

Correlates of Multiple Forms
of Victimization
in Religion-Related Child Abuse Cases

Gail S. Goodman
Bette L. Bottoms
Allison Redlich
Phillip R. Shaver
Kathleen R. Diviak

SUMMARY. Abuse perpetrated under the guise of religion is a devastating form of child maltreatment that often involves multiple types of victimization. In a large-scale survey of clinicians, we investigated the nature and emotional sequelae of religion-related child sexual abuse cases. We predicted that there would be marked differences between cases involving multiple forms of abuse and

Address correspondence to: Gail S. Goodman, PhD, Department of Psychology, University of California, Davis, CA 95616.

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those involving only sexual abuse. Our results indicate that as the number of abuses increases, so does the severity of the abusive experience and the seriousness of psychological consequences for the victim. Thus, religion-related abuse is best understood in light of the specific types and combinations of abuses suffered by victims. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]

INTRODUCTION

Abuse perpetrated under the guise of religion is a devastating form of child maltreatment that has been virtually ignored in the professional and scientific literatures (Bottoms, Shaver, Goodman, & Qin, 1995; Capps, 1992; Greven, 1991). Religious overtones may add an additional layer of complexity to child abuse, further inhibiting a child's ability to cope with the trauma of maltreatment. For example, sexual abuse at the hands of trusted religious officials may be particularly damaging for children who have been raised to fear God and revere the Church and its leaders (Berry, 1992). They may believe that the abuse is parentally, socially, or supernaturally sanctioned, or is a punishment for their own sins (Greven, 1991). Withholding of medical care for religious reasons is another form of religion-related maltreatment that may have severe consequences for children (Bullis, 1991; Skolnick, 1994). Consider, for example, the following case description from Bottoms et al. (1995): "Child's tumor was untreated. Needed amputation was not allowed. Father believed child was being punished for sins and could be cured only through prayer." As a final example, some religions teach that a child's "willfulness" or misbehavior is the result of sin, evil, or the activity of devils who literally possess the child. Adults with such beliefs sometimes consider it their duty to "beat the devil" out of the child, which can cause severe emotional and psychological damage.

Of particular concern for the present discussion, religious beliefs can contribute to single or multiple forms of child abuse. In certain religious sects or cults, for example, children suffer physical abuse as well as emotional abuse and sexual violations. It is believed that some children in the Branch Davidian cult in Waco, Texas, suffered all three kinds of abuse as a consequence of leader David Koresh's religious delusions. Abuse allegations were responsible, in part, for authorities storming the cult's compound, spurring Koresh to start the conflagration that killed many of the children that the government sought to rescue. Of course, it is not just in isolated cults or small religious sects that religion-related ideology can

lead to multiple forms of child abuse. More mainstream religious followers may also justify a variety of forms of child abuse in the name of religion (Greven, 1991).

In this article, we examine the nature and emotional correlates of multiple forms of religion-related child victimization. Given that religion-related abuse may be associated with multiple forms of maltreatment and may be particularly detrimental to children's well being, it is surprising that little research has been conducted to explore its characteristics or consequences. To address this important need, we conducted a large nationwide survey study of American clinicians' experiences with cases involving religion-related child abuse. The findings we detail in this article are based on the reports of clinicians who responded to our questionnaire and described cases they encountered in their practices. All of the cases we discuss involved allegations of child sexual abuse, but many of the cases involved other forms of abuse as well. This afforded us an opportunity to compare correlates of sexual abuse alone with correlates of sexual abuse combined with other types of abuse.

Having outlined several ways in which religion may be involved in child abuse, we next consider the prevalence, in general, of the multiple victimization of children. We then review research on the emotional effects of multiple abuse in comparison to the emotional effects of child sexual abuse alone, and formulate predictions we tested in our data set. Finally, we present the findings of our study and discuss their implications for understanding religion-related abuse and the effects of multiple victimization.

How Often Are Children Multiply Abused?

It is difficult to determine with any precision how often children suffer multiple forms of maltreatment. Official abuse statistics are often presented in the form of tallies for specific kinds of abuse totaled across all child abuse cases reported to state social service agencies, without regard for whether a child was the victim of different forms of abuse (e.g., NCCAN, 1994). In addition, some kinds of child abuse (e.g., sexual abuse, emotional abuse) often go unreported to authorities (Finkelhor, 1984; Russell, 1983), making official statistics problematic in any case.

A few researchers have attempted to determine the prevalence rates for multiple victimization by surveying nonclinical samples. For example, Riggs, Alario, and McHorney (1990) report that 2.7% of 600 children in grades 9 to 12 had suffered both physical and sexual abuse. Moeller, Bachmann, and Moeller (1993) asked 668 middle-class women at a gynecology clinic whether they had experienced sexual, physical, and/or emotional abuse as children. Approximately 53% reported childhood

abuse, with 28.9% reporting one type of abuse, 18.7% reporting two types, and 5.4% reporting all three types. In one of the more methodologically sound studies to date, Finkelhor and Dziuba-Leatherman (1994) investigated whether some children are more at risk of multiple abuse than others. In a telephone survey of a nationally representative sample of 2,000 10- to 16-year-olds, a quarter of the children reported a completed victimization experience in the previous year, and over half of the children reported a completed or attempted victimization at some time in their lives. Finkelhor and Dziuba-Leatherman (1994) noted that "children who experienced one form of victimization were more likely to have experienced another form as well. For example, victims of sexual assault were 2.67 times more likely . . . than other children to have experienced an additional form of victimization" (p. 415).

