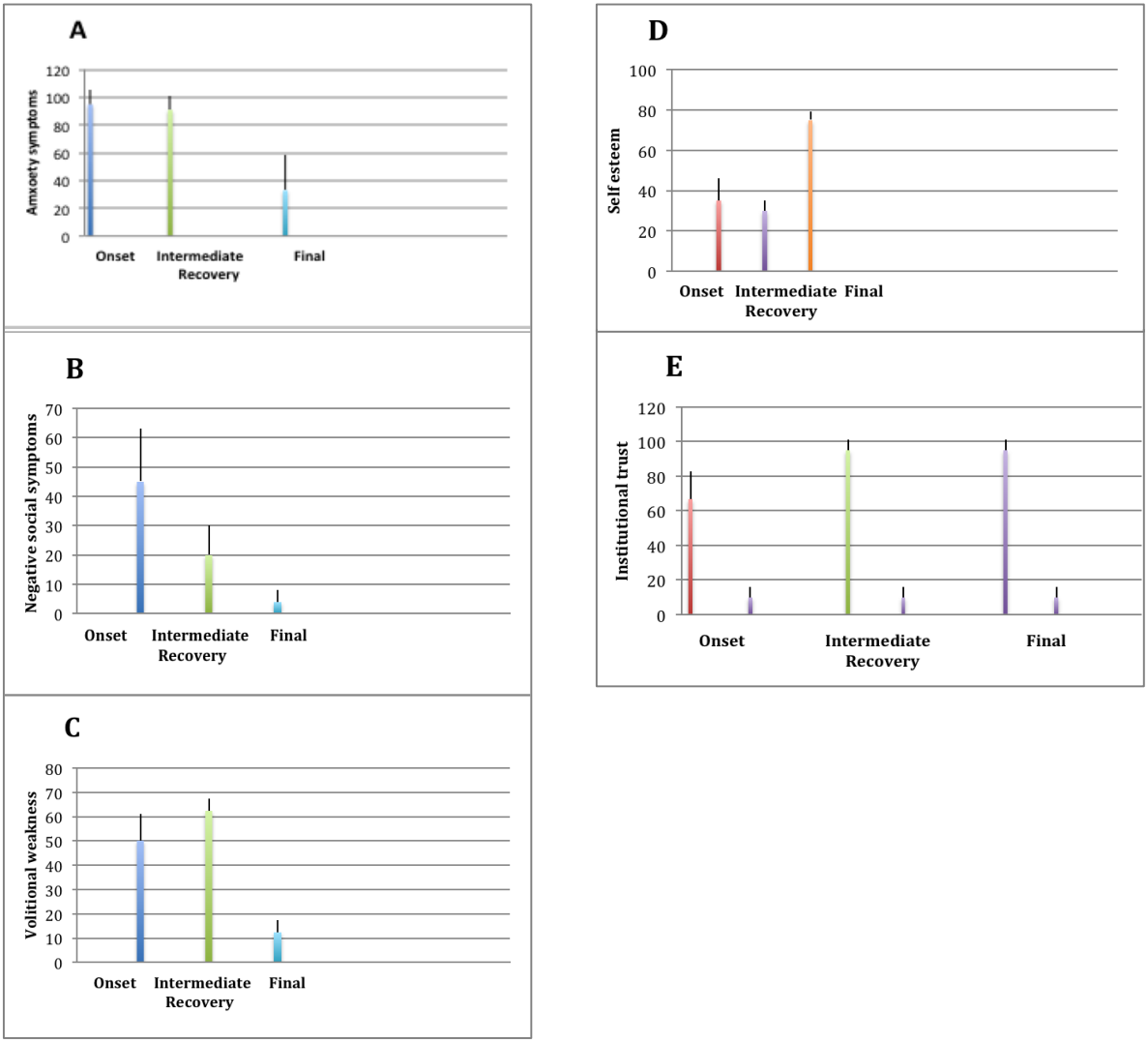

Figure 2. Longitudinal studies

Figure 2. Longitudinal studies. Change in variable parameters as a function of time at onset, intermediate, and final stages. A. Negative anxiety symptoms. B. Negative interpersonal symptoms. C. Negative volitional symptoms. D. Self-esteem. E. Trust in personalistic (elevated) vs institutional (suppressed) care.

Zero order correlations (Figure 1) revealed a) anxiety indices and psychosocial impairment were negatively and significantly correlated with cumulative visit intervals, b) the correlation between anxiety indices and visit intervals significantly differed from the correlation between cumulative visits and psychosocial impairment, and c) self esteem was highly and negatively correlated with anxiety indices. Recovery model correlations are illustrated in Figure 1. Based on the correlation values two pathways are shown for domain reconstruction. The pathway of relational support is shown mediating the reconstruction of the interpersonal domain. A second pathway is illustrated to show recovery of the rational domain that is mediated through self esteem/personal valuation.

The latter pathway is inferred from a) the high negative correlation between recovery from negative anxiety indices and self-esteem and b) the lesser correlation observed between self-esteem and psychosocial impairment.

4. Discussion

Religiously motivated, assault trauma incurs a host of debilitating psychological symptoms in its victims. The current study explores 1) the prospects for successful implementation of a personalistic therapy for victims and 2) the hypothesis that the cluster of symptoms entails a weakening in key personhood domains, which can be restructured through such therapy.

