In the Name of God:

A Profile of Religion-Related Child Abuse

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Running head: Religion and Child Abuse

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The research reported here was funded by the National Center on Child Abuse and Neglect (Department of Health and Human Services) and conducted in collaboration with Alexis Thompson and with the assistance of Kathleen Beety, Jim Brandt, Kathy Cavanaugh, Eugene Colucci, Maureen Coughlin, Leslie Dreblat, Brian Flaherty, Erica Howard, Noelle Kardos, Todd Karl, Wendy Landman, Anne Orgren, Kimberly Packard, Steve Pawlowski, Chowdry Pinnamaneni, Jianjian Qin, Susan Reisch, Chris Rhoadhouse, Karleen Robinson, Julie Rothbard, Tracey Schneider, and Kimberly Tyda. Tina Brown and Michael Raulin kindly consulted on the

use of DSM diagnostic categories. Ken Lanning and Phil Stevens consulted on various issues concerning abuse allegations. We extend special thanks to all of the professionals who completed our survey.

Abstract

Religious beliefs can foster, encourage, and justify child abuse, yet religious motivations for child abuse and neglect have been virtually ignored in social science research. In this article, we examine cases of religion-related child abuse reported to mental health professionals nationwide. In particular, we describe in statistical detail cases involving the withholding of medical care for religious reasons, abuse related to attempts to rid a child of evil, and abuse perpetrated by persons with religious authority such as ministers and priests. We argue that society should protect children's rights and welfare whenever these are threatened by religious beliefs and practices.

In 1993, a California father was convicted of first-degree murder and sentenced to 25-years-to-life for drowning his 5-year-old daughter Lisa in a bathtub. His wife was convicted of second-degree murder. According to the AP wire service, "Lisa's parents thought she was possessed by demons." They were attempting an exorcism. In 1978, David and Tammy Gilmore offered prayers to God, but sought no medical treatment, as they watched their 15-month-old son's flu-like symptoms slowly escalate from high fever to blindness, unresponsiveness, and finally, death (Hughes, 1990). In 1993, Father David Holly, a Roman Catholic priest, was sentenced to 275 years for his admitted sexual molestation of eight young boys--probably only a subset of victims from a period of perpetration that had begun as early as 1968 (Press, 1993). In the late 1980s in Washington state, two adolescent sisters attended an emotional church-camp session on incest and then accused their father, Deputy Sheriff Paul Ingram, of incest and satanic cult abuse. Under the influence of his minister, the father learned to enter a trance state in which he (almost certainly incorrectly) "remembered" the satanic events (Wright, 1994; but see Olio & Cornell, 1993).

These examples illustrate some of the ways in which religion is interwoven with allegations of child abuse in the United States. Religious beliefs can foster, encourage, and justify abusive behavior. The myriad connections between religion and child abuse led Donald Capps (1992), a recent president of the Society for the Scientific Study of Religion, to entitle his presidential address "Religion and Child Abuse, Perfect Together." Although religious himself, Capps sorrowfully traced the indisputable connection between traditional religion and violence against children. Similar points were made in Philip Greven's (1991) chilling book, Spare the Child: The Religious Roots of Punishment and the Psychological Impact of Physical Abuse (see also Pagelow & Johnson, 1988).

In the present article, we explore the complex role of religion in actual and alleged child abuse cases reported to us in the context of a nationwide survey of American mental health professionals. One objective of our survey was to determine the characteristics of child abuse cases that involve religion-related elements. To our knowledge, our sample of child abuse case reports involving religious beliefs is the largest ever to be

examined quantitatively. We review the limited literature on the ways in which specific religious beliefs are involved in child abuse, then examine our own sample of cases, focusing on characteristics of the abuse, the victims, and the perpetrators; psychological sequelae of the abuse; and evidence for and legal response to the cases.

Forms of Abuse Perpetrated in the Context of Religion

Physical Abuse

It may be hard for many Americans to believe that religiously justified child abuse occurs with any frequency. After all, religion is supposed to provide specific directives for moral action and the promotion of human welfare, not add to degradation and misery. Indeed, religious groups often play an active, positive role in prevention of child abuse and treatment of abuse victims. Yet, as historian Philip Greven (1991) points out, encouragement for violent, physically abusive childrearing techniques can be traced to Biblical passages such as, "He that spareth his rod hateth his son: but he that loveth him chaseneth him betimes" and "Withhold no correction from the child: for if thou beatest him with the rod, he shall not die. Thou shalt beat him with the rod, and shalt deliver his soul from hell" (Proverbs 13:24 and 23:13-14, respectively). Says Greven: "For believers in the literal reality of hell, salvation means escape and rescue from the eternity of suffering that many Christians believe awaits the bodies and souls of unsaved sinners. For many . . . hell is an actual, physical place of punishment, the locale of future suffering so vast, so extreme, and so permanent that our minds can hardly grasp the enormity of the threat" (1991, p. 55).

In light of directives such as those from Proverbs, and belief in a vengeful God who would punish earthly pleasure with the ultimate torture of hell, both corporal punishment to enforce parental authority and actions designed to combat Satan make sense. It is thought that sin is the vehicle to hell, inspired by a literal Satan--ergo both sin and Satan must be stopped. Accordingly, it is better that children experience a temporary hell inflicted by loving parents than that they burn in an eternal hell.

Some believers extend a literal interpretation of religious writings so far as to equate children's

misbehavior with the actual activity of Satan or other evil spirits who literally possess the children. Greven recounts an example: "She would fight at school until they whipped her and blood ran down her legs. 'The Devil's in her,' the teachers would tell her mother" (Greven, 1991, p. 192). Adults with such beliefs may consider it their duty to perform some kind of ritualistic exorcism to rid such a child of evil. The outcome can be murderous--to the child's psyche, if not to the child's body.

It is worth noting that beliefs in demonic possession are endorsed not only by lay followers of certain religious ideologies, but also by some mental health professionals. For example, in Phoenix, Arizona, the State Board of Psychologist Examiners recently revoked the license of a psychologist who attempted to exorcise "angry spirits" from a 10-year-old boy who had been beaten, sexually abused, and according to the psychologist, "demonized" by his parents (Berry, 1993). In a recent journal article, a licensed psychologist proposed a new diagnostic category, "Oppressive Supernatural States Disorder," to end the confusion between psychological personality disorders and demon possession (Friesen, 1992). In his book Uncovering the Mystery of MPD: Its Shocking Origins, Its Surprising Cures, Friesen (1991) has argued for the use of exorcism in therapy, the ethics of which have been sharply questioned (Bowman, 1992).

Although humanities scholars such as Greven and Capps are beginning to address the religious roots of harsh child discipline, few social scientists have studied physical child abuse motivated specifically by a belief in literal possession by evil. We describe the nature of such cases in our sample, and compare them to other kinds of cases involving religion.

Medical Neglect

Medical neglect dictated by religious beliefs is another route through which children become victims of religious ideology. Neglect, broadly defined, is the most common form of child maltreatment and can have severe consequences (Crouch & Milner, 1993). Nevertheless, it receives little attention compared to sexual and physical abuse (Dubowitz, Black, Starr, & Zuravin, 1993; Johnson, 1993). Harm resulting from the deliberate withholding of medical care for religious reasons may be particularly serious because it is legally

permitted in most jurisdictions (Myers, 1992), thus unlikely to be stopped. Perhaps because of this legal protection, religious motivations for child neglect have been largely ignored in the child abuse literature, even in work specifically examining medical neglect (e.g., Bross, 1982; Milner, 1993). Such avoidance of discussion and criticism of the negative effects of religion is in fact broadly characteristic of the medical and social sciences.