Researchers have also investigated the prevalence of multiple forms of abuse in clinical samples, arriving at varying prevalence estimates. For example, Brown and Anderson (1991) found that 18% of 947 adult psychiatric inpatients suffered some form of physical or sexual abuse as children, with 3% (more women than men) reporting a combination of physical and sexual abuse. Hobbs and Wynne (1990) report that of 769 children diagnosed with physical abuse, approximately 17% were also sexually abused, and out of 949 diagnosed with sexual abuse, nearly 14% were also physically abused. Somewhat higher rates of multiple victimization were found by Kiser, Millsap, and Heston (1992) in a sample of 241 child and adolescent psychiatric day patients: 60% reported a history of physical and/or sexual abuse, 26% of whom reported both types of abuse. Finally, dramatically higher rates were reported by Ney, Fung, and Wickett (1994) in a study of children's self-reported physical abuse, physical neglect, verbal abuse, emotional neglect, and sexual abuse. Fewer than 5% of the 167 abused children they studied had suffered only one form of abuse, a rate that probably results from the researchers' inclusion of emotional and verbal abuse as maltreatment categories.

In summary, although there is wide variability in prevalence estimates due to differences in samples, sources of report (e.g., self-report versus parental report), definitions of abuse, types of maltreatment investigated, etc., all studies indicate that children who experience sexual abuse not infrequently experience other forms of abuse as well.

Effects of Child Sexual Abuse Alone Compared with Effects of Multiple Forms of Abuse

We were primarily concerned with the emotional correlates of child sexual abuse alone compared with the emotional correlates of child sexual

abuse occurring in conjunction with other abuses. First, it is important to consider what is currently known about the emotional sequelae of childhood sexual abuse. A number of short- and long-term emotional effects have been linked to childhood sexual violations, including (but not limited to) sexualized behavior, symptoms of PTSD, depression, fear, anxiety, aggression, anger, feelings of isolation, and suicidal ideation (Briere & Elliott, 1994; Browne & Finkelhor, 1986). The first of these—sexual acting out—is the most consistently reported consequence of childhood sexual abuse, although symptoms of PTSD are also relatively common (Deblinger, McLeer, Atkins, Ralphe, & Fox, 1989; Kendall-Tackett, Williams, & Finkelhor, 1993). Researchers have also uncovered a significant relation between dissociative symptoms and a history of abuse (Chu & Dill, 1990; Swett & Halpert, 1993). When abuse is particularly severe, it has been proposed that multiple personality disorder (MPD; also known as dissociative identity disorder) may develop (e.g., Coons, 1986; Putnam, Post, Guroff, Silberman, & Barban, 1983), although this diagnosis remains controversial (Spanos, 1994).

For child sexual abuse victims, what are the psychological consequences of additional types of abuse? Most researchers have examined this question within clinical samples. In Brown and Anderson's (1991) study (see above), suicidal tendencies were particularly common in patients with a history of combined childhood abuse, and substance abuse was also prevalent. In a study of 51 inpatient adolescents at a state psychiatric hospital, Hart, Mader, Griffith, and deMendonca (1989) found that child victims of both sexual and physical abuse reported more symptoms than did nonabused children or children who had suffered only one of these two kinds of abuse. In contrast, Kiser et al. (1992) concluded that victims of child sexual abuse reported higher levels of internalizing behaviors than victims of physical abuse or of both physical and sexual abuse. In that study, however, compared to mothers of non-abused children or of children who had experienced only one form of abuse, mothers of children who had been both physically and sexually abused reported the greatest concerns about their children's psychosis, delinquency, hyperactivity, and somatic complaints. They reported the fewest concerns about withdrawal, family functioning, depression, and anxiety. Finally, in one of the few studies of a nonclinical sample (women gynecology clinic patients), Moeller et al. (1993) found that the more kinds of childhood abuse reported by a patient, the more likely she was to have poorer health and to have been revictimised as an adult. In general, then, these studies suggest that multiple victimization is associated with more severe symptoms than single-abuse experiences.

In interpreting these results, however, it is important to consider the overlap between different forms of abuse. It has recently been argued, for example, that all forms of child abuse involve psychological maltreatment (Brassard, Germain, & Hart, 1987; Claussen & Crittenden, 1991; Garbarino, 1980). In fact, Garbarino and Vondra (1987) contend that psychological maltreatment is the concept that unifies all forms of child maltreatment. To the extent that this is true, it is difficult to differentiate emotional abuse from sexual abuse, physical abuse, and neglect. Even so, the magnitude or significance of psychological maltreatment may vary. If a child is classified by authorities as emotionally abused or views him or herself as having suffered emotional abuse in addition to sexual or physical abuse, the psychological abuse may have been particularly salient or severe. In a number of studies, distinguishing between sexual abuse and emotional abuse has been useful. For example, Bagley, Wood, and Young (1994) surveyed 750 males in Canada about unwanted sexual contacts before the age of 17 years. About 16% reported experiencing one or more unwanted sexual contacts. The combination of emotional abuse (as measured by a standardized scale consisting of questions such as "Could you seek comfort from your parents if you were sad?") with multiple incidents of sexual abuse was a significant predictor of poor mental health in adulthood and sexual interest in or sexual contact with children. These findings led Bagley et al. (1994) to conclude that the combination of emotional and sexual abuse in childhood is a risk factor for adult mental health problems. Thus, the classification of children as having suffered emotional abuse in addition to sexual abuse proved important.

These findings are consistent with research on cumulative effects of stressful life experiences ("risk factors") in childhood (e.g., Garbarino, Dubrow, Kostelny, & Pardo, 1992; Sameroff, Siefer, Barocas, Zax, & Greenspan, 1987). Such research indicates that the experience of multiple stressful events places children at risk for emotional and cognitive deficits, particularly in the absence of sufficient compensatory factors (e.g., social support, secure attachment) (Garmezy & Rutter, 1983; Rutter, 1979).

Predictions

A set of predictions emerges from the literature concerning the emotional effects of child sexual abuse and multiple victimization. A primary prediction is that, compared to individuals who experience sexual abuse only, individuals who experience sexual abuse in combination with other forms of abuse will be more likely to evidence psychological disturbance (e.g., more likely to report certain kinds of symptoms when seeking therapy and to be diagnosed with certain disorders). Clinical symptoms that

should be particularly elevated include sexualized behavior, depression, social withdrawal, excessive fears and phobias, suicidal ideation, MPD, PTSD, and other dissociative disorders. Further, these symptoms and disorders should increase as does number of forms of abuse, because, as the studies mentioned above indicate, experiencing child sexual abuse in combination with other kinds of abuse is likely to be more stressful and traumatic than experiencing any one form of abuse alone.

