The Abuse Crisis and the Medical Profession

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It is fair to say that all Catholics have been impacted by the clergy sexual-abuse crisis. This crisis has impacted clergy, laity, bishops, the pope, and those outside the Catholic Church. The evil of sexual abuse cannot be underestimated. As noted in the recent John Jay report, victims of sexual abuse can suffer from depression, anxiety, an increased risk of suicide and suicidal thoughts, substance abuse, anger and resentment, low self-esteem, shame, and self-blame. Victims often have difficulty trusting others, exhibit antisocial behaviors, have strained interpersonal relationships, and may exhibit behavioral problems, including disordered eating and delinquency, promiscuity, and confusion over sexual identity and orientation.¹ It is even more devastating when the perpetrator of abuse is someone in a position of trust, particularly someone representing a religious institution, as it is often to religion and spirituality that victims will turn for support. We all have a responsibility to work to eliminate this evil from our Church and to aid in healing the wounds that have been inflicted and to take additional measures to prevent further sorrow and shame. To do this we need to clearly understand the causes of the problem and how we, as medical professionals, can help.

For those unfamiliar with the *Causes and Context* study, one of the main findings is that the number of incidents of sexual abuse by priests grew from a level of about one hundred per year in 1950–1955 to a peak of over nine hundred per year in the 1970s, and after 1980 declined precipitously to less than one hundred per year by 1994.² The *Causes and Context* study notes that treatment of sexual offenders has evolved over the years, with the main treatment option in the 1940s being castration, with this becoming supplanted by aversive conditioning and then by psychotherapy using primarily the cognitive behavioral model.³ Psychotherapy was the most prevalent form of therapy in the 1980s, particularly

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those employing relapse prevention techniques. While not all perpetrators of sexual abuse were referred for counseling, 1,624 priests received treatment between 1950 and 2002, with 3,041 instances of treatment. Sadly, most of these priests, on completion of treatment, were recommended to be returned to ministry; and some of these went on to abuse additional victims. A notorious example is James Porter who was repeatedly hospitalized for treatment following reports of abuse of children but then returned to ministry in parishes in several different dioceses.⁴

A number of treatment facilities were surveyed in 1994 and 1995, and it was found that they were “generally optimistic about the results of treatment.” Yet there was no empirical research summarizing recidivism rates of offenders leaving these facilities. In the field of psychotherapy, treatment of sexual abusers was in its infancy at the peak of the abuse crisis; and it is interesting to note that Ron Langevin, the founding editor of *Sexual Abuse: A Journal of Research and Treatment*, noted in 1988, “Sex offenders against children and women have also received limited research attention. The bulk of treatments for the offenders have been tried out on homosexual men. There is little convincing evidence that these methods are effective at rehabilitating sex offenders.”⁵ By the late 1980s, it was becoming apparent that treated abusers might abuse again; and so treatment was modified to include after-care programs. However, the damage had already been done.

What can we learn from the dismaying history of the abuse crisis? There are a few take-home lessons for those in the medical profession. One is on focus. As physicians, we typically focus on the patient in front of us. How can we make their lives better? How can we improve their condition? For most illnesses, this may be sufficient. However, for illnesses that affect others, such as sexual abuse, we must broaden our focus to include potential victims. Recidivism rates for sexual abusers treated at some facilities may be as low as 5 percent; and for most treatments, this is a fantastic effectiveness rate. For sexual abuse it is thousands of times too high. The damage done by abusers is so profound that even a single instance of abuse by someone who has been treated and returned to ministry is not justified, even if hundreds of others can return to active ministry and not experience further problems. In addition, putting someone with a history of sexual abuse in a situation where they may again become tempted is bad for the patient. It would be like taking a sober alcoholic and putting them to work as a bartender. Not a good idea. Thus, the zero-tolerance policy makes sense from a therapeutic standpoint as well as from the standpoint of reducing the harm to potential victims.

Another lesson is to consider our therapies in light of the evidence for their effectiveness. As noted above, in 1988 one of the founders of a journal of the study and treatment of sexual abuse noted that there was little evidence that the methods employed for treatment were effective. It is typical, when a field is in its early stages of development, that there is

little hard evidence for the effectiveness of the treatments available. We need to be more guarded about the prospects for success for treatments that have not been evaluated fully, and such evaluation should be part of any new treatment paradigm. That was not done by treatment centers until more recently. In the *Causes and Context* study, it is noted that a survey of treatment centers was carried out in 1994 and 1995, but “there was no empirical research summarizing recidivism rates of offenders leaving the facilities, descriptions of best practices for offenders, or directions on who should or should not have been returned to ministry”.⁶ Although we are taught, in terms of criminal justice, that someone is innocent until proven guilty, for illnesses which include victimization of others as part of the illness, we must assume that they are not cured by our treatment until there is hard evidence that the treatments are effective.

Ultimately, effective treatment for abusers must be based on a proper understanding of the etiology of their illness. The *Causes and Context* study notes that the vast majority of victims were male (81 percent) and that 78 percent were pubescent or postpubescent.⁷ However, they conclude that “the clinical data do not support the hypothesis that priests with a homosexual identity or those who committed same-sex sexual behavior with adults are significantly more likely to sexually abuse children than those with a heterosexual orientation or behavior.”⁸ This discrepancy is discussed more fully in the articles within this special issue, but it would seem obvious that homosexual behavior was certainly a factor in the vast majority of the cases. Unfortunately, several professional organizations have removed homosexuality from their diagnostic manuals and promote the position that same-sex attraction should not be treated but rather should be accepted.⁹ Yet the vast majority of the hard evidence indicates that same sex-attraction is in fact a disorder that can respond to treatment.¹⁰ This may have contributed to inappropriate treatment of priests with same-sex attraction, who may have been told that the origins of their same-sex attractions were genetic or hormonal, thereby failing to help them understand their conflicts that predisposed them to act out sexually. There is more on this in the articles herein by Gerard van den Aardweg, Dale O’Leary, Peter Kleponis, and Richard Fitzgibbons.

