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Divine Retribution

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Abstract

The effects of religious abuse are not well documented with the observation of little empirical data. What is known about religious abuse is the effects of trauma on the body and brain functions and structures, such as reduced white matter in several regions, hyperactivity in neural fear response regions, hypoactivity in the prefrontal cortex, and the continuous hypervigilance experienced by the nervous system. With religious abuse, there have been over 7,000 Catholic priests found credibly responsible for the sexual abuse and theological weaponizing toward over 20,000 children. One in four girls and one in six boys will be sexually abused at least once before their 18th birthday. Case studies provide context toward the effects of sexual abuse in religiosity and spirituality, such as a boy who was abused by a neighbor and lost his connection with his God. Another case study was a 12-year-old girl was also sexually abused and surrounded by healing through her faith community, so she never lost her belief in God. For men and boys, disclosing their sexual abuse is harder than for women and girls because of three domain barriers that prevent them: sociopolitical domain, personal domain, and interpersonal domain. Physical violence, denial of medical care, and sexual abuse by religious authority (SARA) all fall under the umbrella of religious abuse.

Keywords: CSA, religion, sexual abuse, spiritual abuse, childhood trauma

Divine Retribution: A Series of Child Sexual Abuse by Religious Authority

As religion is used as a coping mechanism for a plethora of reasons, it can also be a tool and weaponized for the purpose of maltreatment in the form of sexually abusing children. This is often conducted by clerical personnel or even parents seeking ways to rid the child of demons. Sexual abuse committed by someone in a religious authority position can often be more detrimental than transgressed by a teacher, peer, or family member. When sexual abuse is committed by someone cut from the cloth of God, it can break the spiritual aspects of someone's life (Ben-Ezra et al., 2010). The act and violation of sexual abuse is detrimental no matter who does it or when. When a religious figure carries out this form of betrayal, those who have been victimized have an increased chance of abandoning their spirituality or religion while the brain and body find ways to cope and manage the trauma of the abuse (Helsel, 2014). While there are several open letters and opinion pieces on child sexual abuse (CSA) at the hands of religious authorities, there is very little empirical data readily available (Tailor et al., 2014). There are a select few case studies that focus on what happens to a child's spirituality after CSA, such as Kristy, a seven-year-old girl, who was a victim of CSA at the hands of her Deacon father who used God as a tool to keep her silent (Walker et al., 2010). Bottoms and colleagues (2015) found that three variables of abuse justified by religion exist: (a) abuse carried out by religious figures, (b) medical neglect, and (c) physical abuse. Often, abuse is the result of imbalanced dynamics (Middleton et al., 2017).

Despite some believing that religious leaders would never sin as detrimentally as sexually abusing their congregates, it occurs more often than one may expect (John Jay College of Criminal Justice, 2004). Sexual abuse committed against children is a problem as it sets the stage for detrimental effects such as complications to the various nervous systems. Effects such as this

elucidate the issues in adult life, namely fear of stigmas for seeking professional help as well as other roadblocks that prevent them from pursuing aid to help alleviate symptoms and deal with the root cause of the problems (Helsel, 2014; McCormack & Thomson, 2016). CSA in religious settings is an epidemic that needs to be addressed especially with the barriers toward disclosure and the cascade of events that leads up to the initial abuse that incites the betrayal of the psyche and the spirit.

Sexual Abuse and Exploitation Statistics

In 1989, the Convention of the Rights of the Child (CRC) was held by the United Nations General Assembly. It became the first international law that was attentive to the rights of children everywhere. This law, that has been universally ratified, is the first of its kind regarding human rights treaties (Simon et al., 2020). Article 19 in the CRC narrates as follows:

> States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse. (p. 2)

The CRC differentiated child sexual abuse (CSA) and child sexual exploitation (CSE). Child sexual abuse includes the element of sexual enjoyment of the perpetrator, and child sexual exploitation includes a monetary or bartering element (Simon et al., 2020). Psychologists, sociologists, and social workers use CSA/E as overall terminology for both concepts. A survey disclosed that in 73 countries, a concession was observed from decisive workers in child protection agencies on the CSA/E categories of behaviors (Simon et al., 2020). These behaviors include groping, incest, making/letting a child watch pornographic content, prostitution, solicitation on the internet, marriage of a child, and genital mutilation on girls. Prostitution had

the highest ranking on the agreements at 92% for a behavior that falls under CSA/E, and solicitation over the internet as second highest with an agreement of 86%. After that was child marriage (80%) and mutilation of female genitals (80%) (Simon et al., 2020). Children are at high risk of being exposed to trauma and abuse, even in religious settings.