Regarding the sequelae of specific combinations of forms of child abuse, one might make several predictions. One possibility is that there will be negative effects of abuse regardless of the type of abuse suffered, but somewhat different emotional outcomes of specific types of victimization. For example, if sexual abuse is associated with later sexual problems, and physical abuse is associated with later violence and aggression, and both are associated with PTSD, a child who experiences both sexual and physical abuse may eventually evidence symptoms of PTSD, sexual problems, and inappropriate aggression. In other words, the emotional effects of specific combinations of abuse may be the sum of the effects of each form considered separately.

Alternatively, multiple forms of victimization might result in a set of psychological symptoms not necessarily predictable from the individual components, and certain combinations might be particularly devastating. One of the few studies to explore this possibility was the previously mentioned study by Ney et al. (1994). Although methodological limitations make interpretation difficult, Ney et al. concluded that the worst combination of abuse was physical abuse, physical neglect, and verbal abuse (which we would classify as a form of emotional abuse). Experiencing these three forms of abuse was associated with decreased enjoyment of living and a lack of hope for the future. When sexual abuse was involved, the worst combination included verbal abuse and physical neglect. This combination was associated with decreased enjoyment in life and negative expectations about the future of the world and the future of one's own parenting prospects.

In our research, we examined whether specific combinations of abuse are associated with a greater likelihood of certain presenting symptoms or clinical diagnoses in our sample of religion-related child abuse cases.

An Overview of the Present Research

Although religion makes many positive contributions to society, it can also contribute to, and be used to justify, multiple forms of child abuse. As mentioned earlier, because virtually no empirical studies of religion-related child abuse exist, we felt it was important to begin to collect data on

such cases (see Bottoms et al., 1995; and Bottoms, Shaver, & Goodman, 1996, for further discussion of our investigations into this issue). We concentrated on the following specific kinds of religion-related maltreatment: abuse perpetrated by religious authorities, abuse related to attempts to rid a child of "evil spirits," abuse committed in religious settings, and the withholding of medical care for religious reasons. Our data allowed us to compare the characteristics and psychological outcomes of religion-related cases involving one form of abuse (child sexual abuse) with cases involving multiple forms of abuse.

All cases were encountered by mental health professionals (clinical psychologists, psychiatrists, and clinical social workers) who responded to a nationwide survey concerning religion-related child abuse in the United States. For each case, the clinician/respondent indicated the type(s) of childhood abuse a particular client had experienced: sexual, physical, emotional, and/or neglect. For present purposes, we examined the subset of religion-related cases that involved child sexual abuse, as indicated by the clinicians' reports and case descriptions. We created three case categories, those including sexual abuse only, sexual abuse plus one additional kind of abuse ("sexual abuse plus one"), and sexual abuse plus two or more additional kinds of abuse ("sexual abuse plus two or more"). For example, the following case was categorized by a respondent as "sexual abuse plus two or more" (sexual, physical, and emotional): "Father was abused as a child; father quoted scriptures [demeaning the child] and whipped child; also sexually molested her from ages 13-16." In contrast, another clinician described a sexual-abuse-only case in which a woman had been sexually abused from age 5 to 8 in a parochial school by someone in a position of trust. We sought to determine the nature and correlates of such cases, and to see whether such cases differed from cases involving only sexual abuse.

METHOD

The study was conducted in two phases: (a) a postcard survey to identify clinicians who had encountered relevant cases in their clinical practice, and (b) a detailed survey to obtain more complete information about the cases (see Bottoms et al., 1995, and Bottoms et al., 1996, for more detail about our methods). In the first phase, 19,272 postcard surveys were mailed to members of the American Psychological Association, the American Psychiatric Association, and social workers who were members of the National Association of Social Workers. Each clinician received a cover letter explaining that we were interested in child abuse allegations involv-

ing religious or ritualistic practices. ("Ritualistic" child abuse is multi-victim, multi-perpetrator sexual abuse said to involve allegations of quasi-religious satanic rituals and unspeakable acts of torture, murder, and cannibalism—but rarely substantiated by conclusive evidence. Because discussion of the ritualistic abuse cases is beyond the scope of this paper, we refer the reader to Bottoms et al., 1996, for details.) Respondents were asked to report the number of such cases they had encountered during the 1980s on a return postcard.

After accounting for inappropriately targeted individuals (people who had retired, etc.), our response rate was approximately 37%, of whom 2,136 (31%) reported that they had encountered at least one religion-related or ritualistic abuse case. In the follow-up survey, each of the 2,136 clinicians was asked to provide detailed information about up to eight typical religion-related or ritualistic cases he or she had encountered. The main issues covered by the detailed questionnaire included case features, victim and perpetrator characteristics (including victim's psychological symptomatology), abuse types and settings, and information about case adjudication and outcome. Of these questionnaires, a little more than 37% were returned. After eliminating 77 respondents because they or we decided that they had not actually encountered any relevant cases, there were 720 valid respondents: 297 clinical psychologists, 200 psychiatrists, and 223 social workers. They provided information about a total of 1,548 cases in which a client claimed to have been the victim of religion-related or ritualistic child abuse. Of these, there were 405 religion-related (non-ritualistic) cases: 171 reported to our clinician/respondents by child clients, and 234 reported by adult survivors (i.e., adults who reported abuse that they had experienced as children). Finally, we eliminated cases in which the clinician/respondent failed to indicate the specific form of abuse suffered by the client-victim.