Religious groups most noted for shunning modern medicine include Jehovah's Witnesses, who do not believe in blood transfusions, and Christian Scientists, who favor prayer treatment over other medical procedures. In the New England Journal of Medicine, Christian Scientist Nathan Talbot stated that Christian Scientists are "caring and responsible people who love their children and want only the best possible care for them" (1983, p. 1641). But that "best possible care" includes treating children with prayer alone for such serious afflictions as leukemia, club feet, spinal meningitis, bone fracture, and diphtheria, all of which Talbot claims have been cured by prayer treatment alone. The mechanism for prayer curing? A practitioner, whose "entire training . . . consists of two weeks of religious instruction" and whose services are often covered by insurance companies (Swan, 1983) provides "heartfelt yet disciplined prayer that brings to a case needing healing a deeper understanding of a person's actual spiritual being as the child of God. This understanding is held to be the crucial factor in dissolving the mental attitude from which all disease ultimately stems . . . [Disease] is in the last analysis produced by a radically limited and distorted view of the true spiritual nature and capacities of men and women" (Talbot, 1983, p. 1642).

Other fundamentalist groups also believe that medical treatment is a blasphemous intrusion into God's plan. For example, the religious ideology of Indiana-based Faith Assembly, as expounded by founder Hobart Freeman, is that "Satan controls the visible, sensory realm of nature, and he works through the occult forces of medicine, science, and education" (Hughes, 1990, p. 108). Largely as a result of the members' avoidance of "satanic" modern medicine, during the late 1970s and early 1980s childbirth mortality in Freeman's group was 100 times greater for mothers and three times greater for their infants than rates in the

general population (Hughes, 1990).

Such religious groups cite the First Amendment's prohibition of government interference with religion as legal justification for their negligence. Although other countries such as England and Canada legally mandate medical care for children, all but four of the United States (South Dakota, Hawaii, Massachusetts, and Maryland) grant some form of religious exemption to child protection (Bullis, 1991; Swan, 1994). For example, in its definition of neglected and abused children, Virginia's statute excludes children who are "under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious organization" (pp. 548, Bullis, 1991).

In 1944 the Supreme Court ruled that "the right to practice religion freely does not include liberty to expose the community or child to communicable disease or the latter to ill health or death" (Prince v. Massachusetts, cited in Bullis, 1991, p. 551). This directive was bolstered in 1982 by the Child Abuse Prevention and Treatment Act, which established states' responsibility to enforce newborn medical care (Dubowitz et al., 1993). Even so, either because of their own personal religious beliefs, heavy lobbying from religious groups (particularly Christian Scientists), or reluctance to compromise First Amendment rights, state legislators have been steadfast in their scientifically unjustifiable position of retaining religious exemptions--supporting statutes that exempt parents and others from prosecution for harm to children resulting from religiously motivated medical neglect.

Even though courts can and often do intervene to order medical treatment for children at severe risk, because of legal exemptions religiously motivated child neglect is unlikely to be reported in the first place, even by professionals outside the church. To illustrate, a small survey study of medical doctors revealed that 71% would consider the parents' religious beliefs in their decision about whether or not to report medical neglect cases (Johnson, 1993). When cases are reported, legal action against the perpetrators often stalls, even in the face of conclusive evidence. Worse yet, although religious exemptions are usually contained within child abuse and neglect statutes, they have also been used in defenses against more serious charges.

For example, a California judge acquitted a Christian Science couple charged with manslaughter of their infant son who died of treatable bacterial meningitis. The judge decided that intermittent signs of improvement during the child's illness could be taken as evidence that prayer treatment did not necessarily constitute gross negligence (Bullis, 1991). In so ruling, he applied a good-faith religious treatment exemption to manslaughter culpability.

Nevertheless, in the wake of several widely publicized child deaths and under pressure from various public and professional groups such as CHILD (Children's Healthcare is a Legal Duty) and the American Medical Association (Skolnick, 1994), exemption repeals are being sought in state legislatures, and legal sanctions against neglectful parents are being applied. For example, in perhaps the most publicized case of religiously motivated neglect, 2 1/2-year-old Robyn Twitchell needlessly suffered the excruciating pain of an obstructed bowel for a week before he lapsed into a coma and died (Skolnick, 1990; Treene, 1993). Although Massachusetts maintained religious exemption laws at the time (recently repealed), a jury found parents David and Ginger guilty of negligent homicide. The Christian Science Church considered the verdict a "gross intrusion of the First Amendment" and an "unmitigated attempt to undermine the Christian Science way of life" (Skolnick, 1990, p. 1226). Ironically, although Christian Science ideology had allowed Robyn Twitchell only prayer treatment for his life-threatening illness, it had previously sanctioned his father's surgery for impacted wisdom teeth and his mother's anesthesia during his birth.

It may be a long while before legal exemptions for religiously motivated medical neglect are dismantled. Thus, such neglect is likely to continue. We thought it important to understand the nature of religiously motivated neglect cases, the harm done to victims, and the investigation and prosecution patterns associated with its disclosure.

Abuse Perpetrated by Persons Having Religious Authority

The news media have been flooded recently with claims of abuse perpetrated by religious officials, particularly Catholic priests (Berry, 1992). This abuse may be psychologically damaging for children who

have been raised to fear God and revere the Church and its leaders. To child (and adult) parishioners, clergy are inherently powerful, trustworthy, and free by definition of mortal vice in much the same way as is God. This is illustrated in a recent comment by an attorney pursuing several child abuse suits against the Catholic Church: "We looked up to our teachers, to our Scout leaders, but not like we did to the priest. He was next to God" (Press, 1993, p. 42). Child sexual abuse perpetrated by religious figures is often characterized by the same guilt, betrayal of trust, and shame common to familial incest (Blanchard, 1991). "The priest who's been approved by your parents is saying, 'It's OK, this is normal.' I don't know if anyone can understand the guilt you feel at a moral level" (from a victim of Father David Holly; Press, 1993, p. 42).

The Catholic Church's response has historically been to do nothing more than initiate surreptitious parish changes for offending priests (Blanchard, 1991; Laaser, 1991). (Records reveal that the Catholic Church knew of Holly's perversion as early as 1968; Press, 1993). Only with the advent of recent media attention has the Church begun to investigate itself and admit the need for public accountability. Still, even writers in religiously oriented journals urge that suspicions of child abuse by religious leaders be reported to legal authorities rather than to ineffective Church officials (Isely & Isely, 1990).

Although speculations abound that Catholic celibacy requirements foster the tendency to sexually abuse children (Berry, 1992), sexual abuse is certainly not a problem confined to religious leaders of the Catholic faith (Isely & Isely, 1990; Laaser, 1991). Our data include cases in which priests, ministers, and others with religious authority abused children. Although various incidence estimates have been advanced in media accounts, to date no one from the scientific community has systematically investigated the numbers of these cases being reported to therapists, the characteristics of these cases, and the psychological effects of this abuse on alleged victims.

