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Understanding Healing From Trauma Using Feminist Ethnographic Mixed Methods

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Abstract

Examining the impact of gender norms and social structures on mental health and healing from violence is a World Health Organization global health priority. Help seeking for gender-based violence (GBV) and trauma recovery is shockingly low, with estimates ranging from 4% to 27% depending on the country and violence severity. Themes from limited research are consistent, finding that internal barriers to help seeking include beliefs that the violence is normal, minor, or insignificant; beliefs that interpersonal violence is a private matter; and internalization of cultural stigma. Few studies have examined the sociocultural barriers to help seeking either for escape from violence or for healing after safety has been established. The data from this study were baseline data from a larger study examining the healing trajectory of women after an integrative healing program for 21 women receiving domestic violence (DV) services in rural West Ireland. This project used a feminist ethnographic mixed-methods design with a nested quantitative subsample. We used semi-structured ethnographic interviews to understand the experiences of the participants and surveys to explore symptomatology, well-being, meaning, social support, social conflict, and perceived barriers to seeking help.

Learning Outcomes

By the end of this case, students should be able to

- Understand and conduct a feminist ethnography
- Define the goals of feminist ethnographic methods as an approach to understand gender and women's health
- Describe how feminist ethnography can empower women to gaining self-understanding and strength by contextualizing their experiences
- Give examples of how gendered social and cultural process are revealed using feminist ethnographic methods

Project Overview and Context

Examining the impact of gender norms and social structures on mental health and healing from violence is a World Health Organization global health priority (World Health Organization, 2016). Gender-based violence (GBV) is a pervasive global health priority, and the road to healing can be challenging because of cultural and social barriers, internalization of stigma and shame, and because of the intimate social and emotional engagement required during the help-seeking process. Themes from limited research are consistent, finding that internal barriers to help seeking include beliefs that the violence is normal, minor, or insignificant; beliefs that interpersonal violence is a private matter; and internalization of cultural stigma (Barrett & St. Pierre, 2011; Fanslow & Robinson, 2010; Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Westbrook, 2008). Few

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studies have examined the sociocultural barriers to help seeking either for escape from violence or for healing after safety has been established. This study used mixed methods, which included ethnographic interviews and surveys to understand the healing journeys of 21 women receiving domestic violence (DV) services in a rural region of Ireland.

Studies that have examined help seeking for trauma recovery have focused on the ways that stigmatization can deter help seeking. A review conducted by Westbrook (2008) identified three types of stigmatization, including internalized, social, and cultural stigma. Consistent with other research (Murray et al., 2015), internalized stigma takes the form of self-recrimination, such as feeling weak, helpless, deviant, ashamed, or to blame (Westbrook, 2008). Social stigma was defined as the fear that people would be unsupportive, expect the women to leave the perpetrator, or would find them weak or “stupid” for staying. Cultural stigma involved cultural rules about violence or abuse, or judgmental attitudes, including norms that DV is a private matter and must be kept secret, public beliefs that abuse is normal, and/or beliefs that abuse always involves physical injury.

Help seeking for GBV and trauma recovery is shockingly low, with estimates ranging from 4% to 27% depending on the country and violence severity (European Union Agency for Fundamental Rights, 2014). Research on effectiveness and satisfaction with DV services has been focused on satisfaction with DV-specific services, leaving us with very little information about those who believe they cannot access services or choose not to do so. In addition, most research has focused on the structural barriers (such as cost, transportation, and staffing), access to information about shelters, or navigating legal systems to escape the abusive situation. The study presented here used feminist ethnographic mixed methods to study the healing journey of women in rural West Ireland. We focused on trauma recovery after getting to safety and the internal, cultural, and social barriers that women faced. These women were all out of their DV situations and were receiving services from a DV service agency. Unlike in the United States, Irish DV services can be accessed for years after leaving a shelter. None of these women were in a shelter at the time of their involvement, and the time out of the abuse ranged from 1 to 5 years.

Research Practicalities

Purpose

The purpose of this study was to mix both ethnographic interviewing data and survey data to explore the healing and help seeking for 21 women who were receiving DV services in a rural area in the west of the Republic of Ireland.

Design

This project used a sequential, explanatory mixed-methods design with a nested quantitative subsample.

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We used semi-structured ethnographic interviews to understand their experiences and surveys to explore symptomatology, well-being, meaning, social support, social conflict, and perceived barriers to seeking help. The data from this study were baseline data from a larger study examining the healing trajectory of women after an integrative healing program (Saint Arnault & O'Halloran, 2015). All concepts we explored were examined both quantitatively and qualitatively. The theory that guided the conceptualization of healing was the Cultural Determinants of Help Seeking theory developed by Saint Arnault (2009). This theory defines and operationalizes the cultural and social factors that may contribute to help seeking. Concepts included in the theory are illness descriptions, illness interpretations about cause and meaning, social and behavioral consequences of the illness, and social context.