In the remaining cases, sexual abuse was the most commonly reported form of abuse, occurring in 243 cases. Physical abuse was allegedly involved in 130 cases, emotional or psychological abuse in 174 cases, and neglect in 84 cases. (Cases could include more than one kind of abuse.) As previously noted, we chose to focus specifically on the religion-related sexual abuse cases ($N = 243$). Among them, there were 129 cases involving only sexual abuse (45 reported by children and 84 by adults), 50 cases of sexual abuse plus one other type of abuse (19 reported by children and 31 by adults), and 61 cases of sexual abuse plus two or more additional types of abuse (18 reported by children and 43 by adults). In three cases it was impossible to determine whether the victim was a child or an adult; hence, the sample size was 240 for certain analyses. The specific forms of

abuse involved in the excluded non-sexual abuse cases were diverse: emotional abuse only ($N = 32$), neglect only ($N = 12$), physical abuse only ($N = 21$), neglect and emotional abuse ($N = 13$), neglect and physical abuse ($N = 3$), physical and emotional abuse ($N = 22$), and neglect and physical and emotional abuse ($N = 16$).

RESULTS

We begin with a discussion of the general characteristics and legal outcomes of the cases. We then provide details concerning the psychological sequelae of various forms of abuse, testing the predictions outlined earlier. Whenever respondents provided enough information, we performed 2 (victim type: child or adult survivor) \times 3 (number of abuses: sexual only, sexual plus one, sexual plus two or more) analyses of variance (ANOVAs). When missing data or numerous cells with means of zero would not permit this kind of analysis, we conducted one-way ANOVAs comparing the three number-of-abuse categories, collapsing across victim type. Main effects of number of abuses were followed by Tukey tests (pairwise comparisons of means), as recommended by Keppel (1982). For present purposes, we report only significant effects, placing special emphasis on findings concerning the number-of-abuses variable.

Case Characteristics

First, we conducted analyses to determine whether there were differences in general case characteristics (i.e., victim age, relationship between victim and perpetrator, number and gender of victims and perpetrators, and setting of the abuse). Our 2 (victim type) \times 3 (number of abuses) ANOVAs revealed few significant effects of victim type for these variables. For the sake of brevity in our text and Table 1 (where all means for this section are shown), we have chosen to discuss only the results of one-way ANOVAs investigating effects associated with the number of abuses.

Victim age. As shown in Table 1, victim age when abuse ended and when it was discovered did not differ significantly as a function of the number of abuses suffered. But multiple forms of abuse had a significantly earlier onset than sexual abuse alone. Thus, cases involving multiple forms of abuse are particularly serious not only in terms of the number of abuses suffered but also in terms of the young age at which the abuse purportedly begins.

TABLE 1. Case Characteristics

	Case Type			Significance	
	Sexual only	S + 1	S + 2 or more	Degrees of freedom	F
Age of victim (years) when abuse:					
Began	10.58 _a	7.97 _b	5.67 _c	(2,211)	29.97**
Ended	12.12	11.90	11.81	(2,189)	.09
Was discovered	23.65	20.74	24.04	(2,190)	.80
Relationship of perpetrators to victims (proportions)					
Parent or step-parent	.10 _a	.40 _b	.78 _c	(2,228)	66.43**
Trusted person (e.g., teacher, priest)	.87 _a	.58 _b	.33 _c	(2,228)	35.00**
Number of victims (mean per case)					
Both genders	1.76 _a [#]	2.21 _{ab}	2.96 _b	(2,200)	3.06*
Male	.96 [#]	1.08	1.70	(2,191)	1.20
Female	.81 _a	1.45 _a	2.68 _b	(2,194)	13.59**
Number of perpetrators (mean per case)					
Both genders	1.30 _a	2.12 _a	3.69 _b	(2,213)	18.29**
Male	1.09 _a	1.27 _a	2.67 _b	(2,206)	12.01**
Female	.14 _a	.46 _a	2.00 _b	(2,207)	21.53**
Settings of abuse (proportions)					
Daycare or schools	.11	.16	.05	(2,218)	1.75
Parent's/relative's home	.26 _a	.39 _a	.64 _b	(2,218)	12.49**
Religious setting	.46 _a	.29 _{ab}	.10 _b	(2,218)	12.19**

NOTE. Sexual only = sexual abuse only; S + 1 = sexual abuse plus one additional type of abuse; S + 2 or more = sexual abuse plus two or more additional types of abuse. The gender totals ("both genders") are not simple summations of separate male and female totals because some respondents provided only a total number of victims or perpetrators, without specifying gender. Each case may have included more than one type of perpetrator or setting. Means within a row that differ in their subscripts are statistically different at $p < .05$.

* $p < .05$. ** $p < .001$.

Excludes two cases involving 100 male victims. Including these outliers results in a sexual-only total mean of 3.58 and a sexual-only male-victim mean of 2.88.

Relationship of victim and perpetrator: As is true in most child abuse cases, perpetrators in virtually all cases were people the children knew and trusted. When multiple abuses were committed, the perpetrator was especially likely to be a parent or step-parent. In cases involving only sexual abuse, the perpetrator was most often another trusted person, reflecting the fact that many cases in this category involved abuse committed by a person with religious authority. There were virtually no cases in which the perpetrator was a stranger (< 1% of cases) and relatively few in which the perpetrator was an acquaintance (6% of cases).

Number and gender of victims and perpetrators. There were significantly more victims, especially girl victims, in the cases involving multiple abuses than in cases involving only sexual abuse. Further, as might be expected, the greater the number of abuses suffered by the children, the greater the number of perpetrators (male and female) involved in the cases. These findings again point to the more extreme nature of purported multiple abuse cases: They are more likely than single-abuse cases to involve multiple victims and perpetrators.

Setting of the abuse. In most cases, the abuse took place either in parents' or other relatives' homes or in religious settings such as a church or church summer camp. Consistent with our finding that multiple abuse was usually intrafamilial, multiple abuse cases were more likely to occur in the home than in daycare centers, schools, or religious settings. Cases involving only sexual abuse were more likely to occur in religious settings than in the home or daycare settings. Again, this probably reflects the large number of sexual-abuse-only cases involving religious authorities as perpetrators. The results suggest that parents were inflicting worse levels of abuse on their children than were non-familial perpetrators such as priests or ministers. Of course, as we discuss later, even single forms of abuse can have serious consequences for a child victim.