Overview

In a large, national survey of mental health professionals, we gathered information about reports of religion-related abuse, as well as about ritualistic child abuse. Detailed information about the latter types of

cases are reported elsewhere (Bottoms, Shaver, & Goodman, in press; Goodman, Qin, Bottoms, & Shaver, 1994). We focus in the present paper on the nature of child abuse allegations related to religion in the three ways just described--torturing or killing a child to rid him or her of evil, withholding needed medical care for religious reasons, and abusing a child under the cover of a religious role--as reported to us in the context of our nationwide survey. We provide an overview of our methodology and sample, and then discuss the cases themselves, the abuse suffered by victims, and harm resulting from the abuse.

Method

Survey

We surveyed a total of 19,272 professionals: 5,998 clinical psychologists who were members of the American Psychological Association, 7,381 psychiatrists who were members of the American Psychiatric Association, and 5,896 clinical social workers who were members of the National Association of Social Workers (NASW).[1] Our study was conducted in two phases: a postcard survey to identify clinicians who had encountered relevant cases and a detailed survey to obtain more complete information about the cases. In the postcard phase, each clinician received a cover letter in 1990 or 1991 explaining that we were interested in child abuse allegations involving ritualistic, ceremonial, supernatural, religious, or mystical practices, cases that included one or more of the features in Table 1. On a brief postcard reply form, respondents reported the number of such cases they had encountered during the 1980s. They were asked to differentiate cases reported by children and those reported by adult survivors (i.e., adults 18 or older who claim to have been abused during their childhood).

After initial and reminder mailings of postcards, there were 6,939 valid respondents (at the minimum a 37% response rate, given that our bulk-mailing method undoubtedly resulted in many missed targets), of whom 2,136 (31%) reported that they had encountered at least one ritualistic or religion-related abuse case. A follow-up survey was sent to these 2,136 clinicians, each of whom was asked to provide detailed information about up to eight typical ritualistic or religion-related cases they had encountered. The response

rate to this questionnaire was also 37% (797).[2]

Case Definition

Respondents provided information about a total of 1,652 cases of ritualistic or religion-related child abuse reported by either adult survivor or child clients. Based on the case features shown in Table 1, we distinguished religion-related from ritualistic cases (see Bottoms et al., in press, for details; features F15 through F18 identified kinds of religion-related abuse). There were 417 religion-related cases, of three kinds: (a) abuse involving the withholding of medical care for religious reasons; (b) abuse related to attempts to rid a child of the devil or evil spirits; (c) abuse perpetrated by religious professionals such as priests, rabbis, or ministers. For present purposes, we chose to examine only "pure" instances of each of the three kinds of cases (rather than include four or more kinds of "mixed" cases as well), that is, cases involving no more than one of each of the three defining features. We allowed any of the three, however, to include "abuse committed in a religious setting."[3] The total number of religion-related cases considered in the present analyses was 271: 25 "pure" cases involving medical neglect (17 reported by children, 8 by adults), 69 involving abuse related to attempts to rid a child of evil (41 reported by children, 28 by adults), and 177 in which the perpetrator of abuse had religious authority (55 reported by children, 119 by adults--the status of victim as child or adult survivor was impossible to determine in 3 cases).

Interestingly, our respondents sometimes resisted emphasizing the religious nature of their cases. For example, several clinicians hesitated to classify cases of beatings to rid children of evil as truly "religion-related," noting that the perpetrators were psychotic. We, however, had no hesitation in classifying them so: As told to us by our respondents, the perpetrators' beliefs were shaped and their abuses were scripted by religious ideology. For example, one clinician reported: "The aunt truly believed she could beat the devil out of the children, and mother and brother were present and failed to protect the children . . . I believe psychotic processes were involved, but no one intervened." And another wrote, "I don't know if you would consider this truly related to religious issues: This paranoid schizophrenic mother allegedly said to her 5-year-old son,

'We're going to heaven and you're going first.' She then stabbed him repeatedly before stabbing herself." (Both survived. The mother was tried and acquitted on grounds of temporary insanity.)

Respondents also resisted attaching religious significance to abuse perpetrated by religious professionals, arguing that the abuse was not different from other sexual abuse and that the religious element of the abuse--the status of the perpetrator--was unimportant. For example, one respondent wrote, "It really was not religious in nature--just happened to be perpetrated by a woman who was also a nun." We believe, however, that there are good reasons for considering this abuse as different from other kinds of sexual abuse. Publicly recognized religious leaders have authority and power that provide special access to children. Because religious leaders are thought to be moral or holy, their sexual advances are likely to be particularly confusing, guilt-inducing betrayals for victims. Because victims may be aware of parental and community veneration of religious authorities and of the church and religion they represent, victims may be particularly reluctant to disclose abuse, believing (perhaps rightly) that their claims will be ignored. Even adults who notice a suspicious relationship between a religious professional and a child may be very unlikely to question it (Isely & Isely, 1990). Thus, the special circumstances of abuse by religious authorities may make it particularly likely to go unreported and keep recurring, and to promote painful confusion in young victims that make its long-term psychological consequences difficult to bear.

Results

We first present analyses comparing the three kinds of religion-related cases. When respondents provided enough information, we performed 2 (victim type: child or adult survivor) X 3 (case type: medical neglect, ridding a child of evil, abuse by religious professionals) analyses of variance. However, where noted in tables, when missing data or numerous cells with means of zero would not permit this analysis, we conducted one-way tests comparing the three types of religion-related cases, collapsing across victim type. Main effects of case type were followed by Tukey tests of pairwise comparisons of means, as recommended by Keppel (1982). It should be noted that when proportions appear as cell means, the analyses were based on

dichotomous (feature present vs. feature not present) variables, not on proportions. (The mean of a 0-1 variable is equal to the proportion of 1's.)

Characteristics of Abuse

Forms of maltreatment. What forms of maltreatment are experienced by child victims of religion-related abuse? As shown in Table 2, nearly all reported abuse perpetrated by religious professionals (94%) was sexual in nature. Even if this percentage is inflated by false allegations, as some have suggested, the result is still remarkable. Religious professionals' role as unquestioned moral leaders apparently gave them special access to children, much like the access that trusted family members have in incest cases. For example, one respondent noted that the Archbishop of a Greek Orthodox Church "used position of power to gain access" to teenage girls. Another respondent wrote of a Catholic priest who "used his role to deceive parents and coerce children into sexual behavior." Finally, a clinician provided the following example to show that religious authorities use their roles to gain victims' trust: "Victim was told she could trust her Southern Baptist youth pastor and allow him to fondle her."

About half (48%) of ridding-evil cases and a quarter (23%) of neglect cases included allegations of sexual abuse. For example, a psychiatrist reported that his adult female client claimed that she experienced at age 7 "what is the equivalent of gang rape in the name of religion--announcement was made to assembled men that this was to rid the child of the devil."

Generally, sexual abuse was significantly more likely to be reported by adult survivors than children, especially in neglect and ridding-evil cases. Perhaps only the most severe of such cases come to the attention of authorities when the victims are still children, leaving victims with less publicly noticeable abuse to reveal it later, in psychotherapy.