This research reported here was a collaboration between me (Saint Arnault), an advanced practice psychiatric nurse anthropologist, and Sharon O'Halloran who was a policy activist in a nongovernmental organization (NGO) agency.[1] When I was a practicing psychiatric nurse, I worked with women who had experienced abuse and depression. My treatment perspective was humanistic, existential, and body-oriented. I continue to place utmost emphasis on the relationship between the researcher and the client and aim to help them understand the meaning of their lives. Finally, I do not believe that the mind, the body, and the social nature of humans should be separated, and therefore, I approach health and illness from a holistic view. The co-author is an activist, seeking to engage in social change in all that she does, including her personal transformation, her leadership as the CEO of an NGO, and through her work with women and men in Ireland. She works to change policy and practice to create a safe and productive place for women, men, and families to thrive. She is also a trained biodynamic psychotherapist and uses this body-oriented lens in all that she does.

Feminist ethnography framed this research because we wanted to understand the cultural beliefs, values, and social organization that affected women's ability and willingness to seek help for their trauma recovery. Literature about feminist ethnography tends to focus on power, class, race, definitions about what constitutes "feminism" and the category of "woman," and the importance of women telling their own stories (Schrock, 2013; Stacey, 1988). Our concept of feminism was that there is a phenomenon called "gender-based violence" and that this violence interacts with social rules, norms, organization, and customs in such a way that the women may experience beliefs and attitudes, both within themselves and within their communities, that may be experienced as barriers to seeking help. We believed that research must empower the participant, helping them understand their power and their strength, as well as recognize how they can challenge attitudes and beliefs for the well-being of themselves, their families, and society as a whole. We also believed that participation in research must be "a safe space" for self-reflection. Because our topic was trauma, doing research was a very delicate matter. It was our absolute priority that women left the interviews feeling safe and strong and that they had a secure and available place to process emerging thoughts and feelings after the interview.

We also used feminist mixed methods (Hesse-Biber, 2013). This is an emerging field of research that involves the sequential or simultaneous gathering of both qualitative (and ethnographic) and quantitative data. These

two types of data are merged and integrated at several points in a study so that the researcher can learn more about a phenomenon than they would if they used either method alone. Usually, known concepts are studied using quantitative surveys, and unknown concepts are explored in qualitative ways. Qualitative methods also help the researchers contextualize the problem in question. Our approach was feminist because we gave voice to the women who have been oppressed, or otherwise silenced, by cultural and social forces. We made hearing their stories and witnessing their suffering and their resilience our overarching goal. We also believed that feminist research should involve social action, so that information gained from the research should directly serve to help the women (and women like them) by challenging and changing destructive norms, rules, and customs. We actualized this in a variety of ways, including giving the women a detailed presentation of our findings for discussion and reflection and bringing the data directly into the service sector for service improvement and policy initiatives.

Sampling

A total of 21 women receiving DV services in a rural area of Ireland were recruited with information letters and posted flyers. All participants had been out of their abusive relationship and in stable homes at the time of their interview and were deemed by the refuge staff to be ready and able to participate in our research. Inclusion criteria included women over 21 who were receiving services, who had a case manager, and spoke and read English. Exclusion criteria included severe distress or those who were actively psychotic. Distressed severity was assessed with the Kessler 6, which is a six-item screening tool designed to detect individuals who are likely to be suffering from non-specific psychological distress (Kessler et al., 2002). A score of 13 indicates probable clinically significant psychological distress. If the woman met criteria, they received surveys either by mail or with an emailed online link.

Quantitative Data

Demographic data included age, education, employment, and use of psychological and medical services. *Symptoms* were measured with depression, anxiety, and physical symptoms scales. *Depression* was measured with the Center for Epidemiologic Studies–Depression (CES-D) scale (Radloff, 1977). The CES-D is a 20-item self-report scale, and the cutoff for indicating risk for clinically significant depression is 16. Cronbach’s alpha reliability was .95. *Anxiety* was assessed using the Zung Self-Rating Anxiety Scale (Zung, 1971), which is a 20-item instrument designed to measure state anxiety, and cutoff for moderate to severe anxiety is 45-59 ($\alpha = .88$). *Physical symptoms* were measured with the 22-item Composite Symptom Checklist, which included 22 physical items including sleep, gastrointestinal problems, pain, cardiac, and neurological symptoms (Saint Arnault & Fetters, 2011; Saint Arnault & Kim, 2008; Saint Arnault, Sakamoto, & Moriwaki, 2006). *Health and well-being* were measured with the Medical Outcomes Study Short Form-36 Health Survey (SF-36). The SF-36 was developed in the United States and has been used in a number of countries (Ware et al., 1998; Ware, Kosinski, & Keller, 1994; Ware & Sherbourne, 1992). We selected the subscales representing bodily pain, vitality, social functioning, and role functioning. *Meaning* was operationalized as sense of coherence (SOC) and was measured with the SOC scale which consisted of 13 statements that examine clarity, comprehension, and meaning (Antonovsky, 1993; Eriksson & Lindstrom,