The John Jay Report from the College of Criminal Justice (2004) has isolated credible reports of sexual abuse by religious authority (SARA), in the case of Catholic priests, and found that 7,002 Catholic priests have been credibly accused of CSA in the United States, leaving an estimated 20,052 survivors between the year 1950 to 2018, and those are just the reported cases. Annually, around 37% of American children are reported to Child Protective Services (CPS), 27% of those reports being for children 3 years old or younger, and 4% of those are cases of sexual abuse (Tikkanen, 2017). 51% of women and 48% of men have reported being sexually abused at some point in their life, and if they were abused as children, it normally occurs around age ten (National Sexual Violence Resource Center, 2010; Easton et al., 2014). Researchers have found that one in four girls and one in six boys are sexually abused before they turn eighteen, 20% of male CSA victims are assaulted before their 8th birthday (Easton et al., 2014; Tikkanen, 2017), and 28% of adolescents between the ages of 14 and 17 have been sexually abused (National Center for Victims of Crime, 2022). In the study conducted by Easton and colleagues (2014), consisting of 460 participants, 61.7% disclosed that their sexual abuse was at the hands of a religious figure. One of the questions of the survey asked how long the abuse lasted, to which 30% of the participants disclosed that their abuse lasted less than 6 months, 32.3% stated that it was 6 months to three years, and the remaining 34.3% said it persisted for over three years The data that is readily available on SARA in databases state that most CSA victim participants

in studies were male while national data shows that children who are sexually abused are often female (National Center for Victims of Crime, 2022).

The Body's Response to Trauma

Development

Regarding the development of children and how adverse events affect their development, the psychologist, Erik Erikson, had a theory of the different stages of competence and development in their lives that motivate humans to reach specific achievements which continues to gain momentum amongst psychologists and researchers (Dunkel & Harbke. 2016). Erikson's developmental theory challenges typical and conventional theories by including not only the psychical and cognitive development, but also psychosocial development. The individuality of the child as they grow and develop into adulthood was a key difference in his theory (Dunkel & Harbke, 2016), but he theorized that traumatic events and abuse in a child's life would have long lasting effects on where they stand in their developmental stages regarding the psychosocial aspects. Depending on events that happen in the early stages of development, they would have a forceful impact on which side a child would lean toward in their developmental psychosocial milestone (Dunkel & Harbke, 2016; Orenstein & Lewis, 2021). For instance, between the ages of six and twelve, children run into industry versus inferiority. This is where children would begin to watch their peers and place themselves in juxtaposition with the other children, while deciding for themselves where they stand (Dunkel & Harbke, 2016). The children would place themselves either ahead with pride and feelings of competence, or they would put themselves behind their peers with apprehension that they are inferior and become filled with shame. The conditions on how the children are treated by their family and peers would indicate where they place themselves throughout their adolescent years and can have potentially long-lasting effects into

adulthood (Dunkel & Harbke, 2016; Orenstein & Lewis, 2021). Unfortunately, most abuse occurs during the brain's most pivotal development changes, and those who are sexually abused as children would be on this developmental timeline with the average age being 9 years old (Easton et al., 2014; Indiana Center for the Prevention of Youth Abuse & Suicide, 2022). It is best to quickly deal with the trauma when it presents itself rather than wait as it will lead to an increased stigma internalization, the building of mental walls to protect oneself in a toxic manner, and the revictimization caused by mental health and medical systems (Helsel, 2014; McCormack & Thomson, 2016).

PTSD Criteria

Post-Traumatic Stress Disorder (PTSD) or Complex Post Traumatic Stress Disorder (C-PTSD) are defined by a recurrent psychological dysfunction triggered by unwanted thoughts and memories flooding the mind, heighted sense of vigilance, increase in emotional reactions, and a distorted view of the self. PTSD and C-PTSD can show symptoms within days, and other times it starts months or years after the preface of abuse (McCormack & Thomson, 2016; Harnett et al., 2020). With the understanding of the defining characteristics of (C)PTSD, McCormack and Thomson (2016), from the University of Newcastle in New South Wales in Australia, conducted a study on the complexities of childhood trauma, receiving the diagnosis as an adult, and how to make sense of the double edge sword that's been placed in front of them. Their objective was to create research and find out what hides behind the "double edge phenomenon" of trauma experienced as a child that leads into adulthood. When complex trauma develops in children, it is caused by prolonged dangerous events and acts transgressed against the child (McCormack & Thomson, 2016). To diagnose PTSD or C-PTSD in a child, symptoms such as flashbacks of the event(s), sleep disturbances, mood changes, and age regression need to occur for at least a month

