



# Institutional abuse of children in the Austrian Catholic Church: Types of abuse and impact on adult survivors' current mental health

Brigitte Lueger-Schuster\*, Viktoria Kantor, Dina Weindl, Matthias Knefel, Yvonne Moy, Asisa Butollo, Reinhold Jagsch, Tobias Glück

Faculty of Psychology, University of Vienna, Liebiggasse 5, 1010 Vienna, Austria

## ARTICLE INFO

### Article history:

Received 19 June 2013  
Received in revised form 22 July 2013  
Accepted 25 July 2013  
Available online 7 September 2013

### Keywords:

Institutional abuse  
Childhood abuse  
Clerical abuse  
PTSD  
Mental health

## ABSTRACT

The aim of this study was to explore the nature and dimensions of institutional child abuse (IA) by the Austrian Catholic Church and to investigate the current mental health of adult survivors. Data were collected in two steps. First, documents of 448 adult survivors of IA ( $M = 55.1$  years, 75.7% men) who had disclosed their abuse history to a victim protection commission were collected. Different types of abuse, perpetrator characteristics, and family related risk factors were investigated. Second, a sample of 185 adult survivors completed the Posttraumatic Stress Disorder Checklist (PCL-C) and the Brief Symptom Inventory (BSI). Participants reported an enormous diversity of acts of violent physical, sexual, and emotional abuse that had occurred in their childhood. The majority of adult survivors (83.3%) experienced emotional abuse. Rates of sexual (68.8%) and physical abuse (68.3%) were almost equally high. The prevalence of PTSD was 48.6% and 84.9% showed clinically relevant symptoms in at least one 1 of 10 symptom dimensions (9 BSI subscales and PTSD). No specific pre-IA influence was found to influence the development of PTSD in later life (e.g. poverty, domestic violence). However, survivors with PTSD reported a significantly higher total number of family related risk factors ( $d = 0.33$ ). We conclude that childhood IA includes a wide spectrum of violent acts, and has a massive negative impact on the current mental health of adult survivors. We address the long-term effects of these traumatic experiences in addition to trauma re-activation in adulthood as both bear great challenges for professionals working with survivors.

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## Introduction

In recent years, considerable scientific attention has focused on child maltreatment committed by various types of perpetrators such as family members, acquaintances or strangers (Lacelle, Hebert, Lavoie, Vitaro, & Tremblay, 2012; Lev-Wiesel, Amir, & Besser, 2005; Pereda, Guilera, Forns, & Gomez-Benito, 2009; Snyder, 2000; Stith et al., 2009), and on the long-term consequences of this maltreatment (Gilbert et al., 2009; Raphael & Widom, 2011; Widom, Czaja, Bentley, & Johnson, 2012). Although there is substantial research on the abuse crisis in the Catholic Church from legal, sociological, theological, and policy perspectives (Pilgrim, 2011, 2012), to date the psychological impact of child maltreatment committed in clerical organizations and institutions has scarcely been investigated (Flanagan-Howard et al., 2009; Wolfe, Jaffe, Jette, & Poisson, 2003). Goffman (1987) defined institutional abuse (IA) as abuse that takes place in settings in which the child is controlled in almost every aspect by an institution or a single authority. However, such an explanation tends to overlook that IA also

\* Corresponding author.

takes place in wider institutional and social contexts. Thus, [Wolfe et al. \(2003\)](#) specified IA as an inappropriate use of power and authority, including the potential to harm a child's well-being and development. The setting is interchangeable, and includes community institutions and other established social institutions that are not necessarily residential in the first place ([Sullivan & Beech, 2002](#)).

#### *Different kinds of abusive acts and settings*

Previous research concentrated on sexual abuse of children (CSA) by Catholic priests ([John Jay College, 2004](#)) but disregarded the wider view of different types of violence (e.g. physical violence, emotional violence). As other maltreatment experiences in institutional settings would also be harmful, this approach may exclude a significant portion of victims. There is some evidence that CSA in the Catholic Church differs from CSA in the general population. For instance, 81% of the victims of abuse by representatives of the Catholic Church were male ([Terry, 2008](#)), which contrasts with the results of an Australian study on the general population consisting of 2688 participants in which 80.1% of the victims were female ([Cutajar et al., 2010](#)). [Perez-Fuentes et al. \(2013\)](#) reported 75.2% female victims of CSA in a US national study. So far, only few attempts were made to differentiate various types of violence against children by representatives of the Catholic Church and the impact on adult survivors' later life ([Sullivan & Beech, 2002](#); [Terry, 2008](#)). [Stein \(2006\)](#) and [Ellonen & Poso \(2011\)](#) suggested a profound examination of these issues to increase the understanding of the nature of IA. Diverse psychological processes and experiences are considered to link IA to a poor adjustment capability in adulthood (e.g. [Flanagan-Howard et al., 2009](#)). In a systematic literature review [Wolfe et al. \(2003\)](#) identified traumatization, betrayal, stigmatization, disrespect for authority, and avoidance of reminders of the abuse as relevant factors for this poor adjustment following IA.

#### *Impact on mental health*

In a large US national epidemiologic study, the effects of different types of childhood physical abuse (CPA) on later mental health and the associations with psychiatric disorders were examined. A prevalence of 8% for CPA was found, with a higher offense rate against female than against male victims. Most participants that experienced CPA were also exposed to CSA and childhood neglect (76%) before the age of 18. Of the participants in the study at least 84% had a history of at least one psychiatric disorder. The overall prevalence of any psychiatric disorder was higher than in individuals without CPA ([Sugaya et al., 2012](#)).