Investigation and Adjudication of Cases

Significant effects of both victim type and abuse type were revealed by 2 (victim type) \times 3 (number of abuses) ANOVAs exploring case investigation and outcome variables (see Table 2). First, most cases (70%) were not even investigated by any legal authority or social service agency. This was more likely to be true for adult survivor cases (89%) than for child cases (32%), $F(1, 221) = 118.96, p < .001$, which reflects changes over time in the societal recognition of child abuse. That is, when the adults experienced their abuse decades ago, the social climate was less hospitable towards abuse reporting or investigation.

Table 2 also shows the proportion of cases investigated by specific

TABLE 2. Case Investigation and Adjudication (Proportion of Cases)

Type of investigation	Case type			Mean
	Sexual only	S + 1	S + 2 or more	
Social services^{1,2}				
Child	.36	.63	.61	.47
Adult	.04	.10	.07	.06
Mean	.15	.28	.23	.20
Police²				
Child	.48	.38	.39	.43
Adult	.04	.07	.07	.05
Mean	.19	.17	.16	.18
District attorney^{1,2}				
Child	.10	.44	.11	.17
Adult	.00	.07	.00	.01
Mean	.03 _a	.20 _b	.03 _a	.07
Case outcome				
Social services substantiated^{1,2}				
Child	.22	.39	.28	.28
Adult	.00	.10	.00	.02
Mean	.07 _a	.22 _b	.07 _{ab}	.11
Arrest²				
Child	.38	.50	.39	.41
Adult	.06	.00	.05	.05
Mean	.17	.18	.16	.17
Trial²				
Child	.28	.44	.22	.30
Adult	.03	.03	.00	.02
Mean	.11	.18	.07	.12
Conviction²				
Child	.25	.22	.22	.24
Adult	.03	.00	.00	.01
Mean	.10	.08	.07	.09

NOTE. Sexual only = sexual abuse only; S + 1 = sexual abuse plus one additional type of abuse; S + 2 or more = sexual abuse plus two or more additional types of abuse. Means within a row that differ in their subscripts are statistically different at $p < .05$.

¹Significant main effect of number of abuses, $F_s(2, \geq 219) \geq 3.23, p_s < .05$.

²Significant main effect of victim type, $F_s(1, \geq 219) \geq 24.29, p_s < .001$.

agencies. Child cases were significantly more likely than adult cases to be investigated by police, social services, and district attorneys. There were no reliable differences in police investigation as a function of the number of abuses in cases, but social service workers were more likely to investigate multiple abuse cases than cases involving sexual abuse only. District attorney investigations were more likely in cases involving sexual abuse plus one other form of abuse.

We also examined the outcomes of cases that were investigated (see Table 2). Legal action (e.g., arrest, trial, conviction) and social service substantiation were more likely in child than adult survivor cases. However, the likelihood of legal action did not generally increase as a function of the number of abuses. The one significant difference associated with the number of abuses concerned social service substantiation. Social service agencies were more likely to substantiate sex-plus-one cases than either of the other two types of cases. It is possible that when a child experiences sexual abuse plus another form of maltreatment, there may be more evidence than when a child is experiencing sexual abuse only. Thus, the abuse claims can be more easily substantiated. Moreover, social services may intervene before the number of abuses increases further. It is less clear why cases involving three or more abuses were not as likely to be substantiated. Perhaps some of these cases involve false reports or exaggeration (see Bottoms et al., 1996).

Psychological Sequelae of Abuse

The main goal of our research was to understand the psychological correlates of religion-related abuse. Thus, we examined the relations between the forms of abuse experienced by the victims and (a) the symptoms for which they originally sought therapy and (b) their Diagnostic and Statistical Manual III-R (DSM III-R) diagnoses (made by our clinician/respondents). We performed 2 (victim type) \times 3 (number of abuses) analyses of variance on the proportion of cases involving the various symptoms and diagnoses. In addition, because preliminary correlational analyses indicated that the number of abuses suffered was significantly related to the perpetrator being the child's parent or step-parent ($r = .61, p < .01$), we conducted analyses of covariance with perpetrator relationship serving as the covariate.

Presenting symptoms. As predicted, compared to clients who experienced only child sexual abuse, clients who experienced multiple forms of abuse were more likely to complain of a variety of psychological symptoms. As revealed in Table 3, the number-of-abuses variable was significantly related to depression, insomnia, somatic complaints, excessive fears

TABLE 3. Presenting Psychological Symptoms (Proportion of Cases)

	Case type			Mean
	Sexual only	S + 1	S + 2 or more	
Depression ^{1,2}				
Child	.38	.53	.63	.48
Adult	.63	.67	.83	.70
Mean	.54 _a	.65 _{ab}	.78 _b	.63
Insomnia ^{1,2}				
Child	.00	.05	.25	.07
Adult	.11	.15	.45	.21
Mean	.07 _a	.11 _a	.40 _b	.17
Somatic complaints ¹				
Child	.09	.05	.31	.13
Adult	.13	.19	.45	.23
Mean	.12 _a	.13 _a	.41 _b	.20
Excessive fears and phobias ¹				
Child	.12	.32	.31	.22
Adult	.17	.33	.40	.27
Mean	.15 _a	.33 _b	.38 _b	.25
Suicidal ideation ^{1,2}				
Child	.03	.37	.31	.19
Adult	.26	.44	.55	.38
Mean	.19 _a	.41 _b	.48 _b	.32
Social withdrawal ¹				
Child	.15	.26	.50	.26
Adult	.13	.19	.31	.19
Mean	.14 _a	.22 _{ab}	.36 _b	.21
Inappropriate aggression ^{1,2}				
Child	.24	.16	.38	.25
Adult	.07	.04	.31	.13
Mean	.12 _a	.09 _a	.33 _b	.17

NOTE. Sexual only = sexual abuse only; S + 1 = sexual abuse plus one additional type of abuse; S + 2 or more = sexual abuse plus two or more additional types of abuse. Means within a row that differ in their subscripts are statistically different at $p < .05$.

¹Significant main effect of number of abuses, $F_s(2, 208) \geq 3.94, p_s < .05$.