Physical abuse, psychological abuse, and neglect were present at different levels across the three types of cases. By definition, neglect characterized more withholding of medical care cases than other types of cases, but it was also noted in some cases of ridding a child of evil. The incidence of physical abuse was

higher in ridding-evil cases than in other cases. The physical abuse suffered by victims was often quite severe: One respondent wrote that a client described being "made to kneel on grater for hours. Metal device was put on her head, then her father would use a screwdriver to bang on head." The child had physical wounds as a result. Another respondent told us about a case in which an "eyeball was plucked out of a youth's head during an exorcism ceremony."

Psychological abuse was most commonly reported in child ridding-evil cases and adult medical neglect cases. This victim-type (age) difference in viewing medical neglect as psychologically abusive, which accounts for the interaction referred to in Table 2, may reflect adults' more sophisticated interpretations of the neglect they received as children.

Finally, 2% of all cases involved a murder (three ridding-evil cases and one religious professional case). This probably underrepresents the actual number of cases that result in the death of a child, because our respondents were largely reporting cases in which their clients had survived abuse and entered therapy as a result.

Settings and circumstances of abuse. Clinicians specified whether their clients' abuse occurred in the home, in a daycare setting, or in other settings (see Table 2). The most frequently mentioned other setting was a religious location such as a church, church school, or rectory. Ridding-evil and neglect cases were likely to occur in the home, and none happened in daycare. Abuse perpetrated by religious professionals was most likely to occur in religious settings, but sometimes also in victims' homes or in schools.

One might expect that allegations of abuse would be more likely to come from children whose parents' marriages were in the process of dissolution, but this was not true in our sample. Victims' parents were involved in divorce in only 10% of all cases; rate of divorce did not differ significantly as a function of case or victim type.

Characteristics of Victims and Perpetrators

Number and gender. It has been suggested that most sexual abuse committed by religious authorities, particularly Catholic priests, targets boys rather than girls (Isely & Isely, 1990) and is perpetrated by men rather than women. Surprisingly, our data did not support these assumptions (see Table 3). In religious authority cases, there were more male than female perpetrators, but even so, many female perpetrators were reported.[4] The perpetrators were usually religious leaders such as priests or ministers, but they also included youth ministers, nuns, and at least one tribal medicine man and one archbishop.

Male and female victims were about equally common, even in cases in which the perpetrator was Catholic (M = 1.38 girl victims and M = 1.21 boy victims per case). In fact, in cases reported by adult survivors, more female than male victims were reported to have been involved. Thus, either the media emphasis on the abuse of boys is incorrect, perhaps skewed by a presupposition of homosexual tendencies of priests, or there is a substantial underrepresentation of reports of male abuse to mental health professionals. The latter is certainly plausible; the sexual abuse of boys is generally believed to be underreported, and the reason our adult reports included more female than male victims may be due to the disproportionately large number of women who seek therapy as adults.

Ridding-evil and neglect cases did not differ from religious authority cases in the number of perpetrators, male or female. On average, there were over two perpetrators involved in the neglect cases, split fairly equally in terms of gender, probably reflecting the fact that perpetrators were parents acting in unison to restrict medical treatment, as dictated by a shared religious ideology.

Victim age. Neglect and ridding-evil cases had a relatively early onset, but perpetrators with religious authority did not approach their victims until they were older (around 10 years old), suggesting that these perpetrators on the whole are less likely to abuse very young children (see Table 3). Religious authority cases were also discovered at a later time than other cases, probably because they were characterized by sexual abuse, which is less overtly physically damaging than the abuses associated with the other case types.

Not shown in the table is the fact that children were likely to have entered therapy soon after their

abuse (.87, 1.83, and 4.50 years, respectively, for neglect, ridding-evil, and religious-authority cases). Adult survivors reported entering therapy after longer delays (15.20, 21.16, and 18.56 years, respectively).

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 (Table 3). Abuse by strangers was so rare that we omitted it from the table; there were only 3 cases in all. Neglect and ridding-evil cases were most likely to have been perpetrated by parents. Interestingly, in 20% of the cases involving religious professionals, that professional was also a parent. Acquaintances were more often perpetrators in cases involving medical neglect than in other kinds of cases, probably reflecting the participation of practitioners "accredited" by churches for alternative treatments.

Religion of victims and perpetrators. Of particular interest, respondents were asked to provide the religion of perpetrators and victims (see Table 4). We collapsed responses into the following categories: Fundamentalist (including Mormon, Pentecostal, Seventh Day Adventists, Faith Assembly World Wide Church of Christ, and groups defined by their avoidance of certain medical procedures, such as Jehovah's Witnesses and Christian Scientists); Protestant (including Episcopal, Baptist, Lutheran, Methodist, Presbyterian, Quakers); Catholic (including Roman Catholic and Greek or Russian Orthodox); and "other" (a group of diverse religions, each rarely mentioned and not logically placed within the previous categories: Jewish, Asian, Native American, Satanic, Muslim, and "no religion" or Atheist).

Over half of the religious authority cases involved perpetrators and victims who were Catholic, even though Catholics comprise only around 25% of the U.S. population (see Table 4). In cases in which children were abused in an effort to rid them of evil, most were fundamentalist or Protestant (even though Catholicism is stereotypically noted for its use of exorcism). Fundamentalists were most likely to withhold medical care from their children. Protestantism was about equally likely to be involved in each type of case.

Did the abuse have any effect on the religious orientation of the victims? Respondents knew their clients' religion both before and after abuse in 62% (169) of the cases. Of the victims in those cases, 21%

(36) were reported to have changed religions (75% were victims of abuse perpetrated by a religious professional, 17% were victims of abuse related to ridding evil, and 8% were medically neglected). Most victims who changed religious orientation were Catholic (56%) or fundamentalist (28%). The nature of the change was usually a repudiation of religion: 70% changed to atheism. To illustrate, reporting a case involving an adult male who had been sexually abused as an 11-year-old altar boy by his priest, a clinician noted that the man had become an atheist who "hates Church and hates God and has intense rage about all aspects of religion."

Psychological Sequelae of Abuse

To understand the psychological consequences of religion-related abuses, we examined the psychological symptoms for which clients originally sought therapy and the DSM-III-R diagnoses they were assigned by their therapists. In general, there were few differences between the groups of victims (see Table 5), partly because of the large number of diagnostic categories and the correspondingly small number of cases in each one. One significant difference in the analyses of presenting symptoms was that victims who were abused to rid them of evil (shown above to have been the most violently physically abused group of victims) were the most likely to act out with their own aggression.

Most of the alleged victims originally sought therapy for depression, especially victims of abuse by religious professionals, who also tended to have suicidal ideation and be diagnosed as suffering from affective disorders. Strikingly, over a third of the adult victims of ridding-evil and religious-authority abuse, and almost a fifth of the children who reported being abused by religious professionals, had considered suicide. (See Straus, 1995, Ch. 5, for evidence concerning the link between corporal punishment, depression, and suicide.) The consequences of abuse by religious authorities have been speculatively equated with that of sexual abuse committed by other kinds of perpetrators (Isely & Isely, 1990). Here we document that abuse by religious authorities is as psychologically damaging, and perhaps more damaging, than even the violently physical abuses of parents whose religious beliefs led them to view their children as evil incarnate.