The range of symptoms displayed by the victims of this study is comparable to the spectrum observed in studies of assault trauma in other settings, including those of combat, terrorist, and violent assault (Miller, 2002). Like these studies the most acute impact situates within anxiety variables. Cumulative and ongoing adverse stressors subsequent to trauma further exacerbate anxiety symptoms (Samuels-Dennis, Ford-Gilboe, Wilk, Avison, & Ray, 2010). Additionally, however, psychosocial functioning, agency, and bodily symptoms are also significantly impacted. The trauma event thus mediates numerous and globally effected sequelae within the intended victims. The set of observed symptoms, in fact, appears to fall within clearly circumscribed orbits of the catholic PP model (Table 2), suggesting that the numerous symptomatic outcomes are the result of a few broad assault objectives that impact the principal domain constructs, thus precipitating the observed symptoms. While our study did not explore the specific causal antecedents that may impair psychological function, a considerable body of research relates analogous trauma events with the symptom sequelae observed here.

Invariably trauma victims require some form of assisted recovery, the severity of the symptoms precluding a self-initiated reintegration into the victim's community. While the need for recovery may often be patent, however, the form that the assistance may take is not. Consequently, assisted recovery has assumed a variety of forms, dictated by the availability of resources, prognosis perceptions, and recovery models (Herman, 1998). In circumstances where resources may be limited and subject to interruption, psychological assistance is often intended to address only the most acute symptoms.

Recovery assistance for the widows of the Orissa uprising was predicated on prior experience by Divine Word religious in helping trauma victims to achieve self-sufficiency. The guiding premise for care in the aftermath of trauma exposure emphasizes the intrinsic personal worth of each victim and the self-sacrificial character required to minister to the victims. We propose that this approach is effective due to its restoration of the major psychological domains of the human person identified in the Catholic PP model (Vitz, 2011). Several lines of evidence support this interpretation. First, the model identifies the primal need for interpersonal relations in establishing psychological health. Prior research has shown, in fact, that when there is little emotional support, particularly that of intimate ties such as those of friends and family (Coker, Watkins, Smith, & Brandt, 2003), and ongoing personal devaluation (Hyman, Gold, & Cott, 2003), the recovery period is extended. Thus, the negative symptoms of trauma coincide with the psychological needs explicitly referenced in the model. The widows' loss of familial support constitutes just such a fragmentation of personal relations. Second, the model proposes the fundamental need for a rational recognition of self worth. Our study showed that self-esteem was an important variable in the alleviation of anxiety symptoms, confirming the validity of this proposal of the model. Importantly, negative symptoms associated with all four domains were significantly diminished by personalistic care that emphasized relational integrity and self worth.

The positive impact on all four domains suggested that causal constructs intersecting between the interpersonal and volitional, or rational and volitional, might be operative. While this study did not attempt to identify such causal constructs, the longitudinal study did attempt to discriminate temporal differences between reconstruction of targeted and non targeted domains with the intention of identifying the sequential order of restructuring. In general, symptoms associated with targeted domains were resolved first. For example, the recovery of the interpersonal domain preceded the recovery of personal agency. These observations imply that the existence of intersecting constructs is very likely and that they are mediated via the targeted domains. Consistent with this interpretation, prior studies have shown that negative volitional symptoms are exacerbated by a lack of interpersonal support (Hyman, Gold, & Cott, 2003), thus arguing for intersectional causality in the case of interpersonal and volitional domains. Furthermore, there is likely to be an a priori need for positive constructs that reside in interpersonal and rational domains, such as self-esteem, to be improved prior to a general improvement in personal agency.

Our study also found trust to be an important enabling variable for domain restructuring. In the first place there was little recovery from negative anxiety and psychosocial impairment in the absence of trust in institutional assistance. The reestablishment of trust with the care provided by the sisters, however, was directly associated with recovery. Thus, recovery is facilitated by a trust relationship between victim and caregiver. Among factors likely to effect increased trust is a perception of the caregivers' commitment to faith values. Undergirding the perception of commitment is the affirmation of such values during care of the victim, a perception strengthened by the religious values of the widows, who were themselves Christian.

The re-attainment of psychological health seen here underscores the relevance of a personalistic approach to recovery therapy, even in circumstances in which victims have suffered acute and severe trauma. As an operational dynamic, personalism has been applied to a wide variety of social settings from managerial practice (Alford, 2010), to bioethical constructs (Petrini & Gainotti,

2008), to psychiatric therapy (Vitz, 2011). This study thus extends the context within which personalistic principles may be deemed suitable. A key concept in personalism is the recognition of the human being as both an individual and a person. He is an individual in his possession of a unique constitution that is separated from that of all other individuals and whose physical needs are independently established. He is a person in his relationality and in his subjective personality (Alford, 2010; Coker, Watkins, Smith, & Brandt, 2003). His personhood is thus the constituent feature determining his socially interactive nature. Philosophically, personhood is considered within the conception of self or subject (Evans, 1952), a notion that contemporary neuroscience posits within a physiological framework (Klemm, 2011). The psychological model employed here, accordingly, places strong emphasis on the victim as a person constructed from an interpersonal relationship of self-giving love (Gendreau, 1992). She is thus in need of participation in an exchange that is reciprocally affirmative, and outwardly directed, a self-sacrificial giving of self to self. For the victim weakened by trauma, isolation and family loss constitute the deprivation of such an exchange. Replacement is requisite, provided here by the empathetic care of the sisters who view the victim as another self to whom they are ministering.

5. Conclusion/Implications for the future

In the absence of methodological certainty the prevalence of religiously motivated trauma underscores the ongoing need for sound theoretical proposals to guide assisted recovery. At the heart of this reflection is the person in his inter-relational and self-giving dimension, a notion understood by the perpetrator and in need of redress by the therapist. Afflicted by the intentional malice of the perpetrator the victim can regain her sense of personhood through the intentional and selfless personal exchange of the caregiver. Critical to recovery is the perception that the therapy reflects the guiding values of the therapist. Proposals incorporating this reflection are likely to achieve success.

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