²Significant main effect of victim type, $F_s(1, 208) \geq 6.18, p_s < .05$.

and phobias, substance abuse, social withdrawal, and inappropriate aggression. It was also significantly related to less frequently mentioned symptoms that are not included in the table, including inappropriate toilet behavior (in 5% of cases), obsessive compulsiveness (in 10% of cases), and substance abuse (in 17% of cases), all $F_s(2, 208) \geq 3.63, p < .05$. With the exception of substance abuse, these main effects were all still significant (or closely approached significance in the case of depression) when perpetrator relationship was statistically controlled in the analyses of covariance. For each of the symptom categories, victims who had experienced two or more types of abuse in addition to sexual abuse were significantly more likely to have reported the symptom than victims who alleged only sexual abuse. Moreover, for insomnia, somatic complaints, inappropriate toilet behavior, and inappropriate aggression, having experienced two types of abuse in addition to sexual abuse was associated with more symptoms than having experienced sexual abuse plus one other form of abuse. Finally, victims who experienced sexual abuse plus one other type of abuse presented clinically with more fears and phobias than those who experienced only sexual abuse.

Among children, sexual acting out is one of the most consistent indicators of child sexual abuse (Finkelhor & Browne, 1986; Kendall-Tackett, Williams, & Finkelhor, 1992). Victims in 19% of our cases (23% child and 17% adult) began therapy with sexual behavior problems. Although there were no significant main effects of either victim type or number of abuses, a significant interaction revealed that child cases involving sexual abuse plus one (37%) or two or more (31%) forms of abuse were more likely to result in sexual acting out than cases involving only sexual abuse (12%), $F(2, 208) = 3.19, p < .05$. This predicted pattern did not emerge for adults.

DSM III-R diagnoses. We also examined the DSM III-R diagnoses that the clinician/respondents gave to their clients (see Table 4). Several diagnoses are of particular interest for child sexual abuse cases, including PTSD, MPD, and other dissociative disorders. Victims were diagnosed with PTSD in 24% of cases, with MPD in 15% of cases, and (not shown in the table) with other dissociative disorders in 6% of cases. Because of missing data in some cells, we performed one-way ANOVAs to test for effects of number of abuses for each diagnosis. Significant main effects of number of abuses emerged for all three. However, when relationship to perpetrator was covaried, the main effect of number of abuses remained significant for other dissociative disorders, $F(2, 152) = 3.08, p < .05$, and closely approached significance for MPD, $F(2, 152) = 2.41, p < .10$. Clients who experienced sexual abuse plus two other types of abuse were more likely to be diagnosed with MPD, other dissociative disorders, and

TABLE 4. DSM III-R Diagnoses (Proportion of Cases)

	Case type			Mean
	Sexual only	S + 1	S + 2 or more	
Alcohol/drug problems				
Child	.06	.15	.10	.10
Adult	.08	.12	.00	.06
Mean	.07	.13	.02	.07
Affective disorders				
Child	.19	.38	.00	.21
Adult	.27	.27	.16	.24
Mean	.26	.31	.12	.23
Multiple personality disorder¹				
Child	.00	.15	.20	.10
Adult	.11	.12	.31	.16
Mean	.09 _a	.13 _{ab}	.29 _b	.15
Post-traumatic stress disorder¹				
Child	.25	.15	.40	.26
Adult	.14	.31	.38	.23
Mean	.16 _a	.26 _{ab}	.38 _b	.24
Personality disorders				
Child	.13	.08	.10	.10
Adult	.23	.27	.19	.23
Mean	.21	.21	.17	.20
Sexual disorders				
Child	.06	.00	.00	.03
Adult	.08	.00	.03	.05
Mean	.07	.00	.02	.04
Adjustment disorders				
Child	.19	.08	.10	.13
Adult	.15	.12	.03	.11
Mean	.16	.10	.05	.12

NOTE. Sexual only = sexual abuse only; S + 1 = sexual abuse plus one additional type of abuse; S + 2 or more = sexual abuse plus two or more additional types of abuse. Other diagnoses were mentioned infrequently: organic disorders, schizophrenic disorders, somatoform disorders, and eating disorders in 1% of cases, and impulse control problems in 2% of cases. Childhood disorders were noted only in child cases: 25% of sexual only cases, 8% in S + 1 cases, and 10% of S + 2 or more cases. Means within a row that differ in their subscripts are statistically different at $p < .05$.

¹Significant main effect of number of abuses, $F_s(2, 157) \geq 3.88, p < .05$.

PTSD than clients who experienced sexual abuse only or sexual abuse plus one additional type of abuse.

As would be expected, a variety of other diagnoses were given to victims in the cases, including affective and personality disorders. Interestingly, eating disorders characterized less than 1% of cases, even though such disorders are often thought to be prevalent among survivors of sexual abuse (see Ofshe & Watters, 1994, for a discussion).

Psychological correlates of specific combinations of abuse. Finally, we were interested in victims' psychological symptomatology and diagnoses as a function of the exact combinations of abuse characterizing the cases. In Table 5, we present the proportion of cases (broken down into catego-

TABLE 5. Presenting Symptoms and DSM III-R Diagnoses as a Function of Specific Combinations of Abuse (Proportion of Cases)

		Case type: Combinations of abuse						
		S	S/E	S/N	S/P	S/N/E	S/P/E	S/P/E/N
Symptoms:	N =	113	29	3	14	3	26	26
Depression		.55	.69	1.00	.50	.67	.77	.81
Insomnia		.07	.10	.67	.00	.33	.54	.31
Somatic complaints		.11	.17	.33	.07	.00	.58	.31
Excessive fear/phobias		.16	.34	.33	.21	.33	.42	.38
Sexual acting out		.16	.17	.33	.36	.67	.35	.00
Obsessive/compulsive		.07	.03	.00	.07	.33	.38	.00
Suicidal ideation		.20	.38	1.00	.36	.33	.50	.50
Substance abuse		.11	.10	.33	.29	.00	.35	.27
Social withdrawal		.13	.28	.33	.14	.33	.50	.23
Inappropriate aggression		.11	.07	.00	.21	.00	.42	.27
DSM III-R diagnoses:	N =	84	27	3	10	1	15	23
Alcohol/drugs		.07	.07	.00	.30	.00	.00	.04
Affective disorders		.25	.33	.67	.10	.00	.20	.09
MPD		.08	.15	.00	.10	.00	.40	.26
PTSD		.15	.30	.00	.40	1.00	.33	.35
Personality disorders		.20	.19	.33	.30	.00	.07	.22
Sexual disorders		.07	.00	.00	.00	.00	.07	.00
Adjustment disorder		.15	.07	.00	.20	.00	.00	.09

