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PSYCHOLOGICAL SEQUELAE IN ADULT FEMALES REPORTING CHILDHOOD RITUALISTIC ABUSE

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Abstract—The present study sought to increase current scientific knowledge about the controversial issue of subjectively reported childhood ritualistic abuse by addressing several key unresolved issues. In particular, the possibility that those reporting ritualistic abuse may be characterized primarily by the severity of their abuse histories or the severity of their present psychological symptoms, rather than the veridicality of the ritualistic events, was explored. Adult female outpatients reporting childhood sexual abuse with ritualistic features were compared with a second group of women who reported childhood sexual abuse without ritualism. Measures included characteristics of childhood sexual and physical abuse, current posttraumatic stress disorder (PTSD) diagnostic status and symptom severity, and severity of current dissociative experiences. Women reporting ritualistic features scored significantly higher on measures of childhood sexual and physical abuse. Neither PTSD diagnostic status nor severity for PTSD nor dissociative experiences were significantly different between the groups. While preliminary in nature, these results suggest that it may be helpful to conceptualize reported childhood ritualistic abuse as indicative of the need to assess carefully for severe abuse and its predictable sequelae within existing traumatic victimization conceptual frameworks.

Key Words—Child abuse, Ritualistic abuse.

INTRODUCTION

SINCE THE EARLY 1980s, mental health and law enforcement professionals have been inundated with reports of what has become identified as ritualistic abuse (RA). Within a skeptical legal climate and without an empirical understanding of the psychological processes involved, debate regarding the authenticity of RA as based upon childhood memories has been intense (Loftus, 1993; Van Benschoten, 1990). Mental health professionals have subsequently been left with the daunting task of providing assessment and treatment for persons reporting RA without independent verification of the alleged events.

This study provides no argument for or against the veridicality of RA. Discussions regarding the numerous issues debated in the judicial, psychiatric, and sociological arenas have been provided by the California Office of Criminal Justice Planning (1989), Ganaway (1991), Jones (1991), Lanning (1991), Loftus (1993), Maddox (1991), Putnam (1991), Richardson, Best, and Bromley (1991), and Van Benschoten (1990). Rather, it is our purpose to provide an empirically based assessment of self-reported sexual and physical trauma exposure and current psychological sequelae of adult women reporting childhood RA, compared to adult women reporting only childhood sexual abuse. The use of a control group in RA studies is an essential design

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feature in the development of scientifically based knowledge about RA. This approach does not diminish the need for studies addressing the complex issues regarding memory recall and other controversies surrounding RA. Instead, it is an initial attempt to utilize standard methodology from the field of traumatic stress studies.

Psychological literature on RA includes only a small minority of studies that have employed an empirical framework. The majority of this literature consists of clinical observations, case studies, and surveys of self-reported trauma exposure and symptomatology (Cook, 1991; Driscoll & Wright, 1991; Edwards, 1990; Finkelhor, Williams, & Burns, 1988; Fraser, 1990; Hudson, 1990; Jonker & Jonker-Bakker, 1991; Nurcombe & Unützer, 1991; Wong & McKeen, 1990). In these studies, references to posttraumatic stress disorder (PTSD), dissociative disorders, and major depression and behavioral problems are frequently made without benefit of standardized assessment instruments. Narrative descriptions of alleged abuse provide the data base for trauma exposure, and these are not usually reported systematically. Thus statistical analysis or comparison of findings across studies is not possible. Corroborating data, such as information from legal or medical examinations, family history, mental status, and other basic psychiatric information is either missing or narrative in format.

Methodological problems are particularly salient in studies of adults reporting RA (e.g., Cook (1991), Driscoll & Wright (1991), Shaffer & Cozolino (1992), and Young, Sachs, Braun, and Watkins (1991). While these studies are helpful in developing hypotheses regarding psychological distress and perception of trauma exposure, operational definitions of variables and control groups are lacking.

Among those RA studies using control groups, two examined trauma exposure and psychological sequelae in children, while one examined psychological sequelae of adult women. A study completed by Kelley (1988) compared 32 children reporting RA with 35 children reporting sexual abuse without rituals (SA), and 67 children not reporting abuse (NA) on measures of parent-reported trauma exposure and symptomatology. Significant differences were found in trauma exposure, with the RA group reporting more sexual abuse, ingestion of drugs, use of physical restraints and sexual activity with other children than the SA group. Assessment with the Child Behavior Checklist (CBCL) found significant differences between groups with the RA children having more total behavior problems and internalizing behaviors, RA and SA children having more externalizing behaviors than the NA children, and RA and SA children having less social competence than the NA children.