For survivors of IA in religiously affiliated residential institutions in Ireland, [Fitzpatrick et al. \(2010\)](#) demonstrated that survivors who self-rated CSA as their worst experience reported the highest rates of mental health and psychosocial problems in later life followed by survivors of CPA. Survivors of childhood emotional abuse (CEA) reported the fewest problems. Persons who experienced a combination of CSA and CPA reported poorer health in adulthood compared to survivors of either CSA or CPA ([Bonomi, Cannon, Anderson, Rivara, & Thompson, 2008](#)).

A number of disorders during the life span may be considered as consequences of CSA, such as PTSD, substance abuse, depression, specific phobia, and other medical conditions ([Cloitre, Cohen, Edelman, & Han, 2001](#)). Survivors tend to mitigate symptom distress by using maladaptive methods of self-regulation such as dysfunctional behavioral patterns or suicidal ideations to ease the pain ([Kendler et al., 2000](#); [Owens & Chard, 2003](#)). Moreover, PTSD was shown to highly correlate with a history of childhood maltreatment which included both CSA and CPA ([Oswald, Heil, & Goldbeck, 2010](#)).

The evidence for the impact of these violent acts on mental health is striking, especially when looking at the long-term effects ([Widom, 1999](#)). [Wolfe, Francis, and Straatman \(2006\)](#) found that in a sample of 76 men who had experienced IA in a religiously affiliated institution, 42.1% met the DSM-IV criteria for PTSD, 21.1% for alcohol abuse, and 25% for mood-related disorders. Also, 66.2% of the sample suffered from sexual problems, and half of the sample had a history of criminal involvement. In an Australian sample of 147 men who had experienced CSA, clinically relevant psychopathological symptoms were 10 times higher when compared to a control group of men from a community sample ([O'Leary, 2009](#)). [Smith and Freyd, 2013](#)) point out that the experience of betrayal stemming from a relationship necessary for survival adds uniquely to the risk of later mental health problems.

#### *Risk factors for later development of PTSD*

Furthermore, risk factors present before the abuse in terms of the development of mental health problems in later life also need to be considered. There are a number of family related risk factors for developing PTSD in later life ([Koenen et al., 2002](#)). [Brewin, Andrews, and Valentine \(2000\)](#) reported that factors such as a lower socio-economic status, previous adverse childhood experiences, and a history of prior traumatization increase the risk for the later development of PTSD. Prior victimization was also reported to be a risk factor for later CSA and CSA-related PTSD symptoms ([Boney-McCoy & Finkelhor, 1995](#)).

### The present study

Although many studies focused only on the consequences of CSA within the Catholic Church, in this study we sought to explore a wider scope of IA that included emotional, physical, and sexual abuse. We investigated two main questions from a psychotraumatological perspective: What were the experiences of the survivors, and how did those experiences influence survivors in their adult adjustment? We approached these questions in three different ways: (a) we examined various violent and abusive acts by analyzing the retrospective data and documents reported to the victim commission by adult survivors, including information on perpetrator characteristics; (b) we investigated the prevalence and the influence of risk factors before the abuse occurred; and (c) we collected data on the adult survivors' current status of mental health using standardized self-report questionnaires that focused on posttraumatic distress and psychological impairment.

## Method

### Context

Following the appeal of an Austrian cardinal, an independent victim protection commission, the Austrian Victims' Protection Commission, was established in April 2010. It was led by a former governor of Styria (Lueger-Schuster et al., 2012b). Surviving adult victims of CA committed by representatives of the Catholic Church (e.g. priests) were invited to disclose their experiences to psychologists and psychotherapists with specific training in psychotraumatology in what is called a *clearing process*. Based on the data from the clearing process the commission decided whether financial support and/or psychotherapeutic support were to be paid by the Austrian Catholic Church.

### Procedure

The commission contacted potential participants who had reported CSA, CPA, and/or CEA ( $N = 795$ ) to provide written information on the study and the options for participation. Included in this information was a written informed consent form regarding the analysis of their anonymized data from the clearing process. If participants returned the written informed consent form to the commission, the data from the clearing process were included for further analysis (*passive participation*). Participants who agreed to further active involvement were then contacted by the research team and informed in greater detail about the options (*active participation A or B*). For the purpose of data protection, only the names and phone numbers were forwarded to the research team. A code was then assigned to each participant to ensure anonymity for the questionnaire data.

Active participation – A involved completion of the self-report questionnaires (including analysis of the data from the clearing process), and active participation – B involved semi-structured interviews (including analysis of the data from the clearing process and completion of questionnaires). The qualitative interview data from active participation B are not being reported here.

### Participants

All participants were adult survivors of institutional abuse in settings connected to the Catholic Church in Austria. Demographic characteristics are summarized in Table 1. Gender was unequally distributed; about 75% of the participants were male, and 25% were female. The age range of the participants was from 25 years to 80 years ( $M = 55$  years). No differences were found between the active and the passive sample concerning these demographic characteristics. A comparison to the Austrian population revealed that there were differences in gender with clearly more men in our sample than in the Austrian population and smaller differences in the highest achieved educational level: In our sample more persons completed high school or held a university or college degree than did so in the Austrian general population.

Ethical approval for the study was given by the institutional review board of the University of Vienna. The study was also registered with the German Clinical Trials Register (DRKS00003222) for the purpose of public documentation and transparency.

### Measures

*Data collection for passive participation.* Participants gave written informed consent for a further analysis of the data resulting from the clearing process. Clinical psychologists and psychotherapists conducted the clearing process on behalf of the commission and wrote a clearing report. In the clearing sessions survivors were asked about the violence they had experienced as well as where and how long it had taken place. Information on psychological outcomes related to early abuse (e.g. problems in school, at work, or with relational problems) was also gathered. In addition, information about the perpetrators and the pre-abuse living conditions was collected.