The other key issue is where we go from here, both as a profession and as a Church. While much has been written on the abuse crisis, perhaps the most insightful article was written in 2002 by Father Ronald Rolheiser, O.M.I., and is called “On Carrying a Scandal Biblically.”¹¹ Although the initial part of the essay deals with pedophilia (which we now know represented only a minority of cases), the point remains that the individuals who perpetrate sexual abuse are suffering from an illness and should be objects of our compassion, just as the victims certainly must be.

One tendency during this crisis has been to blame the media for unfair coverage. Father Rolheiser points out that we should view the

media as providing a great service by shining a bright light on the evil of sexual abuse, and this is true. Never mind how disconcerting it is that some of that light falls on us as Catholics—this is a great service. The damage done by sexual abuse cannot be overstated. This should be a focus of all of us, particularly in the medical profession, to not hesitate to point out just how devastating this illness is, and to encourage everyone to better understand the causes of sexual abuse, as well as to become actively involved in efforts to eliminate this scourge from our society. Particularly to the point is this section, extracted from Father Rolheiser's piece:

Right now priests represent less than one percent of the overall problem of sexual abuse, but we're on the front pages of the newspapers, and the issue is very much focused on us. Psychologically this is painful, but biblically this is not a bad thing: The fact that priests and the Church have been scapegoated right now is not necessarily bad. If our being scapegoated helps society by bringing the issue of sexual abuse and its devastation of the human soul more into the open, than we are precisely offering ourselves as "food for the life of the world," and we, like Jesus in his crucifixion, are helping to "take away the sins of the world." And, as stated before, this is not a distraction to the life of the Church, it's perhaps the major thing that we need to do right now for the world and our culture. There are very few things that we are doing as Christian communities today that are more important than helping the world deal with this issue. If the price tag is that we are humiliated on the front pages of the newspapers and that the Anglican, United, and Roman Catholic churches of Canada end up financially bankrupt, so be it. Crucifixions are never easy, and they exact real blood! It might well be worth it in the long run if we can help our world come to grips with this.

As medical professionals, we stand in a unique position to help in this crisis, not by protesting that other churches have problems too, or that the media attention is biased, or that sexual abuse is prevalent throughout society and not just within Mother Church. We need to affirm that sexual abuse is always and everywhere a great evil that our society must exorcise. The causes of sexual abuse must be the subject of serious study, and with understanding we should be able to help develop prevention strategies. We have been given an opportunity to develop these strategies within our Church, where the perceived need is great. These strategies must not be limited to sets of rules that limit the opportunity for occasions of sexual abuse, but should address multiple levels of the problem. How does one identify an abuser, or someone with a predisposition to become an abuser? What are the psychological and developmental factors that predispose someone to become an abuser? How might these be addressed to prevent someone from developing into an abuser? What constitutes effective treatment for someone who has a history of sexual abuse? As noted in the article by O'Leary and Fitzgibbons, the conclusion of the *Causes and Context* study was that the cause of clergy sexual

abuse was opportunity/availability, and not severe psychopathology in the abusers.¹² This bears reexamination in light of the information presented in this special issue. Serious consideration should be given to a reevaluation of the data by competent mental-health professionals with a second opinion of the causes of clergy sexual abuse.

The articles in this special issue address some of the questions noted above. However, more work is needed to better understand the causes of sexual abuse and to develop appropriate treatment and prevention strategies. It is my hope that this special issue can help further this effort. But it is only a small step. Much more remains to be done.

Notes

¹ John Jay College, *The Causes and Context of Sexual Abuse of Minors by Catholic Priests in the United States, 1950–2010* (Washington, D.C.: United States Conference of Catholic Bishops, 2011), 94.

² Ibid., 8.

³ Ibid., 78.

⁴ Ibid., 81.

⁵ Ibid., 79.

⁶ Ibid., 83.

⁷ Ibid., 9–10.

⁸ Ibid., 119.

⁹ American Psychological Association, “Answers to Your Questions for a Better Understanding of Sexual Orientation & Homosexuality” (2008), <http://www.apa.org/topics/sexuality/orientation.aspx>.

¹⁰ Catholic Medical Association, “Homosexuality & Hope: Statement of the Catholic Medical Association” (2000), <http://www.narth.com/docs/hope.html>. See also T.G. Sandfort et al., “Same-Sex Sexuality and Quality of Life: Findings from the Netherlands Mental Health Survey and Incidence Study,” *Archives of Sexual Behavior* 32 (2003): 15–22.

¹¹ Ronald Rolheiser, O.M.I., Ph.D., S.T.D., “On Carrying a Scandal Biblically,” <http://www.ronrolheiser.com/common/pdf/scandal.pdf>.

¹² Richard Fitzgibbons and Dale O’Leary, “Sexual Abuse of Minors by Catholic Clergy,” *Linacre Quarterly* 78 (2011):272–293.