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2006; α = .72). *Social context* was operationalized as support and conflict in the social environment. *Social support* was measured with the Social Support Questionnaire for Transactions (SSQT; Suurmeijer et al., 1995) which measures satisfaction with social support in five domains (α = .94). *Social conflict* was measured with the Social Conflict Scale (SCS), a subscale of the Quality of Relationship Inventory (Pierce, Sarason, & Sarason, 1991; Pierce, Sarason, Sarason, Solky-Butzel, & Nagle, 1997; α = .87). *Perception of care* included the *Barriers to Seeking Care for Trauma Scale* was developed based on the Barriers to Seeking Care scale used in the Mental Health Supplement of the Ontario Epidemiology study in 1996 (Boyle et al., 1996). The original scale included 22 reasons for not seeking professional health for physical or emotional symptoms in the last year. However, based on the literature reviewed above, we added seven items related to trauma help seeking, including shame, confusion, fear of the consequences, normalization, feeling frozen, and feeling undeserving (α = .85).

Ethnographic Semi-structured Interviews

The author interviewed all women with the co-author present, and all but one of the interviews was tape-recorded with the consent of the women. Interviews were about 1 hr in length and took place in a secure environment including either a DV service center or at the Biodynamic treatment center. Interviews and surveys were completed between 2011 and 2013. The interview was carefully designed to assess the social and cultural processes that shaped women's trauma recovery. This included both their strength and resiliency as well as their struggles and challenges. The interview began with a broad question of what was working well in women's lives to help the women begin their examination of their journey from a position of strength. Next, we explored their social relationships. This question gave rise to reflections about both their available support, as well as their social, family, and community relationships, and the presence of conflict in their lives. The next question was about emotions or physical symptoms that they struggle with and how they dealt with them on a day-to-day basis. We followed this question about how they experienced health and well-being. The final question was about the meaning they derived in their lives. This question was simply "How do you understand the meaning in your life?"

Method in Action

Using Theory to Guide Questions

As noted above, we operated from a feminist perspective and believed that our research needed to empower and strengthen the participants. Therefore, we considered the strengths of the women to be as important as their symptoms and their struggles. In addition, we wanted women to understand their situation fully. Therefore, we used well-being concepts, as well as social context. Finally, we helped women explore the meaning of their situation, their strength, and their struggles. These concepts came from the Cultural Determinants of Help Seeking theory, as well as the literature about trauma recovery. This theoretical background helped us to define the survey tools to use and help us to frame our qualitative questions. The

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use of theory is important in all research; however, mixed-methods research requires that the researcher pays attention to how they can connect or integrate findings from different datasets together. Theory can help the investigator connect the numerical quantitative data with the thematic qualitative data because both methods asked about the same thing.

Exploring Life Experience in Context

Feminist research is about the interaction between the subject and their context. In addition, the ethnographic research method explored the rules, beliefs, norms, and customs that exist both within the participant and within their social world. Women told us that exploring their own beliefs and experiences and relating them to the beliefs and norms of their social world was helpful for them to make sense of their lives. There were many "*aha*" moments as women explored their healing journey from this contextual point of view. Many women became more aware of the stigma within their families and communities, as well as the self-stigma and shame they held within themselves. Participants began to acknowledge the social rejection and outright hostility they experienced after leaving their abuser (even from their family!). However, they also began to face the ways that they had cut themselves out of people's lives and chose not to seek help because of fears, self-stigma, and shame.

The Importance of a Safety Net

Studying trauma is a delicate matter, and safeguarding women's feelings of security was paramount in this study. We used flyers for women to learn about the research and made it clear in the flyers that we were seeking women who were interested in exploring trauma recovery. This was critical because there are women in the DV service sector who are in crisis and are gathering strength and resources to escape violence and protect themselves and their family. We believed, therefore, that some women might not have the mental–emotional space to "explore" their recovery journey. We expected that women who were in a safe living situation would be more likely to want to explore this. However, it was the women themselves who needed to define their interest. Despite this, we wanted to engage the DV staff in the inclusion recruitment into the study because they would be our primary referral for women after the interview. We called this "wrap-around services." After women self-identified their interest, they talked with their case worker about this and explored their readiness in a collaborative way. In this way, women began the steps toward self-exploration before they even entered the study and developed the confidence and assurance that they had a safety net ready for them should they need it. In addition, consistent with feminist research, the researcher acted as a present and caring witness who acknowledged their strengths and struggles, which also helped them feel more powerful, more competent, and more able to question their struggles openly.