NOTE. S = sexual abuse only; S/E = sexual and emotional abuse; S/N = sexual abuse and neglect; S/P = sexual and physical abuse; S/N/E = sexual abuse, neglect, and emotional abuse; S/P/E = sexual, physical, and emotional abuse; S/P/E/N = sexual, physical, and emotional abuse, and neglect.

rics of every possible combination of abuse) involving various presenting symptoms and diagnoses. Because the number of cases in some of the categories is quite low, statistical analyses were not performed. However, the breakdown is still interesting and suggestive of future lines of research. For example, the means indicate that, predictably, the presenting symptom of aggression is primarily associated with sexual abuse in combination with physical abuse. Examining DSM III-R diagnoses reveals that MPD was particularly likely to be diagnosed if sexual, physical, and emotional abuse were all alleged to have occurred. Additionally, the table reveals that our sample included more cases involving certain combinations of abuse (i.e., sexual abuse, physical abuse, and emotional abuse) rather than others (i.e., sexual abuse, neglect, and emotional abuse). These trends deserve to be examined in future studies.

DISCUSSION

As expected, the data revealed that, compared to victims who experienced only sexual abuse, clients who experienced multiple forms of abuse were significantly more likely to exhibit psychological symptoms such as depression, suicidal ideation, and phobias, and were more likely to be diagnosed by clinicians with serious conditions such as PTSD, MPD, and other dissociative disorders. In children, sexual acting out was more likely to occur among sexual abuse victims who were also abused in other ways. These results are consistent with previous research on the effects of multiple forms of abuse (e.g., Hart et al., 1989) and with research on the effects of accumulated risk factors (e.g., Garnezy & Rutter, 1983; Rutter, 1979). According to earlier studies and our own findings, children who experience multiple forms of abuse are especially likely to suffer adverse psychological consequences.

However, we did not find a significant increase across the three levels of abuse in the presenting symptoms of substance abuse and inappropriate aggression, or in DSM III-R diagnoses of substance-abuse addictions and impulse control. The occurrence of such symptoms and diagnoses would not be expected to differ significantly if substance abuse and aggression are associated with all of the kinds of religion-related abuse we studied, including child sexual abuse only. It is still surprising that the symptoms and diagnoses did not increase as the number of abuses increased.

Ney et al. (1994) reported that, in child sexual abuse cases, the worst combination of additional abuses is verbal (i.e., emotional) abuse and physical neglect. Unfortunately, very few ($n = 3$) of the cases in our sample fell into this category. However, for those few, there did not seem

to be an increase in presenting symptoms compared, for instance, to cases involving the combination of sexual, physical, and emotional abuse.

It is important to keep in mind that our findings are restricted to religion-related child abuse cases involving allegations of sexual abuse. Although we suspect that the pattern of our results will generalize to other samples, further research is necessary. Religion-related abuse may involve additional stressors not normally included in abuse cases lacking a religious component. Consider, for example, that in many sexual abuse cases the trusted abuser gives contradictory messages—taking sexual advantage of a child while saying, “This is how Daddy shows his love for you.” Consider further that religion-related abuse may create an additional “double bind” for children. Many of the victims in our study were abused by parents who communicated, in effect, that “God wants me to do this” or by religious authorities who indicated, for example, that “You can trust me, I’m a priest.” Thus, like a daughter who is sexually abused by her father and simultaneously told that he is doing it for her own good, religion-related abuse victims may be abused by someone who uses religion as a means of creating, or adding to, a child’s emotional confusion.

Finally, because our findings are correlational, causal relations cannot be confidently inferred. There may be confounding variables about which we are unaware. First, for example, clinicians’ theories about the emotional sequelae of abuse may have affected their diagnoses. Second, although we statistically controlled for perpetrator relationship in our central analyses, the effects of multiple victimization associated with intra- versus extrafamilial abuse should be disentangled further in future studies. Third, we did not examine how compensatory factors within or outside the family might have affected clients’ outcomes. Fourth, we had no measure of abuse severity, independent of the number of kinds of abuses suffered. It therefore remains unknown whether excessive abuse of one type is more damaging than the combined force of several types of abuse that are less serious or long-lasting. Moreover, a child may have suffered multiple forms of abuse even though only one form could be documented with confidence, and different definitions of abuse may have been used by different clinicians. Finally, it is possible that some of the reports of abuse were false; clinicians are generally not in a position to verify reported abuse. Especially when extreme forms of abuse were described and MPD was diagnosed, there is a possibility that highly suggestible, disturbed clients exaggerated or confabulated some of their abuse experiences (Spanos, 1994).

Obviously, random assignment to single versus multiple abuse groups is not, and never will be, feasible. Hence, even correlational results such as ours are helpful in providing insight into the issue of multiple forms of

abuse. As far as we know, ours are the first empirical findings on the correlates of multiple forms of abuse in religion-related abuse cases. We have found that adherence to certain religious ideologies and practices can contribute to single or multiple forms of child maltreatment, and that the psychological sequelae of religion-related abuse are best understood in light of the specific types and combinations of abuses suffered by victims. We hope that our findings will be of benefit to practitioners encountering cases involving multiple abuses and religious ideology, and to future researchers who may address important issues that remain unanswered in the study of religion-related, multi-form child abuse.