Other serious psychological symptoms were displayed by the victims. Multiple personality and other dissociative disorders, once rarely diagnosed, were fairly common in our sample, being diagnosed in over 20% of adult cases of ridding-evil and medical neglect. To illustrate, one clinician noted that she "saw the son of a Jehovah's Witness family. He described the group as trying to rid him of devils or evil spirits. He was dissociative--his lack of ability to concentrate caused poor performance in school, which is why he was referred." It is theorized that the etiology of dissociative disorders is extreme childhood abuse (Putnam, 1989); our data are compatible with the claim that there is a relation between being harshly abused early in life and being diagnosed with dissociative disorders later on.

Credibility of Allegations and Legal Outcomes

It is impossible to validate with certainty the cases reported to us, but we did ask a number of questions designed to obtain some indication of validity. First, we were interested in whether our respondents believed their clients' claims of harm. Overwhelmingly they did. The overall belief level among clinicians was 1.96, on a scale ranging from 0 "not true" to 2 "true." There was no difference in belief among the three case types.

What was the basis for the therapists' strong belief? We asked them to describe the evidence for their cases, both for the harm itself and, separately, for the religious aspects of the case. Responses to the harm question were coded into four categories: (a) client's claims; (b) clinician opinion/psychological symptoms (including the client having psychological or physical symptoms of abuse, special knowledge relevant to the abuse, or convincing memories); (c) physical or other corroborative evidence reported by the client but not necessarily seen by the therapist (e.g., letters and diaries, perpetrator confessions); and (d) miscellaneous. We also further analyzed the physical/corroborative evidence that would meet four criteria commonly employed by the legal system: (a) testimony by a witness or another victim, (b) physical evidence, (c) medical evidence such as venereal disease, and (d) confession or admission by the accused.

Although concrete evidence might be expected in cases involving medical neglect or physical torture

to rid a child of evil, we did not expect to find hard evidence for sexual abuse perpetrated by those with religious authority. Indeed, much controversy currently surrounds the validity of such claims. As can be seen in Table 6, our expectations were supported: Allegations of abuse by religious professionals were the most likely to be supported only by clients' claims and less likely to be accompanied by medical or other physical evidence. Even so, there was convincing evidence in many of the cases; one respondent wrote, for example: "She has clear memories and has confronted the priest. He has reluctantly admitted it."

Interestingly, children's claims were backed with more convincing evidence than adults' (as indicated by significant victim-type main effects noted in the table). Compared to adults' reports, children's reports were significantly more likely to involve corroborative evidence and less likely to be substantiated only by the client's symptomology and therapist's opinion. In general, this is probably due largely to the long delay between the events in childhood and their description to a therapist years or even decades later.

We also asked respondents to indicate evidence specifically supporting the involvement of religion in the abuse. Responses fell into five non-mutually exclusive categories: (a) client reports seemed convincing based on clinical indicators such as flashbacks, post-traumatic play, and dramatic expressions of emotion; (b) client's claims; (c) physical or other corroborative evidence; (d) skepticism expressed by the respondent regarding the validity of the abuse; and (e) miscellaneous.

Again, children's reports were more likely than adults' to be substantiated by corroborative evidence, while the evidence for adults' claims was more likely to consist only of the client's symptomatology and the therapist's opinion (indicated by significant victim-type effects in Table 6). Corroborative evidence was particularly likely in cases involving ridding children of evil and medical neglect. In fact, all child reports of medical neglect were substantiated, either by medical evidence or perpetrator confession. (In the table, figures for child and adult cases are combined.) In contrast, there was little "hard" evidence supporting the claims of abuse by religious professionals. In fact, in 11% of the cases, respondents made a comment indicating skepticism about the religious elements of the abuse, usually about the identity of the perpetrator.

For example, one respondent wrote, "Sexual abuse by priest is patient's self-report. Over two years, it became unclear whether abuse had occurred, or whether 'father' was actually perpetrator and the priest (father) was metaphor."

Overall, there was less compelling evidence in cases reported by adults than in cases reported by children (as indicated by significant victim-type and interaction effects), especially in ridding-evil cases. Evidence for religious beliefs leading to harmful medical neglect or attempted exorcism of children was particularly convincing, often including a straightforward admission by parents, as illustrated in the following quotations from different clinicians about their ridding-evil cases:

"Child and guardian reported that the child's behavior was the result of the child being possessed by the devil."

"Parents reported that their 9-year-old girl 'smelled like evil.' They chained her to drive the devil out."

"Self-report of child and mother that girl had been treated this way her entire life--mother did not view the behavior as abusive."

"The father performed an exorcism on his children by dismembering and then boiling them. Evidence? The children were dead."

There were similarly compelling commentaries concerning the medical neglect cases:

"Abuse was obvious--victim was in hospital when parents refused blood transfusion."

"Child nearly died--court intervened."

We also asked the clinicians to tell us about outside investigations and legal outcomes of the cases (see Table 7). Social services was most likely to investigate ridding-evil and medical neglect cases. Otherwise, there were no significant effects of case type. There were, however, some large victim-type (child vs. adult) differences, not shown in detail in the table, which indicated that social services was much more likely to have investigated child cases (59% of them) than adult cases (8%), and there was much less often an

investigation of any kind in the adult cases (6%) than in child cases (39%). In fact, adult cases were rarely even reported to officials. Although not supported by statistical tests on investigation data, because of too many zero cell frequencies, cases reported by children were much more likely to have been formally investigated by police or district attorneys than cases reported by adult survivors.

Concerning case outcome, claims made by adults were more likely than claims made by children (87% vs. 27%) never to have been never reported. Moreover, compared to adult allegations, claims made by children were more likely to be substantiated by social services or by police arrest, and adjudicated. They were also more likely to be tried successfully: Only 1% of adult cases ended in conviction, whereas almost 20% of all child cases did. Surprisingly, given the pattern of results regarding case evidence, once child cases were reported, arrests, trials, and convictions were most likely in cases perpetrated by religious authorities.

Interestingly, few cases (1% of ridding-evil cases and 1% of religious-authority cases) resulted in civil suits, even though skeptical journalists have recently suggested that victims, particularly those who allege past sexual abuse, may press charges only out of a self-serving desire to seek financial damages.

What are the implications of these findings for the validity of the abuse allegations in our sample? Concerning the difference in evidence between child and adult reports, it is possible that more adult than child claims are false. Alternatively, the lack of hard evidence may reflect the fact that adults are reporting abuse that allegedly occurred many years previously. It would be surprising to find any physical evidence after such a long period of time. Further, when the adult survivors allegedly experienced their abuse--as children 20 to 30 years ago--there was much less societal awareness of child sexual abuse. This would have made them less likely than today's children to disclose their abuse.

The differences in evidence as a function of case type may reflect the nature of the actual harm in the different cases. As discussed earlier, over 90% of the cases perpetrated by religious authorities involved sexual abuse. Sexual abuse often goes undisclosed, and may be especially likely to be undisclosed when perpetrated by a person of powerful religious stature and community recognition. Severe medical neglect and

beatings are by their nature more likely to result in physical evidence and hence come to the attention of authorities.