This clearing report was then forwarded to the commission. Based on this report the commission decided whether the survivor was to receive financial help and/or psychological treatment. The research team had no influence on the process

**Table 1**  
Demographic characteristics.

Characteristic	Categories	Total sample (active and passive)		Active sample		Austrian population <sup>a</sup>
		N	%	N	%	
Gender	Men	448		185		
	Women	340	75.7	141	76.2	49.4
Age		109	24.3	44	23.8	50.6
		M = 55.1		M = 56.3		
Marital status		SD = 10.5		SD = 9.5		
		360				
Highest educational level	Single	63	17.5	33	17.9	13.9
	Married/cohabited	212	58.9	111	60.4	68.4
	Widowed	11	3.1	9	4.9	4.0
	Divorced	74	20.6	31	16.8	13.4
Highest educational level		309				
	Compulsory school or less	49	15.9	31	17.0	23.4
	Apprenticeship	142	46.0	85	46.7	54.6
	High school (A-level equivalent)	64	20.7	42	23.1	10.2
	College/university	54	17.5	24	13.2	11.7

<sup>a</sup> Comparison with Austrian population based on Statistik Austria (2012a, 2012b, 2012c).

of data collection during the clearing process, but to ensure the reliability and consistency of the data, several steps were taken: standardized guidelines for data coding and processing were developed. Research assistants received special training for data coding. Furthermore, the data coding was reviewed by a member of the research team at regular intervals, and the research assistants received psychological supervision from a clinical psychologist once a week.

The clearing reports were analyzed with regard to different aspects: sub-types of violence, offenses committed by the perpetrator, further perpetrator-related information such as gender, title (e.g. priest, nun, bishop), function (e.g. teacher, educator, nurse), and time and place of violent offenses (e.g. orphanage, monastery). The clearing reports also contained information about living conditions shortly before the abuse took place (e.g. physical violence in family, poverty).

To analyze potential differences in the forms of maltreatment on the posttraumatic effects, all violent acts committed by the perpetrators were clustered into categories. First, all offenses reported by each participant were collected and categorized into three subtypes of violence based on the categorization of the World Health Organization (Krug, Mercy, Dahlberg, & Zwi, 2002): emotional, physical, and sexual violence. Next, 200 offenses were randomly selected and then clustered independently for each subtype (see Table 2). Based on the existing literature (cf. Cutajar et al., 2010; Flanagan-Howard et al., 2009; Terry, 2008), we decided to divide the sexually motivated offenses into five clusters. The category of physical violence was divided into four clusters, according to the similarity of offenses. Offenses in the category of emotional violence varied considerably; however, we were able to arrange them into six homogenous clusters.

This clustering approach was also adapted for the analysis of family related risk factors and living conditions.

*Instruments for active participation* – A. Instruments that were considered to be least distressing for a highly vulnerable population were chosen. Psychological support was offered to all participants. The questionnaire batteries were sent by post to the participants and included a prepaid return envelope. Support for filling in the questionnaires was offered via telephone. Data were collected from January until June 2012 using the Posttraumatic Stress Disorder Checklist (PCL-C) and the Brief Symptom Inventory (BSI).

The PCL-C (Weathers, Litz, Herman, Huska, & Keane, 1993) is a self-report inventory to assess 17 PTSD-symptoms based on the criteria of the DSM-IV (American Psychiatric Association, 2000). It examines symptoms of intrusive recollection (criterion B), avoidance/numbing (criterion C), and hyper-arousal (criterion D). The PCL-C is a reliable and valid diagnostic screening instrument for PTSD (Weathers et al., 1993). The German version (Teegen, 1997) of the PCL-C was used in the present study because it showed good psychometric properties in a study of PTSD in elderly Austrian survivors of World War II (Glück, Tran, & Lueger-Schuster, 2012). Participants rate the experience of PTSD-related symptoms in the past month on a five-point scale (1 = none–5 = very). PTSD is diagnosed if an individual scores positive (>3) on at least one symptom of the B criterion, three symptoms of the C criterion, and two symptoms of the D criterion.

The BSI (Derogatis & Melisaratos, 1983; Franke & Derogatis, 2000) is a 53 item self-report measure for clinically relevant psychological symptoms (Derogatis & Melisaratos, 1983). It screens for psychopathological symptoms on nine dimensions: somatization, obsession–compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. A total measure of symptom distress can be obtained (global severity index = GSI). Symptoms are rated on a five-point Likert scale (0 = not at all to 4 = extremely). Psychometric properties of the German version (Franke & Derogatis, 2000) are very good and were validated in two large German clinical and nonclinical samples. The Cronbach's alpha for the GSI is  $\alpha = 0.95$  and ranges from  $\alpha = 0.59$  to  $\alpha = 0.82$  for the nine subscales.