(Stanford Medicine Childrens Health, 2022). Other common signs that are spotted in children are bed wetting, dissociation, and behavioral issues such as acting out or being different than usual (McCormack & Thomson, 2016). More extreme indications and symptoms include suicide attempts, delayed emotional development, and social withdrawal. Diagnoses might later be documented such as Attention Deficit/Hyperactivity (ADHD), PTSD, personality disorders, and many more (Mayo Clinic, 2022). Helsel (2014) explains that the crucial element of treating (C)PTSD is validating the patient's feelings and experience, assistance in creating feelings of safety, and self-regulation. There will often not be communal social support, positive cognitive magnification, and constructive examples of coping skills in the children's lives, which then the children will be observers of maladjusted, abusive emotional relationships of their significant adults prior to their own abuse whether it be psychological, emotional, or physical (McCormack & Thomson, 2016).

Sleep Debilitation in Traumatized Children

There are many known effects of trauma in children such as suicide attempts and suicide ideation, behavioral and emotional dysregulation, dissociative tendencies, and sleep impairment (McCormack & Thomson, 2016; Stanford Medicine Children's Health, 2022; Wamser-Nanney & Chesher, 2018). Along with these debilitating symptoms and wreckage of the nervous system (Helsel, 2014), depletion of sleep that causes impairment in everyday life and maladaptive ways of coping with trauma are known factors in causing severe mental health issues and worsening PTSD and C-PTSD symptoms (Wamser-Nanney & Chesher, 2018). Disruption of sleep is often caused by nightmares of the event(s) and difficulties falling and staying asleep. As further research is established in this area, specifically for adults, it became apparent that there is an obvious observation of lacking research for pediatric sleep disruption. The DSM-5 annexed sleep

disturbances into the catalog of various mental health struggles and diagnoses such as nightmare disorder, insomnia, circadian rhythm disorder, and more (Wamser-Nanney & Chesher, 2018). Researchers also discovered that those vulnerable to traumatic events, and those who have been exposed to such traumatic events, show evidence toward an increase in the activity of the sympathetic nervous system during the rapid eye movement (REM) stage of sleep (Wamser-Nanney & Chesher, 2018). When looking at a sample of trauma induced sleep impairment in children, 3% to 77.1% of the children experienced this symptom and 20.3% to 80.8% experienced sleep disruptions by nightmares. One of the issues with the sample being discussed in Wamser-Nanney and Chesher's (2018) article was that it did not state the size of the sample of traumatized children experiencing sleep disturbances. However, the article elaborated on the effects of interpersonal trauma compared to non-interpersonal trauma. Children who have been sexually abused tend to show more symptoms regarding sleep difficulties (Wamser-Nanney & Chesher, 2018).

Triggers and Memory

With childhood abuse lingering in the past, when those who have been abused reach adulthood, it is not uncommon for them to be revictimized by the medical system with societal stigmas around mental health, physicians not treating them seriously, and a laundry list of diagnoses that also come with their own stigmas and stereotypes (McCormack & Thomson, 2016). (C)PTSD can be triggered by sensations that may not make sense at the time such as hearing a certain sound, word, or sentence (Helsel, 2014). Other triggers can be smelling a certain scent, some triggers can also be bodily sensations including being overwhelmed by lots of pillows or blankets that give a similar feeling of being smothered. These triggers can last for years and can occur at any moment leaving those with PTSD or C-PTSD on edge and

experiencing hypervigilance, and wondering when the other shoe is going to drop (Helsel, 2014; McCormack & Thomson, 2016). With different triggers activating the trauma responses, it needs to be noted that there are different types of PTSD such as single-blow trauma which is an adverse event that occurs only once (Helsel, 2014). This can include car accidents, single incidence of sexual assault, or surviving a natural disaster. However, prolonged trauma, where the events occur more than once, increases the chances of C-PTSD developing and more severe symptoms that can lead to comorbidity of varying mental illnesses (Helsel, 2014). One of the top symptoms of PTSD and C-PTSD is vivid flashbacks in the form of memories popping up or emotional flashbacks of the event occurring. There are two types of memories: implicit and explicit. Implicit indicates that the memories are long-term and store themselves in the body while explicit memories are more short-term that is easier to recall on command (Helsel, 2014).

The Nervous System.