A second study, by Waterman, Kelly, McCord, and Oliveri (1993), involved the psychological assessment of 82 children reporting ritualistic abuse (RA), 15 reporting court-verified sexual abuse (SA), and 37 children reporting no abuse (NA). While therapist-reported sexual trauma exposure did not differentiate the RA and SA groups, the groups differed on exposure to "terrorizing acts" (i.e., RA). Maternal ratings of the CBCL found RA children having significantly more total behavior problems, internalizing and externalizing behaviors, and less social competence than the NA group. Upon comparison to SA children, the RA children had significantly more total behavior problems and internalizing behaviors, while differences in externalizing behaviors and social competence were not significant. RA children were more fearful as measured by the Louisville Fear Survey, and more likely to have a diagnosis of PTSD, based upon a checklist of a working draft of DSM-III-R criteria. Medical examinations found that a majority of the children reporting RA had physical findings consistent with sexual abuse.

The third study involved the assessment of 87 adult women reporting severe sexual abuse for a minimum of 12 months prior to the age of 12, who met DSM-III-R criteria for a dissociative disorder, and were admitted to an inpatient program for dissociative disorders (Leavitt, 1994). Thirty-nine women reported a history of childhood satanic ritualistic abuse (SRA), while 48 reported childhood sexual abuse (CSA) only. Self-reported trauma exposure for the SRA group indicated an average duration of abuse of 11.1 years and 4.4 perpetrators,

compared to an average 6.6 years of abuse and 2.9 perpetrators for the CSA group. Statistical comparison between these trauma exposure variables was not offered. Psychological assessment utilizing the Minnesota Multiphasic Personality Inventory (MMPI) and the Dissociative Experiences Scales (DES) found significant differences between groups, with the SRA group yielding scores higher both on the Paranoia scale of the MMPI and the DES.

Operational definitions used for RA have been inconsistent. While some studies included references to physical, sexual and psychological abuse, other criteria were also included to provide a seemingly credible definition that usually had little empirical and/or forensic backing. For example, Finkelhor, Williams, and Burns (1988) proposed a three-fold typology that included assumptions regarding the motivation of the perpetrator(s). However, forensic literature endorsing these assumptions is absent.

In his reviews of the literature, Lloyd (1991, 1992) asserted the need to find a clear and concise definition of RA that does not hinder psychological and sociological research, nor impede legal investigation. At present, assumptions regarding the actual existence of RA, particularly in relation to Satanism or cultic worship, motivation of the perpetrator(s), and consequences for the victim(s) are speculative. Raising these unresolved issues may polarize those involved with legal investigation and research into camps of "believers" or "nonbelievers." Thus it is important to develop an operational definition that avoids speculation and achieves wide acceptance.

Accordingly, the research presented is designed to empirically assess self-reported sexual and physical trauma exposure and symptomatology in adult female outpatients reporting RA during childhood. As posttraumatic stress disorder (PTSD) and dissociative disorders represent common trauma-induced symptomatology (Kluft, Steinberg, & Spitzer, 1988; Roth, Pelcovitz, & van der Kolk, 1992; Spiegel & Cardeña, 1990), symptoms from both disorders are assessed. Ritualistic abuse is defined as abuse that is recalled as part of a pattern of prescribed formal behavior applied to a specific repeated event. This pattern of behavior involves symbols of a quasi-magical and/or religious meaning, often recalled as including multiple perpetrators and multiple victims. Self-reported trauma exposure and current symptomatology of adult female outpatients reporting childhood ritualistic abuse (CRA) were compared to adult female outpatients reporting only childhood sexual abuse (CSA). It was hypothesized that (a) the CRA group would meet DSM-III-R diagnostic criteria for PTSD at a rate higher than the CSA group, (b) the CRA group would report PTSD symptoms at a higher intensity than the CSA group, and (c) the CRA group would report dissociative experiences at a higher rate than the CSA group.

METHOD

Participants

Admitted to the study were adult females currently involved in outpatient psychotherapy who reported at least one incident of sexual or ritualistic abuse prior to the age of 18. Approximately 50 psychotherapists in Southern California were contacted to request the referral of adult female clients reporting either childhood ritualistic abuse (per this study's definition) or childhood sexual abuse. Consenting therapists gave a form describing the research to their clients. Interested clients called the first author to arrange a 2–3 hour assessment appointment. Each client was assessed by the first author, and was paid $15.00 for her participation.