**Table 2**  
Description of types of violence.

		Total sample (active and passive)		Active sample		Active sample – PTSD				
		N	% of total	N	% of active	N	% of PTSD			
		448		185		89 <sup>1</sup>				
Multiple types of violence	One type reported	57	12.7	27	14.6	10	11.2			
	Two types reported	243	54.2	106	57.3	53	59.6			
	Three types reported	148	33.0	52	28.1	26	29.2			
Type of violence	Examples <sup>2</sup>									
Sexual	Simultaneous abuse by several perpetrators; anal/vaginal rape; painful, brutal insertion of finger Oral sex Masturbation of penis of the survivor; forced manual masturbation of perpetrator Sitting on lap; touching, massaging genital area; games including touching of upper body Caressing; kisses; photographing; getting naked; hitting with a rod on erected penis	Offense cluster Anal/vaginal penetration	81	18.1	36	19.5	23	25.8 <sup>c</sup>		
		Oral sex	75	16.7	29	15.7	16	18.0		
		Masturbation	127	28.3	63	34.1 <sup>a</sup>	34	38.2		
		Other forms of touching	186	41.5	79	42.7	45	50.6 <sup>c</sup>		
		Other	186	41.5	83	44.9	44	49.4		
		Any form of sexual violence	308	68.8	135	73.0	69	77.5		
		Physical	Beating, sometimes until unconsciousness; pulling ears or hair until bleeding Massive beating with carpet beater; beating with hand or ruler; kicks; violent strokes in the face; detaining Kneeling for hours; squats until collapse No food as a punishment; eating vomit; prohibition to go to toilet after 7 pm; cold showering; chaining	Beating with injury as consequence	99	22.1	35	18.9	13	14.6
				Beating	268	59.8	96	51.9 <sup>b</sup>	42	47.2
				Physical activity as punishment	113	25.2	35	18.9 <sup>b</sup>	16	18.0
				Other	117	39.5	66	35.7	36	40.4
Emotional	Isolation from other pupils; prohibition to go home over the weekends; getting locked up; monitoring and persecution Climate of fear; helplessness; powerlessness Threat to not disclose; false accusations; scolding; permanent screaming; exposure as a bed-wetter Said it was no sin, but should not be disclosed; declaration of love; pet names After beating sessions having to endlessly pray rosaries; exploiting information of confessional secrets Survivor was favorably treated; perpetrator set up other pupils against survivor; observing violence against other pupils	Any form of physical violence	306	68.3	111	60.0 <sup>b</sup>	50	56.2		
		Isolation	159	35.5	59	31.9	35	39.3 <sup>c</sup>		
		Fear	103	23.0	41	22.2	21	23.6		
		Humiliation/threat	251	56.0	100	54.1	53	59.6		
		Emotional violence related to sexual violence	44	9.8	15	8.1	9	10.1		
		Clerical aspects	70	15.6	28	15.1	15	16.9		
		Other	183	40.8	73	39.5	36	40.4		
	Any form of emotional violence	373	83.3	149	80.5	75	84.3			

<sup>1</sup> There was no clearing data for one person with PTSD.

<sup>2</sup> Examples given represent the adult survivors (translated) reported actual abusive acts.

<sup>a</sup> Significant difference between active and passive sample with higher rates for active sample ( $p < .05$ ).

<sup>b</sup> Significant difference between active and passive sample with higher rates for passive sample ( $p < .05$ ).

<sup>c</sup> Significant difference between PTSD and non-PTSD sample with higher rates for PTSD sample ( $p < .05$ ).

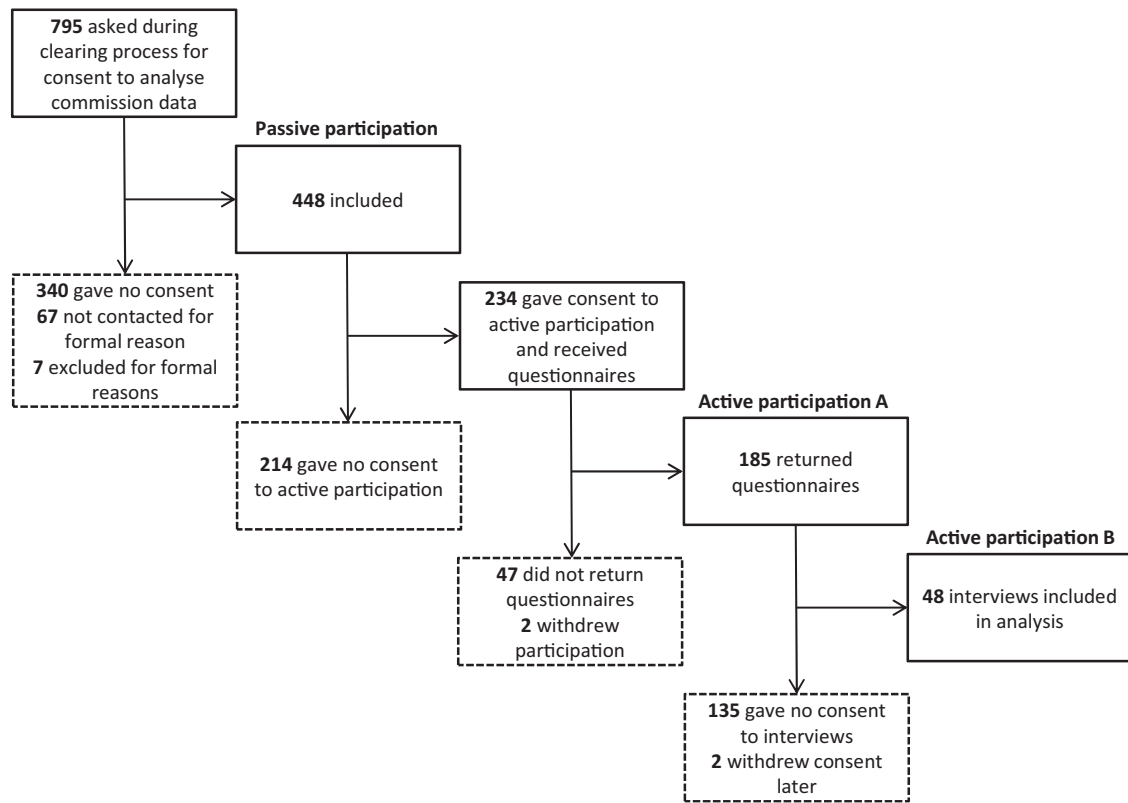


Fig. 1. Flow of participants (active and passive).

### Data analysis

The analysis was divided into steps. First, the types of violence experienced and the perpetrators in institutions of the Catholic Church were categorized. Second, the family related risk factors and the family related living conditions prior to the abuse were investigated. Third, the prevalence of mental health problems after these experiences was analyzed. Results were then related to the development of later PTSD.

We controlled for potential self-selection effects by comparing participants from the active and the passive sample with regard to violent acts and family related risk factors and living conditions.