Memories are not the only aspect that can be triggered and activated. Like how the flashbacks seem to surface either with or without a trigger, the nervous system is also provoked when triggers are presented. To understand how the nervous system is activated, one must know about the different aspects of the system (Helsel, 2014). All the parts and components of the nervous system can be traced back to and are based out of the central nervous system (CNS) which is located in the spinal cord and brain. However, the CNS is more complex than the anatomical structure of the brain and spinal because it includes the cerebellum, pons, medulla, midbrain, cerebral hemispheres, and diencephalon (Purves et al., 2001).

Enteric Nervous System. The enteric nervous system (ENS) is considered the primeval aspect of the nervous system, located in the abdomen, and is also known as the second brain because the majority of neural signals have a direct pathway from the gut to the brain and vice

versa (Helsel, 2014; Purves et al., 2001). When a traumatic event occurs, the person experiencing the matter goes into fight, flight, or freeze, and the ENS is associated with freezing (Helsel, 2014).

Sympathetic Nervous System. The sympathetic nervous system (SNS) is considered to be the second stage of evolution in the nervous system where the fight and flight responses are positioned. Once the fight-flight response is activated, the bodily response that begins is a racing heartbeat and lowered core temperature causing a clamminess sensation. This bodily response helps prepare the body for an attack or for the body to be able to run from the danger presented in the moment (Helsel, 2014). Unfortunately, when triggers are presented that cause flashbacks or other symptoms of PTSD/C-PTSD, the fight-flight-freeze response can be activated even when there is no danger occurring in the moment. The overwhelming feeling of terror, anger, or sadness stimulates hormone production, such as cortisol, which then floods the brain and body even if there is no danger present. However, the body does not know that due to the flashbacks and emotions clouding judgment (Helsel, 2014; Purves et al., 2001). Traumatic events can lead to dissociation in the moment of the event that often continues to occur whenever the body believes that the adverse events are still happening which can last even after years pass by (Lanius, 2015).

Parasympathetic Nervous System. Lastly, the parasympathetic nervous system (PNS) has been noted by neurologists and neuroscientists as the final evolutionary aspect of the nervous system. The PNS oversees social behaviors in positive manners such as utilizing Theory of Mind where one can interpret social cues and body language (Helsel, 2014). Considering the nervous system and the activation that occurs when triggers present themselves, professionals want those treating patients with PTSD or C-PTSD with an abundance of caution as to not rush into the

treatment too quickly to prevent further stress in the nervous systems that is not beneficial to the healing process. By rushing into past traumatic events without having a game plan, such as programming the nervous system to know that it is now in a safe place and not actively in a traumatic event, the symptoms of trauma often get worse for the patient (Helsel, 2014).

Screening in Children

There are many ways to determine if a child is suffering from PTSD or C-PTSD, but what has not been widely documented is the ability and ways to screen for such disorders (Lang & Connell, 2018). Over time, researchers, doctors, and psychologists have been able to compile data regarding the ways in which a child can be traumatized in potential traumatic events (PTEs) whether it is from prolonged physical and psychological abuse, natural disasters, poverty, war, witnessing domestic violence, and a plethora of other events and reasons, and yet there is still much to be compiled in screening and the psychometrics that revolve around it (Lang & Connell, 2018). With so many medical and psychological professionals, legal systems, justice systems, and other professionals and systems that revolve around child welfare and care becoming further informed in a practice called trauma informed care, children are receiving the treatments they need for trauma without being further traumatized. However, even though trauma informed care has become more widespread, the ability to screen for trauma is limited which can cause issues such as children not receiving the care they need and being victimized further by PTEs (Lang & Connell, 2018). A key to understanding why and how children become traumatized is being able to find ways to prevent it, which is why screening for PTEs is so important and crucial.

Brain Function and Structures Affected by Trauma

While about 90% of the population will experience trauma, only a handful of them will develop (C)PTSD, which equals to about seven people out of one hundred (Harnett et al., 2020).

Recent studies have shown that executive control and function along with salience discernment, and retrospective thought of the self are highly impacted by PTSD (Herringa, 2017; Harnett et al., 2020). Psychologists have established that abuse in childhood is often associated with long-term dysregulation of emotions and development of PTSD or other stress related disorders that can continue into adulthood. However, what is not well researched is the way the brain handles and activates mechanisms for maintaining psychopathology of trauma in the early years of one's life (Jackowski et al., 2008).

