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Child abuse in religiously-affiliated institutions: Long-term impact on men's mental health

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Abstract

Objective: To describe the long-term impact of physical and sexual abuse of boys by someone in a trusting, non-familial relationship. This clinical study reports on the psychological functioning of men ($N = 76$) with substantiated claims against a residential religiously-affiliated institution for multiple and severe incidents of sexual, physical, and/or emotional abuse during childhood. The abuse was perpetrated by several adults in positions of authority and trust at the institution.

Methods: Each participant received a clinical interview and was administered psychological tests and a structured interview for DSM-IV diagnoses. The same clinician completed all of the assessments.

Results: DSM-IV criteria were met for current PTSD (42%), alcohol (21%), and mood-related disorders (25%). Over one-third of the sample suffered chronic sexual problems, and over one half had a history of criminal behavior.

Conclusions: The clinical findings provide direction for assessing victims of historical abuse, and underscore the importance of awareness, prevention, and treatment needs for those who have been abused in institutional settings. Conclusions are limited due to participants' involvement in civil action, unknown pre-existing conditions, and the lack of a suitable comparison group.

Keywords: Child abuse; Religious institutions; Sexual abuse

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Men and women who were abused during childhood have a high incidence of current and lifetime PTSD, especially if they experienced chronic or severe maltreatment (Boney-McCoy & Finkelhor, 1996; Widom, 1999). Male victims of physical and sexual abuse report an inability to seek and maintain gainful employment, to trust others, to develop intimate relationships, and to regulate their anger and behavior (Romano & DeLuca, 2001). They also have higher lifetime rates of anxiety, alcohol abuse/dependence, and antisocial behavior than non-abused men (MacMillan & Munn, 2001), which often results in multiple psychiatric diagnoses. Similar to the impact of abuse by a family member, the long-term effects of child abuse in *non-familial* settings have been linked to the nature of the relationship with the abuser, the significance of the setting, and the nature and severity of the abuse (Wolfe, Jaffe, Jetté, & Poisson, 2003). Moreover, persons abused by individuals in a position of trust may manifest not only mental health problems, but also a number of affiliated losses and disruptions that exacerbate mental health symptoms, such as loss of faith and trust (Lawson, Drebing, Berg, Vincellette, & Penk, 1998).

Over the last two decades the victimization of children in non-familial settings has received increased public and professional attention in terms of the prevalence and impact of such events (Nunno, 1997). Although prevalence estimates are unknown, records based on one segment of this population reflect the enormity of the issue: children made more than 11,000 allegations of sexual abuse by over 4000 priests between 1950 and 2002 (U.S. Conference of Catholic Bishops, 2004). Because of their unique dynamics and the large numbers of victims and abusers often involved, cases of abuse by non-familial persons constitute a significant challenge to the legal system and treatment providers (Gallagher, 2000). The present study is unique in that it provides psychological test results and diagnostic outcomes of a large sample of men who were severely abused as children by their male caregivers in a religiously-affiliated institution. We sought to determine the extent to which these men suffered from PTSD, mood, and substance use disorders, as well as associated adjustment problems.

Method

Participants

Participants were 76 men laying claims against the assets of a religiously affiliated institution in relation to acts of physical and sexual abuse perpetrated against them by their surrogate caregivers. A class action lawsuit was announced nationwide from 1997 to 1999 through newspaper and similar media, and men had to come forward to be considered for the claims process. Men had been placed as children in the care of the institution by child welfare authorities due to their parents' inability to care for them, often due to illness or death of a parent, poverty, or alcoholism. The acts of abuse occurred between the early 1960s and the late 1980s, but were not investigated until the 1990s. These acts were validated as part of a civil action, and most were prolonged and severe. Over two-thirds of the men were victims of severe and chronic physical and/or sexual abuse, which included one or more of the following acts: oral sex, anal sex, digital penetration, beatings, major blows with a fist or object, being hit with an object, and thrown against stationary objects. These acts were sometimes accompanied by threats or other life-threatening circumstances. Abusive acts in the remaining one-third of the sample included sexual touching/fondling, masturbation, slapping, pushing, or hitting. Because almost all of the men were victims of both physical and sexual abuse no attempt was made to divide the sample in terms of abuse experiences. Men ranged in age from 23 to 54 years ($M = 39.17$) at the time of the assessment. Almost one third (31.6%) had

never married, while another 35.5% were married at the time of the assessment. Slightly over half of the men had not completed high school (51.3%), and most were either unemployed or employed in semi- or un-skilled positions (73.3%).