For statistical calculations SPSS 20.0 for Windows (IBM Corp. 2011, NY) was used. For categorical data, Chi-squared tests were computed. Comparisons of continuous data were conducted with *t*-tests for independent samples and *U*-tests if assumptions for *t*-tests were violated. A *p* of  $\alpha < .05$  was considered significant.

### Results

In total, 795 individuals who reported CSA, CPA, and/or CEA to the commission were invited to participate in the study. The participating sample (active and passive) for this study was 448 (56.4%) persons. They all gave written informed consent to passively participate. Out of these participants, 234 persons agreed to complete the questionnaires. This included 48 participants who gave their consent for an additional semi-structured interview (see Fig. 1).

#### Types of violence: violent and abusive acts

We distinguished three types of violence: sexual, physical, and emotional violence. The persons concerned experienced between one to three types of violence in a Catholic Church setting. Of the total sample 12.7% reported one type, 54.2% two types, and 33.0% all three types of violence. Persons who actively participated reported a similar frequency pattern: 14.6% (1), 57.3% (2), and 28.1% (3). The pattern did not significantly differ between the active and the passive sample,  $\chi^2 = 3.73$ ,  $df = 2$ ,  $p = .155$ .

Sexual violence was reported by 68% of the total sample and 73.0% of the active sample. Physical violence was experienced by 68.3% of the total sample and 60.0% of the active sample. Emotional violence was experienced by 83.3% of the total and

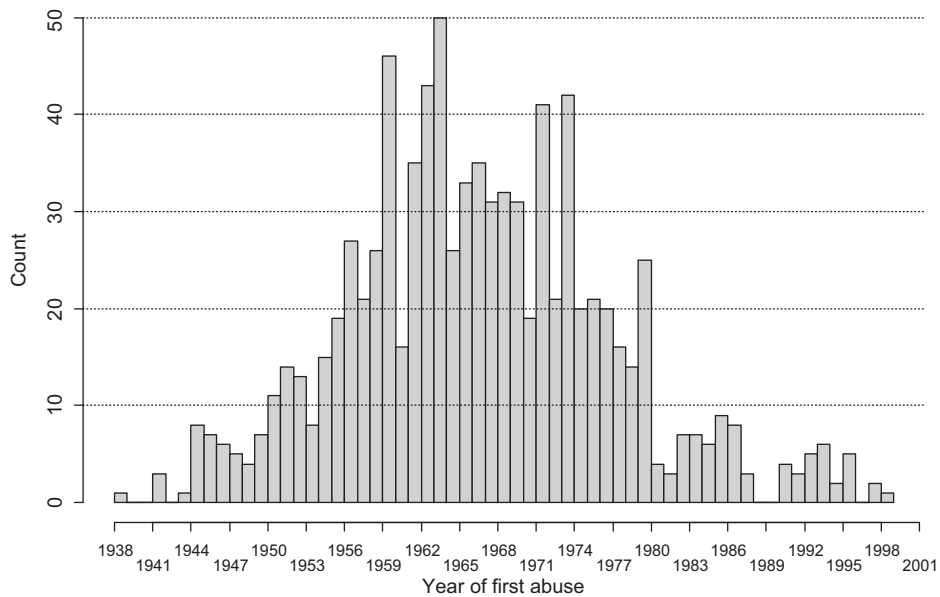


Fig. 2. Reported offenses over the years.

Table 3

Perpetrator characteristics.

	N	%
Diocese priest	138	20.6
Male monastic	218	32.5
Female monastic	117	17.5
Male superior	7	1.0
Female superior	3	0.5
Others	16	2.4
No clerical function	108	16.1
No information available	63	9.4

80.5% of the active sample. The active and the passive sample differed only in rates of physical violence with significantly higher rates in the passive sample,  $\chi^2 = 10.04$ ,  $df = 1$ ,  $p = .002$ .

Physical, sexual, and emotional violence were subdivided into different clusters of similar offenses. The frequencies of the different clusters for all three types of violence are displayed in Table 2. Concerning sexual violence, the only significant difference between the active and the passive sample was in the *masturbation* cluster, with higher rates for the active sample,  $\chi^2 = 5.05$ ,  $df = 1$ ,  $p = .025$ . Concerning physical violence, the passive sample had significantly higher rates in the *beating* cluster,  $\chi^2 = 8.24$ ,  $df = 1$ ,  $p = .004$ , and the *physical activity as punishment* cluster,  $\chi^2 = 6.64$ ,  $df = 1$ ,  $p = .010$ .

Of the sample 99.6% were between 0 and 19 years of age when the institutional violence began ( $M = 9.80$  years,  $SD = 3.51$ ) and this range did not differ significantly between the active ( $M = 10.02$  years,  $SD = 3.69$ ) and passive sample ( $M = 9.64$  years,  $SD = 3.37$ ),  $t(439) = -1.09$ ,  $p = .276$ .

Participants reported that 81.7% of the offenses occurred in contexts such as boarding schools, orphanages, monasteries or convents, 14.4% occurred in other clerical settings such as parishes or churches, and 3.9% reported other or both types of contexts.

The distribution of reported offenses over the years (1938–1999) is shown in Fig. 2. The peaks start in the late 1950s and end in the mid 1970s.

*Description of perpetrator contacts.* Survivors reported information on 670 perpetrators. This number, however, may not reflect the accurate number of perpetrators because different adult survivors may have been abused by the same perpetrator (e.g. when living in the same parish or boarding school). This may have led to an overestimation of the number of perpetrators in our sample. The distribution of clerical functions based on our data is reported in Table 3.

Participants reported the duration of contact with each perpetrator. The mean duration of these contacts was 4.8 years ( $SD = 4.4$ ). There was no difference between the active and passive sample regarding the length of contact time with the perpetrator,  $t(230.7) = -1.79$ ,  $p = .08$ .