Neuroimaging

Trauma is a root cause for the development of PTSD and C-PTSD. An approximate 90% of the United States population will experience trauma or be involved in a traumatic event at least once in their life (Harnett et al., 2020). This has led researchers to look at the neurostructural changes that occur in the brain of someone who has developed PTSD, specifically stemming from childhood trauma (Harnett et al., 2020). PTSD has the characteristic of diminished cognitive processes, which is one of the ways that humans can appropriately defend and protect themselves by being able to identify danger in the environment and adapt to it quickly (Harnett et al., 2020). However, because the amygdala is no longer working properly with the ongoing need to constantly be hypervigilant, and with the fear learning and memory abilities no longer being appropriately mediated in the prefrontal cortex (PFC) and hippocampus, changes occur in the structures of the brain due to these new alarms going off inside (Herringa, 2017; Harnett et al., 2020). The regions of the brain that undergo change due to PTSD become exceptional for researchers to place neuroimaging focus on being able to predict and prevent PTSD in those in the future who are susceptible to it (Harnett et al., 2020). Many studies have shown that the gray matter volume, surface area, and thickness in the hippocampus, amygdala,

and PFC in those with PTSD are altered from what can be assumed as the original baseline for the gray matter for functionality (Herringa, 2017; Harnett et al., 2020).

Affected Brain Regions

With two thirds of youth exposed to traumatic events, and by age 18, approximately 8% of the youth who have been traumatized, meet the DSM-5 criteria for PTSD. Neuroimaging studies in adults who have traumatic adverse childhood events (ACE) in their background shows abnormal functions and structure in the frontolimbic circuitry. This area of the brain is responsible for processing and regulating emotions (Herringa, 2017). The neuroimaging studies that have been done on adults with PTSD stemming from childhood show a reduced amount of gray matter volume that is involved with the dorsal anterior cingulate cortex (dACC). The hippocampus and temporal lobe also showed reduced gray matter (Harnett et al., 2020). It was also found that the amygdala, insula, and midACC can become hyperactive; the important part is that the hyperactivity in the dACC and the medial and lateral prefrontal brain sections are involved with detecting threat-based stimuli. The hippocampus is also critical for discerning an impending threat by use of processing context and declarative memory (Herringa, 2017; Harnett et al., 2020). In Herringa studies (2017), he found that traumatized children, 15 and under, have amygdala activation that is lower than their non-traumatized peers who are developing typically. As they grew older, the images showed that the amygdala started to have hyperactivation once they reached the tail end of teen years. It is theorized that when children with PTSD are younger, they might tend to downregulate the amygdala (Herringa et al., 2017). If that is true, then the children's amygdala then becomes compromised as they grow older. There is evidence that there is some credibility to the theory, which then the compensatory engagement involved with the

prefrontal regulation circuits could be observed in the traumatized children when they are younger (Herringa, 2017; Harnett et al., 2020).

Herringa (2017) mentioned in his research that the abnormalities in the brain regions may not be entirely based on PTSD effects on the brain, but also psychological abnormalities based on various psychiatric disorders. With the brain abnormalities, it can be inferred that frontolimbic models and the hyperactivity of the threat detection structures, such as the amygdala and insula, do cause impairment of the functioning of emotional regulation and context awareness and processing (Herringa, 2017; Harnett et al., 2020). Researchers also theorized that PTSD, becoming associated with the ventromedial prefrontal cortex (PFC), may lead to its hypoactivity, potentially causing the suppression of fear responses. The hypoactivity is believed to be most likely giving rise to the failure of amygdala hyperactivity suppression leading to an outcome of disruption of the fear learning regions (hippocampus and PFC) and memory processing abilities (Harnett et al., 2020).

White Matter Reduction. On top of the hyperactive fear response in neural structures and the abnormal functions in the frontolimbic circuitry, it is also important to identify what is happening in the corpus-callosum (CC) and its white matter just as the gray matter in the PFC, hippocampus, and amygdala are affected critically. Unfortunately, there is a small amount of empirical data surrounding the gray matter reduction in pediatric settings (Jackowski et al., 2008; Herringa et al., 2017; Lim et al., 2019). However, there is data on the white matter reduction in the CC. Jackowski and colleagues (2008) conducted a study with 32 children as research participants to find out the effects of trauma on the CC and the reduction of white matter in this brain region. Research has shown that there is no significant reduction of white matter in the hippocampus in children with PTSD, however, data has conveyed that there is white matter