Nevertheless, considerable controversy surrounds claims of abuse made by adults who allege that religious professionals sexually abused them as children, and it is possible that some of these claims are false. Claims made by adults supposed to have recovered formerly repressed memories of the abuse are of particular concern. For example, in a recently well-publicized case in Chicago, charges were brought against Cardinal Joseph Bernardin by a man who claimed to have recovered memories of sexual abuse during hypnotherapy (e.g., Ness & Salter, 1994). Later, the alleged victim recanted, denying the veracity of his memories and dropping all charges against Bernardin (though not against the Catholic Church for other alleged abuse). In contrast, other victims, like David Clohessy--who claimed to have regained memories through "flashbacks" as an adult (Press, 1993)--remain convinced of their childhood abuse. In some of our cases, and in several widely publicized cases around North America, confessions by Catholic priests have corroborated adults' memories of childhood molestations.

Within psychology, opinion has polarized regarding the validity of repressed memories of childhood sexual abuse in general (Loftus, 1992). We did not ask clinicians specifically whether repressed memory was involved in their religion-related cases. Nevertheless, we were able to code the cases as involving repressed memory when the clinician noted that feature 20 (see Table 1) was involved in the case and volunteered that the client had experienced amnesia for the abuse and recovered memories of it. In fact, this would have been an appropriate response to open-ended questions regarding the circumstances of abuse disclosure. No child cases and only 3% of adult cases involved specific indication of repressed memory. This included three cases of abuse by religious professionals, and one case of abuse to rid evil.

Thus, with the caveat that our method of coding is conservative, it is possible that recently publicized cases in which memories of abuse by Catholic priests are first repressed, then uncovered in contexts like psychotherapy, are probably rare compared to the number of cases in which abuse victims always

remembered they were abused.

Finally, perhaps our most disturbing finding is that cases involving medical neglect were unlikely to be prosecuted even in the face of compelling evidence and the extreme nature of the abuse. It is remarkable that current laws protect perpetrators who act in ways such as the following, described in separate clinicians' case descriptions:

"Chants, candles, and other ritualistic treatments were used in place of scientific medicine because parents believed that a 'hex' was put on their child by someone who disliked them."

"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."

According to a representative of the largest of religious groups that avoid medical treatment, such actions are only exhibitions of love for a child. "The only purpose of Christian Scientists' work with legislators has been to ensure that the responsible use of prayer on behalf of children is not equated with abuse and neglect" (Talbot, 1983, p. 1644). Of course, the validity of this claim depends on the definition of "responsible." In our opinion, sole reliance on prayer in the absence of most modern medical care--the treatment plan of Christian Scientists (Talbot, 1983)--is irresponsible. Thus, we do equate this kind of treatment with abuse and neglect, as have others (Swan, 1983).

Ritualistic Abuse

Our findings concerning ritualistic abuse cases have been presented in detail elsewhere. Here, we need mention only that such cases were generally marked by extreme and florid features--large numbers of perpetrators and victims, bizarre cult practices, animal and human sacrifices, diagnoses of multiple personality disorder--for all of which there was little convincing evidence. Moreover, only 2% of our clinician respondents were responsible for most of the reported cases, suggesting that they might be doing something special in their therapy sessions to generate or reinforce accounts of ritualistic abuse. The extreme features and diagnoses were especially characteristic of adult-survivor cases, which (like some of the adult

religion-related cases) were difficult to corroborate. We came away from these results sympathizing with skeptics (e.g., Richardson, Best, & Bromley, 1991; Stevens, 1992; Victor, 1993) who believe that the "satanism scare" was created, at least in large part, by religious publishing companies, television evangelists, and self-styled satanism experts, many of whom seem to have been traditionally religious, whose intense worries eventually became communicated to local clergy and parishioners. Thus, religion--perhaps including the religious beliefs of certain clinicians--may be largely responsible for the perceived threat of satanism.

Discussion

In a 1988 review article, Gorsuch asked, "Is religion an important psychological variable?" When considering the abuse of children, our data indicate that it is. We uncovered several factors that make religion-related abuse worth considering apart from other forms of child abuse. For example, religion-related abuse can be particularly damaging because young victims may come to believe that the abuse is parentally or supernaturally sanctioned or required, or is a punishment for their own sins, as illustrated by these comments from different respondents:

"The older brother of a 10-year-old girl invoked religion in continuing sexual abuse that had been begun by another unknown adult. Victim was told it was God's punishment."

"Victim told mother when it happened. Mother told no one else and is still friendly with the offender-priest."

"Abuse was done by priest and his wife--the boys were told it was part of their religious obligation, they had to do it to be 'good Christians.'"

"Victim had overt, chronic sexual abuse by both parents. She was placed out of home with minister, who then fondled her because she was a 'bad girl.'"

Religion-related abuse is particularly insidious when it is sanctioned or hidden by a church, causing victims to internalize blame and avoid disclosure, and, in turn, resulting in the perpetrators continuing their

abuse as their chances for being discovered and punished are diminished. Our respondents noted organized church sanctioning of abuses:

"Grandmother reported she witnessed the child's abuse at church, justified by the religious idea of ridding children of the devil."

"Parents initiated request for a gathering of Pentecostal church members to pray together to rid 9-year-old girl of evil spirit. The mother felt powerless to control child. She joined charismatic church and out of desperation had child prayed for in front of church."

Coverups by churches were also noted:

"In all five cases, the fact that the abuses were perpetrated by the clergy with the approval of the Catholic church made it difficult for the children to believe their feelings of being abused . . . At first, they believed they were wrong or bad, not the church."

Such practices, perhaps most widely noted in the Catholic church, led sociologist Andrew Greeley (himself a priest) to write in his preface to Jason Berry's (1992) book on sexual abuse by Catholic priests, "Bishops have with what seems like programmed consistency tried to hide, cover up, bribe, stonewall; often they have sent back into parishes men whom they knew to be a danger to the faithful . . . Catholicism will survive, but that will be despite the present leadership and not because of them." Other religions may also be at fault for cover-ups. For example, one clinician wrote of a Jehovah's Witness congregation's response to her male client's charges of sexual abuse against their minister: "Victim aware that revealing sexual abuse by minister would likely (and did) result in 'disfellowship,' isolation from all significant others, due to his 'lie.'"

Of course, not all abuse is performed with a church's tacit permission, as illustrated in this example: "Father believed son was possessed by devil and that he must be stopped from influencing others. Father took son to Catholic priest to be exorcised. Priest called social services . . . "

Other Forms of Religion-Related Abuse

It is important to note that in this article and in our survey, we have ignored other forms of religion-

related child abuse that are of importance and need future examination if we are to fully understand the point at which religion fosters damaging abuse rather than compassionate child-rearing. As an example, one of our clinicians wrote about the abuses reported by several adult clients who attended Catholic schools in their childhood: "They reported crowded classrooms with poorly trained, ill-equipped teachers who ruled by playing on the children's fear of hell and sin. It locks the children into self-doubt, fear of authority, impairment of adult identity."