Procedures and measures

This assessment was conducted as part of a court settlement to compensate victims. Men understood that the purpose was to evaluate their current psychological adjustment and offer an opinion to the court as to the extent of damages due to their abuse. Informed consent regarding the purpose and nature of the psychological assessment was obtained prior to the assessment through their counsel; the University of Western Ontario institutional review board considered the protocol exempt from ethical review because these data were from a standard clinical assessment. Each man was assessed individually by the same clinical psychologist to permit relative comparisons of the impact of abuse on their functioning. This clinician had access to all clinical notes and records relating to the claimant's background and medical/psychological history, including police, school, counseling, and medical records. The 6 h assessment involved a semi-structured interview, followed by psychological testing and a structured clinical interview. The semi-structured interview assessed men's family and social relationships, sexual adjustment, substance use, criminal histories, education, and employment. Men also described the impact of the abuse on their past and current functioning in their own words.

The *Trauma Symptom Inventory* (TSI; Briere, 1996) assessed each claimant's trauma-related symptoms over the past 6 months. The TSI includes 100 items tapping into 10 scales assessing a variety of trauma-related symptomatology, and has shown acceptable reliability and validity. The *Personality Assessment Inventory* (PAI; Morey, 1991) provided a standardized assessment of each claimant's psychological functioning. The PAI contains 344 items that comprise 11 empirically-derived clinical scales, as well as four validity scales. The *Structured Clinical Interview for DSM-IV, Clinician Version* (SCID-CV; First, Spitzer, Gibbon, & Williams, 1996) is a diagnostic interview designed to assist clinicians in making reliable DSM-IV Axis I psychiatric diagnoses. This interview was conducted at the end of the assessment and after the tests were computer-scored, to permit the psychologist to have an adequate basis for administering only those modules that were indicated by presenting symptoms and PAI findings, which included Mood Episodes, Psychotic Symptoms, Psychotic Disorders, Mood Disorders, Substance Use Disorders, and Anxiety Disorders. The PTSD module was administered with respect to their trauma experience(s) at the institution. Data analysis involved descriptive statistics of means and standard deviations.

Results

Axis I disorders

Over half of the participants (59.2%) presented with a current Axis I disorder, while 88.2% had had an Axis I disorder at some point. The most common disorders were PTSD, Alcohol Disorder, and Major Depressive Disorder. As Table 1 illustrates, nearly two-thirds of the sample was diagnosed with either current (42.1%) or past (21.1%) PTSD; similarly, many met criteria for current (21.1%) or past (44.7%) Alcohol Disorder and/or Mood Disorder (25% current). Four men presented with a history of non-alcohol substance use disorder. Of those men who met diagnostic criteria for more than one of these three disorders

Table 1
Psychiatric disorders (PTSD, alcohol, mood, and anxiety) and criminal histories of men with severe abuse histories ($N=76$)

	Current (%)	Past (%)	Ever (%)
Psychiatric disorders			
PTSD	42.1	21.1	63.2
Alcohol	21.1	44.7	65.8
Mood	25.0	11.8	36.8
Other anxiety disorders	5.3	1.3	6.6
Pattern of disorders[a] (N)	22	43	
PTSD and alcohol	40.9	46.5	87.4
PTSD and mood	50.0	16.3	66.3
Mood and alcohol	.0	7.0	7.0
PTSD, mood, alcohol	9.1	30.2	39.3
Criminal history[b]			
Property	–	–	50.7
Substance-related	–	–	49.3
Violent	–	–	39.4
Sexual	–	–	5.5

[a] Refers to the pattern of individuals presenting with more than one of the three most commonly reported disorders: PTSD, mood, and alcohol disorders. A small number of participants presented with multiple diagnoses that included a non-alcohol substance use disorder or other anxiety disorder (see text).
[b] Represents the proportion who have been arrested for an offense as indicated by self-report.

at the time of the assessment ($N=22$), half presented with PTSD and mood disorders or PTSD and alcohol disorders; 9.1% presented with all three disorders.