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REFERENCES

- Bagley, C., Wood, M., & Young, L. (1994). Victim to abuser: Mental health and behavioral sequels to child sexual abuse in a community survey of young adult males. *Child Abuse and Neglect, 8*, 683-697.
- Berry, J. (1992). *Lead us not into temptation: Catholic priests and the sexual abuse of children*. New York: Doubleday.
- Bottoms, B.L., Shaver, P.R., & Goodman, G.S. (1996). An analysis of ritualistic and religion-related child abuse allegations. *Law and Human Behavior, 20*, 1-34.
- Bottoms, B.L., Shaver, P.R., Goodman, G.S., & Qin, J. (1995). In the name of God: A profile of religion-related child abuse. *Journal of Social Issues, 51*, 85-111.
- Brassard, M., Germain, R., & Hart, S. (1987). *Psychological maltreatment of children and youth*. New York: Pergamon.
- Briere, J.N., & Elliott, D.M. (Summer/Fall 1994). Immediate and long-term impacts of child sexual abuse. In R.E. Behrman (Ed.), *The future of children:*

- Sexual abuse of children* (Vol. 4, pp. 54-69). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.
- Brown, G.R., & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry*, 148, 55-61.
- Browne, A., & Finkelhor, D. (1986). Impact of sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66-77.
- Bullis, R.K. (1991). The spiritual healing "defense" in criminal prosecutions for crimes against children. *Child Welfare*, 30, 541-555.
- Capps, D. (1992). Religion and child abuse: Perfect together. *Journal for the Scientific Study of Religion*, 31, 1-14.
- Chu, J.A., & Dill, D.L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry*, 147, 887-892.
- Claussen, A.H., & Crittenden, P.M. (1991). Physical and psychological maltreatment: Relations among types of maltreatment. *Child Abuse and Neglect*, 15, 5-18.
- Coons, P.M. (1986). Child abuse and multiple personality disorder: Review of the literature and suggestions for treatment. *Child Abuse and Neglect*, 10, 455-462.
- Deblinger, E., McLeer, S.V., Atkins, M.S., Ralphe, D., & Fox, E. (1989). Post-traumatic stress in sexually abused, physically abused, and nonabused children. *Child Abuse and Neglect*, 13, 403-408.
- Finkelhor, D. (1984). *Child sexual abuse*. New York: Free Press.
- Finkelhor, D., & Dziuba-Leatherman, J. (1994). Children as victims of violence: A national survey. *Pediatrics*, 94, 413-420.
- Finkelhor, D., Williams, L.M., & Burns, N. (1988). *Nursery crimes*. Newbury Park, CA: Sage.
- Garbarino, J. (1980). Defining emotional maltreatment: The message is the meaning. *Journal of Psychiatric Treatment and Evaluation*, 2, 105-110.
- Garbarino, J., Dubrow, N., Kostelny, K., & Pardo, C. (1992). *Children in danger: Coping with the consequences of community violence*. San Francisco, CA: Jossey-Bass.
- Garbarino, J., & Vondra, J. (1987). Psychological maltreatment: Issues and perspectives. In M. Brassard, R. Germain, & S. Hart (Eds.), *Psychological maltreatment of children and youth* (pp. 25-44). New York: Pergamon.
- Garnezy, N., & Rutter, M. (1983). *Stress, coping, and development in children*. New York: McGraw-Hill.
- Greven, P. (1991). *Spare the child: The religious roots of punishment and the psychological impact of physical abuse*. New York: Knopf.
- Hart, L.E., Mader, L., Griffith, K., & deMendonca, M. (1989). Effects of sexual and physical abuse: A comparison of adolescent inpatients. *Child Psychiatry and Human Development*, 20, 49-57.
- Hobbs, C.J., & Wynne, J.M. (1990). Sexually abused battered child. *Archives of Diseases in Childhood*, 65, 423-427.

- Kendall-Tackett, K.A., Williams, L., & Finkelhor, D. (1992). Impact of sexual abuse on children: A review and synthesis of recent empirical findings. *Psychological Bulletin*, 113, 164-180.
- Keppel, G. (1982). *Design and analysis*. New York: Prentice Hall.
- Kiser, L., Millsap, P., & Heston, J.D. (1992). A clinical description of victims of psychical and sexual abuse in a day treatment population. *International Journal of Partial Hospitalization*, 8, 89-96.
- Moeller, T., Bachmann, G.A., & Moeller, J.R. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: Long-term health consequences for women. *Child Abuse and Neglect*, 17, 623-640.
- NCCAN (1994). *Child maltreatment 1992: Reports from the States to the National Center on Child Abuse and Neglect*. Washington, DC: U.S. Department of Health and Human Services.
- Ney, P.G., Fung, T., & Wickert, A.D. (1994). The worst combinations of child abuse and neglect. *Child Abuse and Neglect*, 18, 705-714.
- Ofshe, R., & Watters, E. (1994). *Making monsters: False memories, psychotherapy, and sexual hysteria*. New York: Scribners.
- Putnam, F.W., Post, R.M., Guroff, J., Silberman, M.D., & Barban, L. (1983). 100 cases of multiple personality disorder. *New Research Abstract #77*. Washington, DC: American Psychiatric Association.
- Riggs, S., Alario, A.J., & McHorney, C. (1990). Health risk behaviors and attempted suicide in adolescents who report prior maltreatment. *Journal of Paediatrics*, 116, 815-821.
- Russell, D. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect*, 7, 133-146.
- Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M.W. Kent & J.E. Rolf (Eds.), *Primary prevention of psychopathology*, Vol. 3. Hanover, NH: University Press of New England.
- Sameroff, A., Siefert, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotient scores of 4-year-old children: Social-environmental risk factors. *Pediatrics*, 79, 343-350.
- Skolnick, A.A. (1994). Massachusetts' new child abuse and neglect felony law repeals religious exemption. *Journal of the American Medical Association*, 271 (7), 489-491.
- Spanos, N. (1994). Multiple identity enactments and multiple personality disorder: A sociocognitive perspective. *Psychological Bulletin*, 116, 143-165.
- Swett, C., & Halpert, M. (1993). Reported history of physical and sexual abuse in relation to dissociation and other symptomatology in women psychiatric patients. *Journal of Interpersonal Violence*, 8, 545-555.