### Family related risk factors and family related living conditions

Several family related risk factors which were present prior to the abuse or violence committed in a Catholic institution or community setting were reported: neglect, physical violence, poverty in the family, emotional distance to the family, substance abuse within the family, serious illness of a parent, separation from siblings, negative experiences in foster homes, and other adverse living conditions; all frequencies were below 7.1%. Odds ratios for the relative frequencies in the active and in the passive sample varied widely,  $OR = [0.8; 2.7]$ . Prevalence of all factors was very low, causing this wide range of odds ratios. After Bonferroni adjustment for multiple testing ( $\alpha_{adj} = .05/9 = .006$ ), none of these odds ratios remained significant (all  $p > .026$ ).

Several family related living conditions which were present prior to the abuse or violence were reported such as born to an unmarried mother, parents divorced/stepchild, lived with foster family, lived in an institution, grew up without biological parents, felt oppressed by a conservative Catholic family background. All frequencies were below 17.4%. After Bonferroni adjustment for multiple testing ( $\alpha_{adj} = .05/7 = .007$ ), no significant differences between the active and passive sample remained,  $OR = [0.7; 1.6]$ , all  $p > .116$ .

### Impact of abuse on later mental health

Ninety (48.6%) of the participants were screened positive for PTSD with the PCL-C, which indicates that about half of the adult survivors had a diagnosis of PTSD at the time of the survey. PTSD prevalence reported for Germany is 2.5% among 30–93 year olds (Maercker, Forstmeier, Wagner, Glaesmer, & Brähler, 2008). No comparable research is available for Austria, but it is likely to be very similar for the general population.

When we assessed psychopathological symptom scales, 157 persons (84.9%) scored positive for at least one symptom. Results of all BSI subscales and total symptom distress (GSI) together with the BSI scores of several other studies on childhood abuse are reported and contrasted in Table 4. Especially obsession–compulsion, paranoid ideation, and interpersonal sensitivity scored extremely high. To compare the different results we analyzed the GSI mean differences with *t*-tests and effect sizes (see last column of Table 4). The only study with a sufficient sample size (Rosen & Martin, 1996) reported significantly lower general symptom distress. This difference can be interpreted as belonging to the medium to large range.

### Later development of PTSD

There was a significant difference regarding the total number of family related risk factors between survivors with a diagnosis of PTSD ( $M = 0.47$ ,  $SD = 0.78$ ) and survivors without this diagnosis ( $M = 0.24$ ,  $SD = 0.58$ ),  $U = 3531$ ,  $p = .017$ ,  $d = 0.33$ . For the total number of family related living conditions, no significant difference was observed between survivors with a diagnosis PTSD ( $M = 0.51$ ,  $SD = 0.74$ ) and survivors without this diagnosis,  $M = 0.40$ ,  $SD = 0.639$ ,  $U = 3953.0$ ,  $p = .45$ ,  $d = 0.16$ .

After Bonferroni adjustment for multiple testing, there was no significant difference between survivors with a diagnosis of PTSD and survivors without this diagnosis for any of the individual family related risk factors ( $\alpha_{adj} = .05/9 = .006$ ),  $OR = 0.2; 1.4$ , all  $p > .110$ . This was also the case for the family related living conditions ( $\alpha_{adj} = .05/7 = .007$ ),  $OR = 0.6; 0.9$ , all  $p > .358$ .

Regarding the offense clusters, there were significant differences for sexual violence and for emotional violence. Survivors with a diagnosis of PTSD reported significantly more experiences of anal/vaginal penetration and other forms of touching within the sexual violence clusters, and significantly more experiences isolation within the emotional violence clusters. There were no differences with respect to PTSD diagnosis for experiences regarding the physical violence clusters.

The age at which the first institutional violence was experienced did not differ significantly between the survivors with a diagnosis of PTSD ( $M = 10.00$  years,  $SD = 4.10$ ) and survivors without a PTSD diagnosis ( $M = 10.03$  years,  $SD = 3.30$ ),  $t(178) = 0.58$ ,  $p = .954$ . The duration of perpetrator contact was not significantly different between survivors with a diagnosis of PTSD ( $M = 6.04$  years,  $SD = 7.35$ ) and those without ( $M = 4.56$  years,  $SD = 4.30$ ),  $t(174) = -1.64$ ,  $p = .10$ . There was also no difference for all BSI subscales (clinically relevant vs. clinically nonrelevant symptoms) in the age at which the first institutional violence was experienced, all  $t(176) < 1.03$ , all  $p > .31$ , and in the duration of perpetrator contact, all  $t(174) < 1.48$ , all  $p > .14$ . It was not possible to analyze a potential specific influence of the contexts where the maltreatment happened (e.g. boarding schools vs. parishes) because some victims reported contacts with perpetrators in multiple contexts.

### Discussion

In 2010 the Austrian Catholic Church was confronted with claims by survivors of child maltreatment within their institutions. As a response a survivors' protection commission was established. To date, more than 1000 survivors disclosed their traumatic experiences to this commission. Most of these survivors received financial compensation and/or psychological treatment. This study included survivors who had completed the clearing process.

In this study we examined the nature and scope of IA committed by members of the Catholic Church in Austria. Pre-existing family related risk factors, and other living conditions present before the abusive events were investigated, and related to current mental health problems. We then pictured the extent of mental health problems in this special population, and contrasted our results with those reported in other studies regarding the consequences of childhood abuse in noninstitutional settings.