Perhaps the most obvious of the forms of abuse we did not investigate is severe physical punishment for disciplinary reasons rooted in religious ideology. One of our respondents wrote: "In addition to these cases, I have seen several others (maybe two dozen) in which there was neglect and/or physical abuse and the parents related their actions to their religious value systems (i.e., 'spare the rod, spoil the child'), but I would not consider them to be abuse inspired by religion as much as abusive parenting rationalized by religion." We do not agree with this respondent's conclusion, nor would others such as Greven and Capps who have written about this form of religiously motivated and sanctioned abuse. Some non-mainstream religious groups and isolationalist cults have been found to practice severe beatings in the name of Godly discipline (e.g., Malcarne & Burchard, 1992). When discovered, such cults' abusive practices and even their particular religious beliefs are immediately highlighted in the news media, and criticized and rejected by society with much self-righteousness. Yet how different are these beliefs and practices from those of many Methodist, Baptist, or Catholic parents? As Greven notes, abusive parenting styles have been driven by mainstream religious beliefs for centuries. They are part of our Euro-American heritage, and if religion-related child abuse is not acknowledged now as a problem by our society and its lawmakers, it will be our legacy to the future.

Social scientists in general and child abuse researchers in particular have tended to steer clear of connections between religion and child abuse. There is little information about how religion relates to spending time with children, using various child-rearing techniques with children, allowing religious professionals to abuse children, and so on. We analyzed information made available by the windows of social

service investigations and psychotherapy sessions; we have no way of moving from our data to base rates in the general population.

Conclusion

One of our respondents, the head of a child and adolescent psychiatry unit at a prominent mental health center, commented: "The cases I report herein are sad: an adult recalling abuse by fundamentalist parents who may have been psychotic, two children who were abused by fundamentalist parents who believed that they were carrying out Biblical injunctions. These are bad enough situations without having the general population alarmed about some sort of satanic conspiracy." We agree. Our study leads us to believe that there are more children actually being abused in the name of God than in the name of Satan. Ironically, while the public concerns itself with passing laws to punish satanic child abuse, laws remain established that protect parents whose particular variants of belief in God deny their children life-saving medical care. The freedom to choose religions and to practice them will, and should, always be protected by our constitution. The freedom to abuse children in the course of those practices ought to be curtailed. In the long run, society should find ways to protect children from religion-related abuse and to help religions evolve in the direction of better treatment of children.

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Footnotes

[1]To increase the likelihood of finding clinicians who had worked with child abuse victims, we oversampled certain subcategories of the professions, except social workers: NASW could not provide us with mailing labels broken down into subspecialty categories. Among psychologists, we randomly selected 3278 members whose primary specialties were clinical, counseling, school, or child, and 2720 from all other specialties. Among psychiatrists, we randomly selected 2995 child psychiatrists, 1908 dissociative disorder specialists, and 2478 from all other specialties.

[2]Of the 7249 postcard respondents, 6939 were deemed valid (not retired or deceased, etc.), of whom 2722 were clinical psychologists, 2083 were psychiatrists, and 2134 were social workers. Of the 797 clinicians who returned detailed surveys, 720 were deemed valid. Of these, 297 were clinical psychologists, 200 were psychiatrists, and 223 were social workers. Seventy-seven respondents to the detailed survey were eliminated either because they decided after reconsidering our criteria that they had not encountered any cases or because we decided their cases were inappropriate; for example, the alleged victim was an animal rather than a child.

[3]We did not analyze cases involving abuse committed in a religious setting separately because many of the other kinds of cases included that feature, and because those cases were not as conceptually interesting: We wanted to examine cases in which the perpetration of abuse was connected with religious ideology or authority, which was not necessarily so in cases that just happened to occur in religious settings such as religiously sponsored schools.

[4]Several outliers were noted in the data: one report of 100 male victims and another of 40 victims (gender unspecified). Because these values were more than three standard deviations above the mean number of victims, and were far removed from the next highest values reported to us, we removed them from the total number of victims and total number of male victims.

Table 1

Features Used to Define Ritualistic and Religion-Related Abuse Categories

F1: abuse by a member or members of any cult-like group in which members feel compelled to follow the orders of a leader or leaders
F2: abuse related to any practice or behavior repeated in a prescribed manner (including prayers, chants, incantations, wearing of special costumes)
F3: abuse related to symbols (for example, 666, inverted pentagrams, inverted or broken crosses), invocations, costumes, beliefs, etc. associated with the devil
F4: abuse related to belief in supernatural, paranormal, occult, or special powers (for example, magical surgery, calling on spirits, magical flying)
F5: abuse associated with threats or activities involving graveyards, crypts, bones, the dead, ghosts, etc.
F6: abuse involving rituals using human or animal excrement or blood
F7: abuse involving rituals that include special knives, candles, altars, etc.
F8: abuse involving actual or staged sacrifice or killing of humans
F9: abuse involving actual or staged torture of humans
F10: abuse involving actual or staged cannibalism (eating human flesh)*****
F11: abuse involving actual or staged sacrifice, killing,or torture of animals
F12: ritualistic abuse involving forced participation in or observation of sexual practices*****
F13: ritualistic abuse involving child pornography
F14: ritualistic abuse involving drugs
F15: abuse involving the withholding of medical care for religious reasons, resulting in harm to a child
F16: abuse related to attempts to rid a child of the devil or evil spirits
F17: abuse by religious professionals such as priests, rabbis, or ministers
F18: abuse committed in a religious setting, a religious school, or a religious daycare center
F19: abuse related to the "breeding" of infants for ritual sacrifice
F20: ritualistic abuse resulting in amnesic periods or preoccupation with dates*****
F21: abuse disclosed by an individual with a dissociative or multiple personality disorder traceable to earlier ritualistic or religious abuse

Note. Features marked by asterisks were added in the second phase of the study based on phase-one respondents' comments.

Table 2

Form and Setting of Abuse (Proportion of Cases)

	Case type		
	Medical neglect	Ridding evil	Religious authority
Form of maltreatment			
Sexual[1,2,3]	$.23_a$	$.48_b$	$.94_c$
Physical[1]	$.09_a$	$.32_a$	$.68_b$
Psychological[1,3]	$.35_a$	$.68_a$	$.31_b$
Neglect[1]	$.06_c$		
Setting of abuse			
Daycare or schools	.00	.00	.12
Parents' or relatives' homes[1]	$.67_a$	$.78_a$	$.25_b$
Religious setting[1]	$.05_a$	$.06_a$	$.42_b$

Note. Each case may have included more than one type of maltreatment and may have occurred in more than one place. For settings, a foster care/group home category, mentioned in only 1% of cases, was omitted. Means within a row that share letters in their subscripts do not differ from each other at $p < .05$.

[1]Significant main effect of case type, $Fs(2, \geq 230) \geq 12.08$, $ps < .001$.

[2]Significant main effect of victim type, $F(1, 243) = 4.68$, $p < .05$.

[3]Significant interaction, $Fs(2, 243) \geq 3.15$, $ps < .05$.

Table 3

Characteristics of Perpetrators and Victims

	Case type		
	Medical neglect	Ridding evil	Religious authority
Number of victims (per case)			
Both genders[1]	3.05_{a}	1.43_{b}	2.25_{ab}
Male	1.19	.56	1.40
Female	1.29	.88	1.70
Number of perpetrators (per case)			
Both genders	2.42	2.26	1.95
Male	1.28	1.32	1.73
Female	1.17	.89	.82
Victim age (in years)			
When abuse began[1]	7.15_{a}	5.70_{a}	9.71_{b}
When abuse ended	11.43	11.19	12.20
When abuse was discovered[1]	12.61_{a}	18.85_{ab}	23.66_{b}
Relationship of perpetrators to victims (proportion of cases)			
Parent or step-parent[1]	$.76_{a}$	$.85_{a}$	$.20_{b}$
Person in position of trust[1] (e.g., teacher, relative)	$.19_{a}$	$.21_{a}$	$.79_{b}$
Acquaintance	$.19_{a}$	$.06_{a}$	$.02_{b}$

Note. 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 (e.g., parent, acquaintance). Relationship variables were analyzed with 2 (victim type) X 3 (case type) ANOVAs, all other variables were analyzed with one-way ANOVAs. Means within a row that share letters in their subscripts do not differ from each other at $p < .05$.