reduction in the CC in traumatized children (Jackowski et al., 2008; Saar-Ashkenazy et al., 2014). With brain development being complex and constructed out of genes and environments, the effects of trauma were shown in a structural MRI. In the MRI, it was found that the gray matter volume in multiple late-developing brain structures and areas were abnormal (Lim et al., 2019). White matter is the foundation for the connectivity that regulates the activation of neural network communication through speed and timing of the neurotransmitters and synapses (Jackowski et al., 2008; Saar-Ashkenazy et al., 2014; Lim et al., 2019). Lim and colleagues (2019) conducted a study to analyze the relationship between abuse in childhood and the abnormal structuring of the white matter. This was done through a tract-specific analysis of the brain with 23 participants in their early, 13 years old, to late adolescent years, 20 years old, who were not psychiatrically medicated and experienced abuse. The other group was comprised of 20 participants of the same age range, however, despite being similar to the first group on the psychiatric comorbidity scale, these youth disclosed that they had never experienced abuse (Lim et al., 2019). The results of the study elucidated that the group who has experienced maltreatment in childhood had a significant amount of reduction in the white matter in the bilateral inferior longitudinal fasciculus (ILF) that is connected to the anterior temporal cortex. There was also a significant reduction of white matter in the left side of the inferior fronto-occipital fasciculus (IFoF) (Lim et al., 2019). The MRIs also revealed that the abuse groups had a higher rate of reduction in the fractional anisotropy (FA) which concurs the high rates of maltreatment that the abuse group experienced (Lim et al., 2019).

Religious Justification in Child Abuse

Children trust in the words that are spoken by their religious leaders, despite what religion and belief system they follow and put their hopes in the clergy's actions that they may

be keepers of peace and spiritual safety. Nonetheless, these priests and rabbis, and other people who hold a clerical title, are still human and are not infallible. They too step out of line to commit sins and actions that are disgraceful to the church, such as child molestation and other forms of religious abuse. "...how do you tell on God (Bottoms et al., 2015, pg. 562)?"

Sexual Abuse by Religious Authorities

Despite the many CSA victims who have been sexually molested and have been taken advantage of by religious authority, there is little empirical data on the topic of what happens to one's religious and spiritual standings after the abuse (Tailor et al., 2014). When CSA is committed by those who are not clerical in occupation, it often leads to the extinguishing of any religious beliefs in the victims as many of those who have been abused have strong feelings of mistrust, asking God why he would allow such acts to be transgressed against them, and overwhelming emotions tied to abandonment from their church community and from God himself (Bottoms et al., 2015, Tailor et al., 2014). However, when exploitation occurs in the name of religion, or God by either family or by someone holding a clerical title as an occupation, the few findings that are readily available explain that those that were sexually abused by a priest found hesitation when contemplating disclosing the crime (Bottoms et al., 2015; Easton et al., 2014). There are many reasons why survivors of child sexual abuse (CSA) might not disclose their experiences. One key reason is that they view the priest as a revered figure, having grown up being told that priests are a conduit to God. This reverence makes it difficult for them to explain how someone they believed to be 'cut from the cloth of God' could take advantage of them in such a malicious way. A participant who experienced SARA stated, "...it was like being raped by God (Easton et al., 2014, p. 465)". With over 7,000 priests being credibly accused of CSA, leaving over 20,000 survivors, it is not a surprise that those survivors feel overwhelming

emotional amounts of shame, anger, and confusion regarding their religious beliefs that they once had or still adhere to along with the relationship with their God (John Jay College of Criminal Justice, 2004; Bottoms et al., 2015; Tailor et al., 2014).

Denial of Medical Care

While it is essential to look at sexual abuse committed by religious figures, there are many other forms of religious and spiritual abuse that are not sexual, such as medical neglect and physical abuse (Bottoms et al., 2015). Regarding medical denial and neglect, parents and caregivers are often the transgressors towards children who become injured, physically sick, or mentally ill and may seek faith healing rather than modern medical attention from doctors and clinical mental health care from therapists. There are many reasons why a caregiver, mainly those who fall in line with fundamentalist beliefs, will favor faith healing over modern medicine, such as being indoctrinated into thinking that medicine and science are the work of the devil for God is the only one who is capable of healing those who are ailing (Bottoms et al., 2015). When child victims who have experienced religious medical neglect seek help as adults from clinical therapists and doctors, they state that the consequences that occurred include, but are not limited to (a) aggressive emotions and behaviors towards the caregivers and faith healers, (b) lingering physical ailments, (c) persistent depressive states, and (d) diminished self-value and worth (Bottoms et al., 2015). In known severe cases where a mandatory reporter became aware of the situations, 41% of caregivers were reported to social services and child protective services, 14% of the cases had police involvement and court trials while only 5% of the abusive caregivers were ever convicted of child abuse and negligence (Bottoms et al., 2015).