Current PTSD diagnosis was determined with the Structured Clinical Interview for the DSM-III-R (Spitzer, Williams, Gibbon, & First, 1988), while current symptom intensity was determined with the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) and the Los Angeles Symptom Checklist (Carroll, Rueger, Foy, & Donahoe, 1985). Current level of dissociation was assessed with the Dissociative Experiences Scale (Bernstein-Carlson & Put-

nam, 1986). Level of traumatic violence was assessed with the Sexual Abuse Exposure Questionnaire (Rowan, Rodriguez, Ryan, & Foy, 1991) and the Assessing Environments III (Berger, Knutson, Mehm, & Perkins, 1988). Demographic information was gathered on a separate questionnaire (see Table 1).

Instruments

Structured Clinical Interview for DSM-III-R/PTSD module (SCID). The SCID (Spitzer, Williams, Gibbon, & First, 1988) for PTSD is a structured interview based upon DSM-III-R criteria for PTSD. A kappa coefficient of .93 was found when compared with diagnostic classification by expert clinicians. Subsample analysis found it's sensitivity at 81.2, specificity at 97.6 and kappa at .821. Interrater reliability analysis is not currently available (Litz, Penk, Gerardi, & Keane, 1992).

Impact of Event Scale (IES). The IES (Horowitz, Wilner, & Alvarez, 1979) is a 15-item self-report questionnaire that measures the form, quality, and quantity of conscious psychological symptoms related to trauma. Split-half reliability has been found at $r = .86$, internal consistency of intrusion at alpha = .78 and avoidance at alpha = .80, and test-retest reliability of total scale $r = .87$, intrusion $r = .89$, and avoidance $r = .79$ (Seidner, Amick, & Kilpatrick, 1988).

Los Angeles Symptom Checklist (LASC). The LASC is a self-report inventory originally designed by Foy, Sipprelle, Rueger, and Carroll (1984). The present modified version (Carroll, Rueger, Foy, & Donahoe, 1985), is composed of 43 items of which 17 are characteristic of

Table 1. Demographic Information

Item Group	CRA $N = 19$	CSA $N = 27$	Total $N = 46$
Age	38.7	38.4	38.6
Ethnicity			
Caucasian	19 (100%)	24 (88.9%)	43 (93.5%)
Hispanic	0 (0%)	3 (11.1%)	3 (6.5%)
Current Marital Status			
Never married	6 (31.6%)	11 (40.7%)	17 (37.0%)
Married	10 (52.6%)	8 (29.6%)	18 (39.1%)
Separated/divorced	3 (15.8%)	8 (29.6%)	11 (23.9%)
Parental Alcohol Abuse			
No	8 (42.1%)	13 (48.2%)	21 (45.6%)
Yes	11 (57.9%)	14 (51.8%)	14 (54.4%)
Parental Drug Abuse			
No	13 (68.4%)	26 (96.3%)	39 (84.8%)
Yes	6 (31.6%)	1 (3.7%)	7 (15.2%)
Chi Square (1, $N = 46$) = 6.72, $p < .01$			
Rutter's Risk Factors			
Mean	2.8	2.2	2.5
Sexual Assault as an Adult			
No	7 (36.8%)	12 (44.4%)	19 (41.3%)
Yes	12 (63.2%)	15 (55.6%)	27 (58.7%)
Physical Assault as an Adult			
No	12 (63.2%)	24 (88.9%)	36 (78.3%)
Yes	7 (36.8%)	3 (11.1%)	10 (21.7%)
Chi Square (1, $N = 46$) = 4.34, $p < .04$			
Psychiatric Hospitalization (lifetime)			
No	6 (31.6%)	17 (63.0%)	23 (50.0%)
Yes	13 (68.4%)	10 (37.0%)	23 (50.0%)
Chi Square (1, $N = 46$) = 4.39, $p < .04$			

PTSD, reflecting physiological arousal, intrusive experiences, and patterns of avoidance. Each item is rated on a 5-point severity scale, ranging from *Not a problem* (0) to *An extreme problem* (4). A brief follow-up interview was utilized to confirm that certain items endorsed were actually related to the trauma under study. Preliminary psychometric analyses across five trauma populations (N = 740) have found internal consistency alpha equal to .95. Factor analysis yielded a single primary factor of General Distress (Foy & Leskin, 1993).