Psychometric findings

We approached the self-report data in a conservative manner to minimize possible reporting bias. Accordingly, 24 men (31.6%) were removed from PAI analyses due to significant elevations on the Negative Impression or Inconsistency scales, resulting in 48 valid (63.2%) PAI profiles (4 men were missing these data). This step resulted in fewer PAI scales that were clinically elevated, although the profile pattern of the reduced sample was similar to that of the full sample. Two clinical scales remained significantly elevated: Anxiety-Related Disorders (T-score $M=70.15$, $SD=13.30$) and Borderline ($M=71.31$, $SD=12.77$), with elevations on each scale accounted for by one principal subscale (Traumatic Stress, $M=80.13$, $SD=13.44$; Negative Relationships, $M=70.17$, $SD=11.82$; subscales of Anxiety-related and Borderline scales, respectively). Further examination of other subscales also revealed a sub-clinical elevation on Physical Aggression ($M=69.50$, $SD=18.59$).

Similarly, 58 valid TSI profiles were obtained (84% of the 69 completed). As with the PAI, this conservative approach produced no significant change in the mean pattern of responding from the total sample. Valid profiles showed significant elevations on the Depression, Intrusive Experiences, Defensive Avoidance, and Dissociation scales, as well as the Trauma and Dysphoria factor scales. The mean for the Intrusive Experiences scale was elevated to a level at or above 98% of subjects in the TSI standardization sample.

Additional adjustment problems

One in four men (27.5%) reported a history of confusion concerning their sexual orientation (typically in their late teens and early 20s), and one in five (21.7%) were currently experiencing confusion or uncertainty. Three men (4.1%) considered themselves homosexual or bisexual; three (4.1%) met criteria for homosexual pedophilia. Over two-thirds (66.2%) of the sample reported a history of sexual problems in their personal relationships, and 46% were experiencing sexual difficulties at the time of the interview. Such difficulties included hypersexuality (8.3%), hyposexuality (31.7%), feelings of inadequacy (6.7%) and related difficulties. Of the men who had ever had an intimate partner of at least 1 month, nearly half (49%) reported verbal and/or physical abuse of their partner. Many men reported a history of criminal involvement (see Table 1). Approximately half of the sample had been arrested for a property offense (50.7%) or substance-related offense (49.3%). Many had also been arrested for violent offenses (39.4%).

Almost all men in the study expressed a sense of betrayal and loss of trust, which extended beyond the interpersonal realm to include a loss of faith and a devaluing of the Church. They described a global loss of trust that generalized to other institutions sanctioned by society, such as schools and workplaces. Many men expressed anger toward the institution and the lengthy claims process, and had a lack of respect for authority and a poor outlook on their future, which they attributed to the years of silence and inaction regarding their abuse.

Discussion

Men with histories of severe abuse by caregivers at a residential setting demonstrated severely disrupted mental functioning. They typically met criteria for more than one diagnosis, especially current or past alcohol abuse, PTSD, and mood disorders. The frequency of PTSD-related symptoms, as determined by multiple assessment methods, is consistent with longitudinal studies, although the extreme nature of the multiple forms of abuse they experienced resulted in even higher current and past levels (e.g., Widom, 1999). A substantial number had a criminal history involving both person- and property-related crimes, and suffered from sexual orientation confusion or sexual dysfunction. They expressed strong emotions and memories associated with their abusive experiences, despite the years between the abuse and the current assessment.

The impact of abuse by persons in authority at community-sanctioned institutions and organizations is similar to that of intrafamilial abuse, with some important distinctions. The importance of the institution, the role of the perpetrator(s) within the setting, and the community's response to allegations of abuse affect long-term adjustment, in addition to post-abuse events such as arrest, denial, or punishment of the offender. In the present case, perpetrators used their position within the organization to obtain the child's compliance; they also used verbal coercion by telling children that such acts were "the will of God," or that God would punish them if they did not do what they were told. Like abuse in family settings, explicit threats are often not necessary, as the child has been raised to never question the authority of religious leaders (Kennedy, 2000). On several occasions a child's efforts to disclose the abuse were thwarted by the strong community support for the institution, as well as the resources and power of the institution itself. Because the institution was located in a small, closely knit community that was bound by cultural, ethnic, and religious identities, formidable resistance still remains to acknowledging the men's abusive experiences and ongoing needs.

The present findings are limited by several considerations. Some accounts of abuse were retrospective and thus susceptible to distortion and memory biases. This bias was reduced by thorough investigation and cross-referencing to factual circumstances by court-appointed investigators. Similarly, the court process may have affected men's reporting of symptoms. Almost one-third of the PAI profiles could not be properly interpreted due to excessive negative self-presentation. It is unknown whether these respondents represent a subgroup of abused men who were over reporting in the context of seeking compensation, or whether they experienced exceptionally or severely high levels of distress and symptomatology beyond the original validation sample (i.e., there are no published norms for victims of extreme physical and sexual abuse). Even with the removal of invalid profiles, the men's pattern of responding revealed high levels of distress. In addition, all of the men in this sample experienced very severe forms of abuse within a 24 h residential setting, which may not be representative of other forms of abuse in non-familial settings. Comparisons with a matched sample of individuals with no abuse experience, or with non-institutional abuse experiences, would help determine the unique elements and impact of institutional abuse.