**Table 4**  
BSI scores of adult survivors in comparison to other samples.

	GSI <i>M</i> [95% CI]	Somatization <i>M</i> ( <i>SD</i> )	Obsession- compulsion <i>M</i> ( <i>SD</i> )	Interpersonal sensitivity <i>M</i> ( <i>SD</i> )	Depression <i>M</i> ( <i>SD</i> )	Anxiety <i>M</i> ( <i>SD</i> )	Hostility <i>M</i> ( <i>SD</i> )	Phobic anxiety <i>M</i> ( <i>SD</i> )	Paranoid ideation <i>M</i> ( <i>SD</i> )	Psychoticism <i>M</i> ( <i>SD</i> )	<i>T</i> -test for GSI difference: Cohens' <i>d</i> ( <i>p</i> )
Present study	1.20 [1.09–1.31]	1.09 (0.95)	1.31 (0.98)	1.38 (1.05)	1.28 (1.02)	1.19 (0.92)	1.01 (0.78)	1.00 (1.02)	1.62 (1.02)	1.02 (0.88)	
Braver et al. <sup>a</sup>	1.28 [–0.95–3.51]										–0.03 (.865)
Bennet & Hughes <sup>b</sup>	0.99 [0.82–1.16]										0.29 (.066)
Rosen & Martin <sup>c</sup>	0.74 [0.66–0.82]	0.73 (0.81)	0.88 (0.88)	0.71 (0.89)	0.82 (0.92)	0.64 (0.77)	0.88 (0.95)	0.45 (0.74)	1.11 (0.98)	0.66 (0.81)	0.63 (.000)
Collings <sup>d</sup>	1.27 [1–1.54]	0.75 (0.69)	1.45 (1.02)	2.02 (1.21)	1.29 (0.95)	1.10 (1.00)	1.41 (0.73)	1.06 (0.87)	1.73 (0.77)	1.26 (0.83)	–0.09 (.658)
Young et al. <sup>e</sup>	0.61	0.5	1.13	0.92	0.63	0.58	0.71	0.2	0.85	0.6	

<sup>a</sup> Braver, Bumberry, Green, and Rawson (1992): *N* = 30, adults with some form of CA.

<sup>b</sup> Bennett and Hughes (1996): *N* = 54, female college students, sexual abuse survivors.

<sup>c</sup> Rosen and Martin (1996): *N* = 313, male and female non-combat soldiers with history of CSA.

<sup>d</sup> Collings (1995): *N* = 26, students with one or more childhood sexual experiences involving physical contact.

<sup>e</sup> Young, Harford, Kinder, and Savell (2007): *N* = 155, undergraduates with CSA, mean estimated based on reported *T*-values, *SD* was not available.

One of the strengths of this study is its accuracy in displaying various forms of abuse. In our study we investigated CPA, CSA, and CEA, while most other studies focus only on one type of abuse, such as CSA (cf. Maniglio, 2009; Springer, Sheridan, Kuo, & Carnes, 2007; Sugaya et al., 2012). This study provides a better understanding of the extent and types of violence experienced by this sample. The majority experienced at least two types of abuse (87.3%); the most prevalent type was CEA (83.3%), CSA (68.8%) and CPA (68.3%) were reported almost equally often by survivors. This is a different finding when compared to rates of CPA and CSA in community samples (Briere & Elliott, 2003; MacMillan et al., 1997), and in samples with a history of childhood abuse (e.g. Widom, DuMont, & Czaja, 2007) where CSA and CPA were reported less frequently (Pereda et al., 2009; Tolin & Foa, 2006).

Most offenses happened between the late-1950s and mid-1970s. This is similar for the time period in which a peak of abuses was reported in the US Catholic Church (cf. Terry, 2008). Possible reasons for these peaks may be found within societal, cultural, and internal aspects of the church. Relatedly, perpetrators were distributed throughout the hierarchy of clerical functions; however, most offenders were monastics or clergies who had an easy access to the children. They acted as their teachers, educators, or leaders of youth groups organized by the church. These aspects could be addressed by future sociological, educational, and historical research to shed light on the conditions forwarding IA in that period, and to find aspects that prevent future IA.

In-depth analyses of the reported offenses showed that for CSA various forms subsumed under the category “others” were reported most frequently (58.0%) such as kisses, caressing or getting naked. Terry (2008), for example, categorized these kinds of acts of CSA as paraphilia behavior. However, from our data we are not able to derive the motives of the perpetrators, and whether these acts were based on pedophilic motives per se or whether they were related to biased sexual scripts that led to a confusion of intimacy and sexuality (Ward & Sorbello, 2003). In the group of CPA beating (59.8%) and for CEA humiliation and threat (51.3%) were reported most frequently. Some acts, such as hitting with a rod on erected penis were formerly seen as physical punishments, but clearly classify as sexual abuse, even combining the experience of CSA and CPA in one humiliating act.

The majority of survivors in our sample (84.9%) reported clinically significant psychopathological symptoms on at least one of the BSI scales and/or with respect to PTSD. In our sample current psychopathological symptom distress is higher than that reported in other studies. Especially the high scores of obsession–compulsion, paranoid ideation, and interpersonal sensitivity could be connected to the betrayal aspect of the experiences (Smith & Freyd, 2013). These symptoms were also extremely high in the study of Collings (1995). Most of the previous studies on child maltreatment reported BSI scores with quite small sample sizes. Only the study by Rosen and Martin (1996), which investigated psychological symptoms in male and female non-combat soldiers with a history of noninstitutional CSA, seems to be comparable. They reported significantly lower symptom distress. Very recent findings suggest that sexual trauma and associated symptoms are exacerbated in an institutional environment, where these experiences are likely to happen and/or difficult to report (Smith & Freyd, 2013), as it is the case for the contexts reported in our study.