Dissociative Experiences Scale (DES). The DES is a 28-item self-report questionnaire by Bernstein-Carlson and Putnam (1986) for the assessment of dissociative experiences. This questionnaire utilizes a visual analog format with participants marking a 100 mm line to indicate the percentage of time each item is experienced. Psychometric analysis has yielded internal consistency alpha = .95, interrater reliability coefficient of absolute agreement a = .96 and relative agreement = .99, test-retest reliability coefficient of absolute agreement = .93, and relative agreement = .96 (Frischholz, Braun, Sachs, Hopkins, Shaeffer, Lewis, Leavitt, Pasquotto, & Schwartz, 1990). Bernstein-Carlson and Putnam (1986) found a median score for a sample of 10 Vietnam veterans diagnosed with PTSD as 31.25, while Branscomb (1991) reported a mean score of 41.11 for 35 inpatient Vietnam Veterans diagnosed with PTSD. A study on adult female outpatients by Strick and Wilcoxon (1991) found median scores of 37.1 for patients diagnosed with PTSD reporting incest, and 26.7 for patients diagnosed with PTSD reporting no incest. Factor analysis with a nonclinical population by Ross, Joshi, and Currie (1991) yielded three different factors: absorption, dissociation, and memory complaints. Similar results were found by Albrecht, Hyer, Touze, and Boudewyns (1991) with inpatients diagnosed with PTSD.

Sexual Abuse Exposure Questionnaire (SAEQ). The SAEQ (Rowan, Rodriquez, Ryan, & Foy, 1991), is a self-report questionnaire that measures exposure, duration, relationship to perpetrator(s), and psychological sequelae. Preliminary psychometric analyses found split-half reliability at r = .73. Construct validity, measured by PTSD intensity and diagnostic status, was found to be within acceptable limits (Ryan, Rodriguez, Rowan, & Foy, 1992).

Assessing Environments III (AEIII). The AEIII is a 155-item self-report questionnaire that investigates a variety of childhood experiences, personal attitudes, and perceptions. Childhood experiences are assessed by forced choice response (True, False, or Not Applicable) and organized into 15 scales based upon common themes. Of particular significance to the current study is the Physical Punishment Scale (PP Scale). The PP Scale is composed of 12 items of behavioral descriptors of abusive action by a parent. Endorsement of four or more items is considered indicative of severe physical abuse. Psychometric properties include KR–20 coefficients ranging from .65 to .79 for nine scales, with the remaining three ranging from .48 to .52. Test-retest reliability coefficients range from .61 to .89 (Berger, Knutson, Mehm, & Perkins, 1988).

Demographics questionnaire. A general demographics questionnaire was designed to assess for age, ethnicity, marital status, socioeconomic status, current substance abuse, and revictimization via sexual and physical assault sustained as an adult. This questionnaire also solicited information regarding six familial risk factors identified by Rutter, Yule, Quinton, Rowlands, Yule, and Berger (1974) as significantly associated with child psychiatric disorders: severe marital discord of parents, low socioeconomic status, overcrowding or large family size, paternal criminality, maternal psychiatric disorder, and removal from the family into the child protective services system.

RESULTS

Nineteen adult women reporting childhood ritualistic abuse, and 27 adult women reporting childhood sexual abuse participated in the study. General demographic variables did not vary significantly across groups. The average participant was 38.57 years old. The majority were Caucasians from a middle-class socioeconomic family background. In terms of current marital status, 39.13% were married, 36.96% never married and 23.91% separated or divorced. In addition, mean number of familial risk factors did not significantly differentiate the CRA and CSA groups.

A majority of the participants from both groups reported sexual assault during adulthood (59%). Reports of physical assault sustained during adulthood were significantly different between groups, with 37% of the CRA and 11% of the CSA groups reporting a minimum of one physical assault (χ^2 [*1*, N = 46] = 4.34, $p < .04$). Significant differences between groups were also found in terms of psychiatric hospitalization, with 68% of the CRA group and 37% of the CSA reporting a minimum of one psychiatric hospitalization (χ^2 [1, N = 46] = 4.39, $p < .04$).

Regarding parental substance abuse, 54% of the total sample reported at least one parent abused alcohol. A significant difference between groups was found in parental drug abuse, with 31% of CRA and 4% of CSA reporting at least one parent abused drugs (χ^2 [1, N = 46] = 6.72, $p < .01$).