Physical Violence

Sexual abuse leads to lasting PTSD or C-PTSD symptoms. Medical neglect also has those same symptoms as well as physical health complications from injuries and illnesses that are never resolved (Bottoms et al., 2015). Bottoms et al. (2015) research showed that while those two aspects of justified religious abuse are critical variables that cause the development of PTSD or C-PTSD in children, it is also essential to understand the physical abuse and violence that the children go through as well in the name of religion. The caregivers are under the impression that they need to physically exorcise the evil or demons within the child when the child is only exhibiting signs of going through the stages of development which can be uncomfortable for new parents especially if they come from fundamentalist backgrounds at 43% (Bottoms et al., 2015). Unfortunately, there is little empirical data surrounding this type of religious abuse toward children even though Bottoms et al. (2015) found that religion-inspired physical abuse is more detrimental to developing children than those who physically abuse without religious justification. The abuse is shown to occur between the ages of 5 and 11 years old (Bottoms et al., 2015).

Case Studies

Abandoning faith is one of the first ramifications to occur and be seen in children who have been abused and come from a religious background (Walker et al., 2010). The child will come to question their faith and become angry with God for letting the abuse to transpire and/or continue for months or years. Others will come to see God as terrifying and become truly "God-fearing." If the situation is handled correctly, using religion in conjunction with therapy and treatment can produce a positive outcome. Walker, et al., (2010), investigated addressing religious issues amongst those who have experienced trauma, they examined several different case studies to see how religion affects each child who has a history of trauma. One of the case

studies was of a Caucasian seven-year-old girl named Kristy who was abused by the deacon of the church who was also her father. He kept her quiet under the threat that everyone, including God, would detest her for being immoral and impure thus sealing her fate with damnation (Walker et al., 2010). Child protective services eventually took her away and placed her in the child protective care and foster system and in intensive psychotherapy but not before the damage was done. God became an antagonist in her story that she came to fear. Another case study was a Hispanic girl who had been sexually assaulted by an individual outside of her Church and family circles (Walker et al., 2010). While undergoing psychotherapy, her family surrounded her with love and quoted the Bible with verses that contained God's love and protection to encourage her and help her heal with spiritual aid which proved to be successful (Walker et al., 2010). While both girls experienced sexual abuse and assault and both grew up and lived in religious families, they turned out very different and that was due to how the sexual assault went down. In the first case, the girl had been abused in church and by her father. With the location and the pretense of the threats being the wrath of God and damnation, her relationship with God became impaired and statistically speaking the relationship will potentially never be fixed or become healthy (Walker et al., 2010). The second case took place outside of the family and religious settings which did not put God in the limelight in a negative perspective. Due to her supportive and protective family, she was able to be supported by love from blood and from the divine saving her relationship with God, her own spirituality, and religious standings. For some people, strengthening their bond and connection to divinity is crucial in their healing process while others find it hard to maintain their connection and religious or spiritual beliefs (Walker et al., 2010).

Consequences of Religious Abuse

Barriers of CSA and SARA Disclosure in Men

There are overbearing barriers to disclosing sexual abuse that happened in childhood for men whether that be due to the threat of the perpetrator or traumatic side effects that occurred during the initial abuse. They are often not believed, or they are told that they should have enjoyed it and that it is impossible for a man to be raped because they are so much bigger, despite being children at the time. As these men grow older and become adults, they are also unaware that what occurred could be called sexual abuse (Easton et al., 2014). Easton and colleagues (2014) surveyed 460 males who reported being a victim of CSA and found that 61.7% of those abused were at the hands of a clergy member. The goal was to determine what the barriers to disclosing the abuse and found that the obstacles consisted of sociopolitical reasons, personal, and interpersonal domains (Easton et al., 2014). The participants in Easton's research then gave information on the event of the abuse starting with how old they were that led to the researchers determining that age 10 was the mean of the initial abuse and that 94.6% of those who assaulted them was a man. To provide resourceful methods, Easton's experiment took place in several empirical phases. The first phase was where the data was broken down into separate parts that each consisted of a near number of responses (Easton et al., 2014). To analyze the first segment of information provided, the researchers each looked at the participants' responses and comments with great concentration for intricate details. A common theme between all the answers was the word "shame." Later in the survey, shame is categorized and labeled as "internal emotions." The middle phase of data adhered to similar processes as the first phase where the researchers took themes and applied them to other segments of data (Easton et al., 2014). The middle phase, while similar to the beginning phase, the themes and trigger words were recompiled and reexamined a multitude of times leaving thirty-six themes and codes to be

categorized into nine sections. The ending phase was where the researchers took their final pile of specific categories of barriers to disclose CSA, giving them the opportunity to pressingly review the categories and sets to find answers on how they all work together and find the answer to why men do not disclose their CSA experience (Easton et al., 2014). Through the survey, the researchers were able to unveil the sources of barriers of disclosure ranging from sociopolitical status, interpersonal issues, and personal issues.