The prevalence of PTSD in our sample (48.6%) was comparable to the prevalence reported in other studies on IA (Fitzpatrick et al., 2010; Wolfe et al., 2006). Studies that investigated PTSD and other disorders related to CSA, CPA and CEA also reported similar rates in their samples, especially after CSA (Hillberg, Hamilton-Giachritsis, & Dixon, 2011; Perez-Fuentes et al., 2013; Sugaya et al., 2012). As pointed out in the results section, this prevalence is much higher than in the general population (e.g. Maercker et al., 2008; Perkonig, Kessler, Storz, & Wittchen, 2000).

Diverse physical offenses did not differ between the survivors with PTSD and those without. However, survivors with PTSD reported significantly more and diverse types of sexual offenses. The analysis of the impact of the various subcategories of violence revealed that this was especially true for survivors who experienced anal/vaginal penetration, and for those who experienced other forms of touching. Our findings are in line with previous findings, indicating that CSA apparently has a greater impact on later mental health (Boney-McCoy & Finkelhor, 1995; Maniglio, 2009; Oswald et al., 2010), and that sexual abuse with penetration has the worst consequences for the victims (cf. Cutajar et al., 2010; Fitzpatrick et al., 2010). Moreover, as suggested by Smith and Freyd (2013), the worst consequences of sexual abuse may also be explained by feelings of betrayal in survivors toward the institution. Physical and emotional violence might have been part of the ‘norm’ in the 1950’s; thus, sexual violence could clearly be rated as betrayal.

Relatedly, in epidemiological studies rape was associated with the highest prevalence of PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), and the early life experience or witness of sexual violence was highly associated with PTSD and increased distress (Lueger-Schuster, Glück, Tran, & Zeilinger, 2012a).

Although sexual violence is generally the most distressing type of violence, the combination of CPA, CSA and CEA in institutions might be a kind of *general factor* for the later onset of PTSD and the high rates in all BSI factors. This may also explain why the age at the time of exposure and the duration of contact with the alleged perpetrator did not reveal differences between the PTSD and the non-PTSD group. IA includes a sense of powerlessness and a betrayal dynamic, which are both factors that negatively affect the development of psychopathology and damage coping abilities (Wolfe et al., 2003). Most of the survivors in our sample were very young when they experienced the abuse and the overall exposure to a climate of violence and sexual abuse in the context of an emotionally oppressive system. This could explain why we did not find specific offense-symptom profiles.

Although many pre-existing risk factors and other living conditions prior to IA were reported, the individual factors reported were generally of low prevalence, and not specifically predictive for later PTSD symptoms after the abuse. Only when all family related risk factors were added up, a higher number was associated with a diagnosis of PTSD. A similar finding

was also reported in a longitudinal community study, in which PTSD symptoms were only predicted by a combination of a prior exposure to multiple trauma, anxiety disorders, and adverse family experiences (Copeland, Keeler, Angold, & Costello, 2007). This supports our understanding of IA as a general factor for later mental health problems comprising of multiple traumas, as it does not seem to matter what offenses specifically took place with respect to the later development of PTSD. The simple fact of experiencing violence in an institutional context can lead to the development of severe psychological problems in later life and most pre-existing factors do not lead to differences in PTSD rates when IA was experienced.

### Limitations

Reports from the clearing process regarding the frequency of the offenses might have been biased. Some survivors later reported that during the clearing process they did not give an account of every violent act. Some felt that certain acts of abuse were “normal”, such as some kinds of CEA and they only reported “the really bad experiences”. As reported in other studies (Edwards, Holden, Felitti, & Anda, 2003) underreporting might also have occurred in our study. A spurring of false reports is highly unlikely, because our study was not related to the compensation procedures. Standardized interviews and questionnaires might improve the validity and the accuracy of reports of institutional CA (Ellonen & Poso, 2011; Flanagan-Howard et al., 2009).

With regard to most sociodemographic characteristics, our sample was mostly representative of the general Austrian population. However, our sample was gender imbalanced with more men than women being affected. Additionally, participants of our sample had a slightly higher level of education in comparison to that of the general population. Both, gender and education might be consequences of the setting. Many institutions of the church that worked with children were boarding schools (higher schools) for boys. They provided a very good education – despite the abuse that happened there. These factors could have positively influenced resilience and coping strategies of our sample (cf. Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Edmond, Auslander, Elze, & Bowland, 2006). Further limitations are the retrospective nature of childhood data and the absence of a control group. The participants of the active sample were representative of the total sample but we do not know whether the total sample or the active sample is representative for all survivors of IA in the Austrian Catholic Church. This group might have had a better mental health status compared to the group of non-disclosers, who could be less resilient or able to cope. A comparison with a group of survivors of non-institutional CA would have allowed an evaluation of the idiosyncratic consequences of IA on later adult adjustment.

### Conclusion

With this study we set out to explore different forms of abusive violence and their consequences on current mental health in a sample of survivors of IA in institutions within the Austrian Catholic Church. We found an enormous diversity of sexual, physical, and emotional acts of violence. All participants in this study were exposed to these offenses, and reported to a victim protection commission prior to participation in the study. Almost 50% of our sample suffered from PTSD, and consequences of CSA with penetration were most devastating for later mental health. In our study psychopathological symptom distress was very high when compared to other studies on CA. We were not able to identify specific family related risk factors or living conditions prior to the abuse that predicted poorer adult adjustment capabilities of survivors.

Future research on IA should also address factors related to the age of disclosure, to whom the maltreatment was reported, and the cognitive development at the time of the abuse. Furthermore, special attention needs to be drawn to the psychosocial care for adult survivors of IA. They are a heterogeneous group with a range of current mental health problems united by aversive histories of abuse and violence. Clinicians should be made aware of these consequences of CA and IA, and specialized treatments, and programs need to be developed to support survivors. Finally, the prevention of IA, and the structures, and conditions under which it happens need further research. For this, changes in law, policy, and practice need to be implemented to make CA an experience of the past (John Jay College, 2004; Stein, 2006).

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