Significant differences were found between groups across four trauma exposure variables (see Table 2. The CRA group was more likely to report abuse over a longer duration (F [1, 44] = 11.18, $p < .002$), a greater number of perpetrators, (F [1, 44] = 47.20, $p < .0001$), penile penetration (χ^2 [1, N = 46] = 12.75 , $p < .0004$), and severe physical abuse (χ^2 [1, N = 46] = 7.28, $p < .007$).

In terms of the first hypothesis, that the CRA group would be diagnosed with PTSD at a rate higher than the CSA group, analysis found the difference in rates of PTSD diagnoses to be statistically insignificant (χ^2 [1, N = 46] = 1.17, $p < .28$). Diagnostic rates for CRA and CSA groups were 84% and 70% respectively, indicating that a total of 76%. of the total sample were found to have PTSD.

Table 2. Exposure Variables According to Group

Item Group	CRA N = 19	CSA N = 27	Total N = 46
Duration (years)			
Mean	14.1	9.0	11.1
SD	5.7	4.7	5.7
	F = (1, 44) = 11.18, $p < .002$		
Number of Perpetrators			
Mean	11.7	2.6	6.4
SD	6.7	1.7	6.4
	F = (1, 44) = 47.2, $p < .0001$		
Sexual Abuse (SAEQ)			
No penile penetration	0 (0%)	13 (48.2%)	13 (28.3%)
Penile penetration	19 (100.0%)	14 (51.8%)	33 (71.7%)
	Chi Square (1, N = 46) = 12.75, $p < .0004$		
Physical Abuse (AEIII)			
No to mild	1 (5.3%)	11 (40.7%)	12 (26.1%)
Severe	18 (94.7%)	16 (59.3%)	34 (73.9%)
	Chi Square (1, N = 46) = 7.28, $p < .007$		

Note. SAEQ = Sexual Abuse Exposure Questionnaire; AEIII = Assessing Environments III.

Relative to the second hypothesis regarding PTSD symptom intensity as measured by the SCID (i.e., number of symptoms), IES and LASC, differences between trauma groups were insignificant. However, tendencies in the predicted direction were found for each of the measures. Results for the SCID were most salient, with the RA group reporting a mean of 11.5 symptoms relative to the SA group's 9.5 symptoms (F [1, 44] = 3.74, $p < .06$).

The third hypothesis, that the CRA group would yield higher DES scores than the CSA group, also yielded negative results. Tendencies in the predicted direction were again noted, with the CRA having a mean DES score of 33 compared to 22.4 for the CSA group (F [1, 44] = 3.64, $p < .06$). Median scores for CRA and CSA were 34 and 18 respectively.

To investigate the possibility that sexual and physical abuse intensity may be more salient than trauma type in the development of symptom formation as measured by the SCID, LASC, and DES, a series of covariate analyses were run. Results indicated that sexual and physical abuse intensity were not significant covariates for PTSD symptom formation nor dissociative experiences.

Step-wise multiple regressions using trauma type, sexual abuse intensity and physical abuse intensity as predictive of PTSD intensity and dissociative scores were performed. Results for the SCID were not significant while the intensity of sexual abuse was found as the most significant predictor of dissociative experiences ($T = 2.12$, $p < .04$).

DISCUSSION

A substantial number of the CRA group met DSM-III-R criteria for PTSD, suggesting that PTSD is an appropriate diagnostic category for persons reporting RA. Neither the diagnostic rate nor intensity of symptoms were significantly higher for the CRA group relative to the CSA group as predicted. Such results are not surprising for four reasons. First, as with the CRA group, the majority of the CSA group were help-seekers who had been subjected to severe forms of sexual and physical abuse. In terms of diagnostic rates, it is conceivable that the lack of differentiation may be accounted for by a ceiling effect based upon high levels of trauma exposure reported in both groups. Furthermore, therapists of the CRA group frequently stated to the interviewer that clients referred were those considered more stable, less symptomatic and thus less likely to be distressed by disclosing past trauma to a stranger. Therefore, the lack of differentiation may be due to a narrow range of sexual abuse clientele coupled with a more functional group of CRA clients. Second, the sample size of both groups was relatively small. Third, the overlap in traumatic sexual exposure between groups may have decreased the utility of incorporating persons reporting childhood sexual abuse as a control group. Fourth, in terms of measurement of psychological sequelae, the measures utilized may lack sensitivity relative to the groups studied. In addition, SCID results may have been influenced by experimenter bias due to the interviewer's awareness of each participant's group status. Further research incorporating a broader range of trauma exposure and psychological functioning, larger sample sizes, and standardized measurement is needed.