Practice implications

Victims of historical abuse are coming forward at alarming rates, and the field of mental health needs to become more familiar with their particular assessment and treatment needs. This study revealed numerous mental health and adjustment problems in these men, which had previously been overlooked or misunderstood in the absence of information and awareness pertaining to their early abuse experiences. The current findings suggest that men often attempt to control their discomfort and distress through substance abuse, and may suffer long-term posttraumatic stress symptoms that may interfere with many aspects of daily life, such as employment, family and peer relationships, and self-regulation. Clinical assessments are an important aspect to the recognition and eventual recovery from these significant events.

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213 **Résumé**

214 **Objectif :** Décrire les conséquences à long terme lorsque des garçons sont maltraités physiquement
215 ou sexuellement par une personne sans lien parental en qui ils avaient confiance. Cette étude clinique se
216 penche sur le fonctionnement psychologique de 76 hommes qui revendiquent un grand nombre de mauvais
217 traitements physiques, sexuels et psychologiques graves perpétrés lorsqu'ils étaient des enfants résidant
218 dans une institution confessionnelle. Un bon nombre d'agresseurs occupaient des postes d'autorité et
219 auraient dû inspirer la confiance.
220 **Méthode :** Chacun des participants de l'étude a été soumis à une entrevue clinique et une entrevue
221 structurée et a complété des tests psychologiques afin d'être classé dans une catégorie diagnostique du
222 DSM-IV. Cet ensemble de tests a été mené par la même personne.
223 **Résultats :** Pour ce qui est du désordre de symptômes post-traumatiques, 42% des critères ont été
224 satisfaits; pour les désordres relatifs à l'alcool, 21%; et pour les désordres affectifs, 25%. Plus d'un tiers
225 de l'échantillon ont souffert de problèmes sexuels chroniques et plus de la moitié du groupe ont eu des
226 comportements criminels.
227 **Conclusions :** Les constats cliniques nous rappellent l'importance d'une anamnèse des mauvais traite-
228 ments et soulignent l'importance d'être conscient des possibilités de mauvais traitements, la prévention
229 et les besoins thérapeutiques des personnes qui ont été victimes de mauvais traitements résidentiels. Les
230 conclusions sont limitées parce que les participants sont engagés dans une processus juridique, parce
231 que les antécédents des victimes sont inconnus et parce qu'il n'existe pas de groupe de comparaison
232 adéquat.

233 **Resumen**

234 **Objetivo:** Describir el impacto a largo plazo del maltrato físico y el abuso sexual cometido sobre chicos
235 por parte de alguien que tiene una relación de confianza y no es familiar. Este estudio clínico se basa en el
236 funcionamiento psicológico de 76 varones con quejas comprobadas contra una institución religiosa por
237 haber sufrido múltiples y severos incidentes maltrato físico, emocional y/o sexual durante la infancia.
238 El maltrato fue perpetrado por varios adultos con una posición de autoridad y confianza dentro de la
239 institución.

Método: A cada participante se le aplicó una entrevista clínica, test psicológicos y una entrevista estructurada para detectar trastornos psicopatológicos en base al DSM-IV. Todas las evaluaciones fueron llevadas a cabo por el mismo clínico.
Resultados: Los criterios DSM-IV para PTSD actual fueron alcanzados por un 42% de los pacientes. El 21% cumplieron los criterios para abuso de alcohol y el 25% para trastornos afectivos. Cerca de un tercio de la muestra sufrió problemas sexuales de tipo crónico y más de la mitad presentó una historia de comportamiento delictivo.
Conclusiones: Los hallazgos clínicos proporcionan indicadores para evaluar a las víctimas de maltrato en la infancia y para subrayar las necesidades de reconocimiento, de prevención y de tratamiento de aquellos que han sido objeto de maltrato en ambientes institucionales. Las conclusiones pueden estar limitadas por la implicación de los participantes en movimientos de acción ciudadana, ciertas condiciones preexistentes desconocidas y la falta de grupos de comparación adecuados.