Practical Lessons Learned

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The Power of the Survey

We gave the women the survey before we met them for the interview. During the interview, the women often referenced the survey, explaining their answers, and also explaining that they had been thinking about the survey since they had filled it out. One woman said she cried the whole time she was filling it out, describing how the questions, or rather the picture that was painted by her answers to the questions, was startling and painful. She was especially struck by her answers to the questions about her social support network, realizing how cut off she had become. Another woman said that she "thought she was doing fine" until she began to answer the questions. These internal processes during a survey point out three things. Surveys can be an important tool for self-assessment and self-discovery. Unfortunately, in most research, the participant rarely has an opportunity to debrief or discuss the survey in any way. This leads us to our second point. Mixed-methods research provides the researcher and the participant multiple ways to explore the topics under study, leading to a deeper understanding for the researcher and the participant. Our focus on safe self-discovery in the interviews left the door open for them to talk about the survey, and this was helpful for them. Finally, it is important for people who have participated in research to understand their own findings within the broader context of the total research participant pool. At the final debriefing, after the research was over, women were fascinated to revisit their memories of doing the survey (and the interview) and compare that with the group scores for the various items.

Healing From a Well-Structured Interview

As discussed earlier, we approached constructing the survey and the interview process carefully, focusing on safety and security for the women. We had a rationale for the questions, their order, their phrasing, and the like. Good qualitative interviewing requires attention to the structuring of the questions, as well as the "phases" or journey that the participant will go through as they participate in the study. In our research, since we would be discussing trauma and trauma recovery, this was especially important. Revisiting traumatic events can not only be painful, it can retraumatize the teller unless it is handled carefully (Brown et al., 2014). Our strategy was informed by both feminist philosophy (as described earlier) and humanistic and existential psychology. In practice, this meant that we concentrated on the women, their story, and the effect it was having on them to tell it (rather than focusing on the interview protocol). We also focused on the meaning and understanding of events and social relationships, rather than the content of the event. Rather than asking probes like "what happened" or "tell me about the details of that experience," we focused on the meaning of that for the women in their lives, using probes like "how did you understand that" or "what did that mean to you at the time (or now)." This was consistent with our theory, but also served to create safety in the interview. Although some people generally benefit from trauma-focused research (DePrince & Chu, 2008), we believe that meaning-centered interviewing can help create mastery and coherence, which provides strength and security (Wong, 2013).

The Value of Mixed Methods

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In our survey, we got a glimpse of the struggles of the women, as well as the resources they could draw on. In the interview, we understood these processes holistically, hearing women put together the concepts as they lived them. However, as a researcher, our full understanding of help seeking really came when we put the two types of data together. We discovered how much the social context affected women's ability to reach out for help and how much their symptoms became disabling to them despite their success in finding safety. We also discovered that although access to services is critical, help seeking from those services was part of a personal journey that required women to feel secure with themselves (addressing their feelings of shame and self-stigma), as well as secure in their social world (addressing stigma and negativity in their social world). Using theory to identify concepts, and looking at the same concepts quantitative and qualitatively in the same study, enabled us to achieve these integrated findings.

Conclusion

Using a feminist approach went a long way in our research processes. It helped us to empower women, affirmed the importance of telling the story in a safe container with a caring witness, have a secure safety net during the research process, and bring the findings back to the women. Although beyond the scope of this case, the outcomes of this research were far reaching. Safe Ireland embarked on a large project about the legal system and developed new media campaigns. And the authors are working with partners in other European countries to expand on our help-seeking research based on these methods and findings. In addition, mixed-methods research led to new discoveries that single methods may not have found. We hope to see more feminist mixed-methods studies in the future to foster complex investigations that help empower women (and men) to tell their stories in safety.

Notes

1. The Biodynamic Psychotherapy partners in the project were involved in the larger project, but not the portion of the project reposted here (Saint Arnault, Molloy, O'Halloran, & Bell, 2013; Saint Arnault & O'Halloran, 2015).

Exercises and Discussion Questions

1. What strategies can the researcher use to promote safe self-exploration and self-expression in a research study?
2. How are the goals of research and the goals of feminism in tension, and how can the researcher navigate these waters?
3. How can theoretical frameworks help the clarity and focus of gathering data using multiple methods?

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