[1]Significant main effect of case type, $Fs(2, \geq 219) \geq 3.48$, $ps < .05$.

Table 4

Religious Affiliation of Perpetrators and Victims at Time of Abuse

	Case type		
	Medical neglect	Ridding evil	Religious authority
Perpetrator			
Protestant	.33	.38	.27
Fundamentalist[1]	$.60_a$	$.43_a$	$.12_b$
Catholic[1]	$.07_a$	$.16_a$	$.53_b$
Other	.00	.03	.08
Victim			
Protestant	.17	.41	.25
Fundamentalist[1]	$.56_a$	$.38_a$	$.13_b$
Catholic[1]	$.06_a$	$.15_a$	$.54_b$
Other	.22	.05	.07

Note. All analyses were one-way ANOVAs. Different alphabetical subscripts denote case type means significantly different from each other at $p < .05$.

[1]Significant main effect of case type, $Fs(2, \geq 180) \geq 13.05$, $ps < .001$.

Table 5

Proportion of Cases Involving Particular Presenting Symptoms and DSM Diagnoses

	Case type		
	Medical neglect	Ridding evil	Religious authority
Presenting symptoms			
Depression[1]	$.30_{a}$	$.49_{ab}$	$.63_{b}$
Insomnia	.05	.16	.16
Somatic complaints	.20	.16	.22
Excessive fears, phobias	.15	.25	.24
Sexual acting out	.05	.09	.20
Obsessive compulsiveness	.15	.03	.11
Suicidal ideation	.10	.19	.30
Substance abuse	.10	.18	.15
Social withdrawal	.10	.28	.17
Inappropriate aggression[1]	$.20_{ab}$	$.29_{a}$	$.14_{b}$
DSM-III-R diagnoses			
Alcohol/drug problems	.00	.12	.09
Affective disorders	.09	.16	.25
Multiple personality disorder	.18	.16	.10
Other dissociative disorders	.09	.06	.05
Post-traumatic stress disorder	.18	.22	.22
Anxiety disorders	.18	.02	.08
Personality disorders	.18	.14	.20
Childhood disorders	.18	.08	.03
Adjustment disorders /life problems	.09	.16	.15

Note. Other diagnoses were rarely mentioned: Organic disorders (1% of cases), schizophrenic disorders (1% of cases), sexual disorders (3% of cases), eating disorders (1% of cases), and impulse control problems (4% of cases). All analyses were one-way ANOVAs. Means within a row that share letters in their subscripts do not differ from each other at $p < .05$.

[1]Significant main effect of case type, $Fs(2, 234) \geq 4.05$, $ps < .05$.

Table 6

Proportion of Cases Having Various Forms of Evidence for Allegations

	Case type		
	Medical neglect	Ridding evil	Religious authority
Evidence of Abuse/Harm			
Client's claims[1]	$.05_{a}$	$.26_{ab}$	$.42_{b}$
Clinician opinion/ psychological symptoms[2]	.10	.34	.34
Corroborative evidence[2]	.57	.49	.26
Eyewitness	.14	.04	.08
Physical[1]	$.10_{ab}$	$.13_{a}$	$.01_{b}$
Medical[1]	$.48_{a}$	$.19_{b}$	$.02_{c}$
Confession	.10	.13	.06
Miscellaneous	.33	.17	.19
Evidence of religion-related case elements			
Convincing report	.00	.10	.11
Client's claims[2]	.11	.35	.31
Corroborative evidence[2],[3]	.89	.67	.57
Eyewitness#	$.11_{ab}$	$.17_{a}$	$.01_{b}$
Physical#	.00	.02	.00
Medical#	.61	.00	.00
Confession#	$.17_{a}$	$.13_{a}$	$.01_{b}$
Skepticism/faked#	.00	.04	.11
Miscellaneous#	.06	.02	.03

Note. Means within a row that share letters in their subscripts do not differ from each other at $p < .05$.

#Too many cells with zero means to perform valid 2 (victim type) X 3 (case type) ANOVAs. One-way ANOVAs were performed on eyewitness, confession, and miscellaneous categories, revealing significant case type main effects for eyewitness and confession variables, $Fs(2, 203) \geq 7.22$, $ps < .001$.

[1]Significant main effect of case type, $Fs(2,187) \geq 3.57$, $ps < .05$.

[2]Significant main effect of victim type, $Fs(1, \geq 187) \geq 4.54$, $ps < .05$.

[3]Significant interaction, $Fs(2, 197) = 4.91$, $p < .01$.

Table 7

Investigation and Case Outcomes (Proportion of Cases)

	Case type		
	Medical neglect	Ridding evil	Religious authority
Type of Investigation			
No investigation[2]	.45	.41	.71
Social service[1,2,3]	$.41_a$	$.56_a$	$.17_b$
Police#	.14	.19	.21
District attorney#	.14	.06	.06
Case Outcome			
Never reported[2]	.45	.41	.70
Social services unfounded#	.05	.07	.02
Social services substantiated#	.36	.29	.10
Arrest#	.14	.13	.16
Trial#	.14	.12	.12
Conviction#	.05	.09	.09

Note. Three percent of the cases were still open at time of survey. A plea bargain was the outcome in 4% of cases; dismissal, acquittal, or reversal was the outcome in 5% of cases. Means within a row that share letters in their subscripts do not differ from each other at $p < .05$.

#Too many cells with zero means to perform valid 2 (victim type) X 3 (case type) ANOVAs. One-way ANOVAs revealed no significant case type main effects.

[1]Significant main effect of case type, $Fs(2, \geq 235) \geq 10.22$, $ps < .001$.

[2]Significant main effect of victim type, $Fs(1, 235) \geq 82.91$, $ps < .001$.

[3]Significant interaction of case and victim type, $Fs(2, 235) \geq 3.39$, $ps < .05$.

Biographical Sketches

Bette L. Bottoms is Assistant Professor of Psychology at the University of Illinois at Chicago. She received her Ph.D. in Social Psychology from the State University of New York at Buffalo. Her research has focused on issues of psychological and legal interest, including the reliability of children's eyewitness testimony and jurors' perceptions of child sexual assault victims. She is co-editor, with Gail S. Goodman, of the book Child Victims, Child Witnesses (Guilford Press, 1993).

Gail S. Goodman received her Ph.D. in developmental psychology from UCLA and is currently professor of psychology at the University of California, Davis. She served on JSI's editorial board and edited its 1984 issue on child witnesses (Vol. 40, No. 2). She is past president of the American Psychological Association's Division 37 (Children, Youth, and Family Services); co-winner in 1994 of SPSSI's Robert Chin Award for an article about child abuse; and winner of the Career Research Achievement Award from the American Professional Society on the Abuse of Children.

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