Dissociation scores of the CRA group were consistent with those reported in other outpatient, trauma-related studies (Bernstein-Carlson & Putnam, 1986; Branscomb, 1991; Strick & Wilcoxon, 1991). In addition, the DES scores of both groups in this study were considerably lower than the scores of the inpatients reported by Leavitt (1994). Within the population sample of the current study, severity of reported sexual abuse appeared to be the most influential trauma factor in the development of dissociative experiences, rather than the trauma type.

The level of trauma reported by the CRA group was significantly higher in measures of sexual and physical traumatization, duration of abuse, and number of perpetrators. Though familial risk factors associated with childhood psychiatric disorders did not differentiate the

two groups, the fact that the CRA group reported an average of 2.76 out of 6 possible factors, in addition to high rates of parental substance abuse is evidence of high levels of family dysfunction in the CRA group's families.

The symptoms exhibited by the participants in this study alleging RA are consistent with profiles of individuals who have suffered other, more visible forms of traumatization. This finding in itself does not substantiate the veracity of the alleged ritualistic abuse. It does, however, suggest that self-reported sexual traumatization serves as the major point of reference in which ritualistic abuse may be studied. Further empirical research involving collaborative information surrounding sexual abuse, such as medical assessments and legal investigations may provide a deeper and more integrated understanding of the phenomena of a presentation of ritualistic abuse.

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Résumé—Cette étude a voulu apporter des connaissances scientifiques plus approfondies sur la question des rituels abusifs signalés par des victimes. Plusieurs questions encore non résolues font l'objet de l'étude. En particulier, on a cherché a déterminer si les signalements dévoilant ces types de mauvais traitements ne sont pas colorés principalement par la sévérité de l'expérience ou la gravité de l'état psychologique de la victime, plutôt que reflétant la véracité de l'événement. Des patientes adultes d'un service externe qui ont dévoilé des expériences de rituels sexuels durant leur enfance ont été comparées à un second groupe de femmes victimes d'abus sexuels non associés à des rituels. On a étudié les caractéristiques des mauvais traitements, tant physiques que sexuels, les désordres de stress post-traumatique et la sévérite des symptômes attenants, ainsi que la gravité de leurs expériences de dissociation actuelles. Les femmes rapportant des agressions associées à des rituels avaient des scores plus élevés lorsqu'on a mesuré le niveau d'abus sexuels et physiques vécus durant leur enfance. Ni le diagnostique du désordre de stress post-traumatique, ni la gravité du désordre même, ni les expériences dissociatives étaient remarquablement différentes dans les deux groupes. Bien que ces résultats soient préliminaires, ils suggèrent que dans des situations de rituels abusifs en enfance, les intervenants devraient effectuer une évaluation attentive pour déterminer s'il y a eu agression grave et des séquelles typiques, ceci dans le contexte des cadres conceptuel de l'agression traumatisante qu'on connait déjà.

Resumen—El presente estudio pretendió aumentar el actual conocimiento científico acerca de la controvertida cuestión de la notificación subjetiva de casos de maltrato infantil de tipo ritualístico, focalizandose en varias cuestiones clave no resueltas. En particular, se exploró la posibilidad de que los casos notificados de abuso ritualístico se caractericen principalmente más por la severidad de las historias de maltrato o por la severidad de los síntomas psicológicos presentes que por la verificabilidad de los acontecimientos rituales. Se compararon los datos de un grupo de mujeres

adultas pacientes externas que habían informado de una historia de abuso sexual infantil con hechos de tipo ritual con los de un segundo grupo de mujeres que informaron de una historia de abuso sexual infantil sin acontecimientos de tipo ritual. Las medidas utilizadas incluyeron las características del maltrato físico y el abuso sexual, el diagnóstico actual y la severidad de los síntomas de un trastorno por estrés postraumático (PTSD) y la severidad de experiencias disociativas actuales. Las mujeres que informaron de hechos ritualísticos puntuaron de manera significativamente más alta en las medidas de maltrato físico y abuso sexual infantil. Ni el diagnostico ni la severidad de los sintomas de trastorno por estres postraumatico ni las experiencias disociativas fueron significativamente diferentes en los dos grupos de mujeres. A pesar de ser preliminares, estos resultados sugieren que puede ser importante el conceptualizar el abuso infantil de tipo ritualístico como indicativo de una necesidad de evaluar cuidadosamente la severidad del abuso y sus predecibles secuelas dentro del marco conceptual existente de victimización traumática.