Sociopolitical Domain. Inside of the sociopolitical domain lies the social values such as gender norms that showed an influence on the decision to disclose CSA which can be found in the results section of the article (Easton et al., 2014). Masculinity came up often enough that it was categorized under the sociopolitical domain where the participants made comments such as "...sexual abuse to a man is an abuse against his manhood as well" (p. 463). Another participant commented "feeling weak and powerless, even for little boys, is a terribly painful experience" (p. 463). Feelings that were aroused during the time of the assault adhered to the following emotions: weak, frightened, confused, and guilty. Having feelings as these makes it difficult for the child to understand what is happening. All they are aware of is that they are scared and uncomfortable and in a potentially dangerous situation (Easton et al., 2014). A coping mechanism that these men developed over the years after the abuse could be classified as feelings of strength (mainly physically) so that they may be able to defend themselves. They believed that if they disclosed the fact that they are a CSA victim, their symptoms may be prolonged or reinforce their own personal weakness. A participant explained the situation, "Being abused assumes you were somehow weak and allowed the abuse to happen . . . there is still a sense that talking about the abuse and the effect it had on you just reveals another level of weakness in you" (Easton et al., 2014, p. 463). Their idea of getting through the abuse and the

aftereffects was to be stoic, tough, and ride it out as if it were an illness, such as a common cold. These men were scared that if they disclosed the information, they would elicit strong feelings such as crying along with depression and humiliation (Easton et al., 2014). Along with masculinity, limited resources were also categorized in this section. Many of the men sought help afterwards only to find themselves dejected due to lack of resources for men who are CSA victims or facilities were ill-equipped to deal with their cases (Easton et al., 2014).

Interpersonal Domain. The second domain of the results is the Interpersonal Domain where the attitudes and norms as well as values of their culture and society are permeated into interpersonal relationships. The Interpersonal Domain goes on to discuss that the barriers revolved around negative consequences that could occur if the disclosure came out, however, one of the categories in this domain does speak of the actual consequences that occurred as a response to disclosure (Easton et al., 2014). Mistrust is a large factor in reluctancy towards disclosure. Another participant of this study stated that the person they trusted most was their pastor and they were betrayed by them spiritually, physically, and emotionally the second the abuse began (Easton et al., 2014).

Personal Domain. The third and final domain for the results narrative for learning what causes barriers to disclosure for those who have experienced CSA is the Personal Domain which incorporates various sets of barriers that provide a narrower scope in focusing on the internally placed barriers rather than external ones such as Masculinity and being labeled as gay (Easton et al., 2014). Internal Emotions were the first category in the third domain where participants felt that they had a laundry list of negative emotions that come on strong that derail their course towards disclosure in childhood, and across most of their lifespans such as shame and embarrassment (Easton et al., 2014). Shame and embarrassment are a powerful instrument in

disclosing the history of CSA, especially if it happened in a religious setting or with a religious figure who are considered to be the highest authority for the divine and offer a covenant to the divine. Easton's conclusion led to the knowledge that disclosure is not simply a one-time event shrouded in secrecy, but rather a life-long process that slowly unfolds (Easton et al., 2014).

Conclusion

The Bible says, "But Jesus called them unto him, and said, suffer little children to come unto me, and forbid them not: for of such is the kingdom of God (King James Version, 2017, Matthew 19:14)." The trust that is placed in clerical figures by children, those of the next generation, then having the figure turn around and make them a CSA victim is the ultimate religious, spiritual, and betrayal trauma. The power dynamics that lie at the foot of CSA and SARA often have a cascading chain of events that eventually leads up to CSA such as grooming (Raine & Kent, 2019). While children are no longer objectified and considered a property and nuisance, as they were in Dickenson's books, they are now living a better life with brighter futures, even if they ended up becoming victims of CSA caused by SARA or physically and medically neglected by caretakers in the name of religion (Middleton et al., 2016). However, no matter how better off children may seem from a century ago, CSA and SARA are still very much detrimental and there need to be more support systems in place to help those who have experienced this trauma. With the little empirical data on SARA, medical neglect, physical abuse, and the need for more neuroimaging to understand PTSD in the brain, there should be more researchers looking into the phenomenon of these transgressions against children so psychologists can further understand why this happens and how it can be prevented.

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