Original Article

Sexual Abuse at the Hands of Catholic Clergy

A Retrospective Cohort Study of Its Extent and Health Consequences for Affected Minors (the MHG Study)

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Summary

Background: When cases of sexual abuse within the Catholic Church became known, the German Bishops' Conference (Deutsche Bischofskonferenz, DBK) commissioned a study by an interdisciplinary consortium to determine the frequency of sexual abuse by Catholic clergy in Germany (the MHG study).

Methods: Qualitative and quantitative research methods were used and the subject matter of the study was analyzed in seven component projects. To determine the frequency of sexual abuse, 38 156 personnel files of Catholic clergy from the period 1946 to 2014 were studied, and the epidemiologic findings of these evaluations are presented.

Results: 1670 persons belonging to the Catholic clergy who were accused of sexual abuse of minors were identified from their personnel files, corresponding to 4.4% of the clergy overall. 3677 victims of sexual abuse could be linked to the accused persons; 62.8% of them were male, and 66.7% were under 14 years old when the abuse took place. The mean duration of the abuse in individual cases was 1.3 years. "Hands-on" abuses (i.e., abuses involving bodily contact) occurred in more than 80% of cases. Many of the affected persons suffered serious consequences for their health and social functioning. The ones most commonly reported were anxiety, depression, mistrust, sexual problems, and difficulties with interpersonal contact.

Conclusion: The figures reported here should be considered a lower bound to the actual frequency of sexual abuse. Asymmetrical power relationships in a closed system such as the Catholic Church can facilitate sexual abuse. Physicians play an important role in the diagnosis and treatment of the victims of sexual abuse, in the diagnosis and treatment of persons inclined to commit abuses and actual abusers, and in the development and implementation of preventive strategies.

Cite this as:

Dreßing H, Dölling D, Hermann D, Kruse A, Schmitt E, Bannenberg B, Hoell A, Voss E, Salize HJ: Sexual abuse at the hands of Catholic clergy—a retrospective cohort study of its extent and health consequences for affected minors (the MHG Study). *Dtsch Arztebl Int* 2019; 116: 389–96. DOI: 10.3238/arztebl.2019.0389

Sexual abuse of children is a global problem with high prevalence rates of 18% in girls and 7.6% in boys (1). The use of dissimilar inclusion criteria and survey methods has resulted in higher or lower reported lifetime prevalence rates (2). The effects of sexual abuse offenses can be significant and comprise direct and indirect as well as short-term and long-term consequences. The younger the age at which the sexual abuse occurred, the higher the likelihood of a poor state of health (3). Numerous studies have shown an increased prevalence or a greater severity of posttraumatic stress disorder in victims of sexual child abuse (4). Other potential consequences of abuse offenses experienced as a child include anxiety disorders, depression, suicidal behavior, sleep disorders, and eating disorders (5). In addition, studies reported an association between sexual abuse and later substance abuse as well as self-injurious behavior as elements of maladaptive coping strategies (6).

Sexual child abuse most frequently occurs in families, followed by institutions (7). Systematic research into the prevalence of sexual abuse in an institutional setting is worldwide primarily available for the Catholic Church (8). Although some structures and dynamics regarded as risk factors for sexual abuse are unique to the institutions of the Catholic Church (9), insights into abuse events in the Catholic Church can be held as exemplary for how sexual abuse is dealt with in other institutions. Comparable data on the prevalence of sexual victimization of children in, for example, the Protestant Church or other institutions have not yet become available (10). The aim of this study is to work out how the insights from the MHG Study can be translated into clinical practice.

Methods

This study reports epidemiological data obtained by analyzing personnel records of clergy. All during the analysis period from 1946 to 2014 active or retired clergy as well as minor victims of sexual abuse were included in this study. The clergy comprised Catholic priests ("diocesan priests"), full-time deacons and priests within religious orders who are governed by "Gestellungsverträge" (a contract conferring a form of

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stipend), i.e. priests within Catholic orders who, temporarily or permanently, exercise functions of priests within the area for which the German Bishops' Conference is responsible. A detailed description of the methodology is provided in the *eMethods* section.

Results

Accused clergy

Information about allegations of sexual abuse of minors was found for altogether 1670 persons. This corresponds to 4.4% of persons in the study population. The share among diocesan priests was 5.1%, among full-time deacons 1.0% and among priests within religious orders who were governed by "Gestellungsverträge" 2.1% (*Table 1*). The difference between the shares of accused diocesan priests and accused deacons was statistically significant ($\chi^2 = 78.6607$; $p < 0.0001$).

For 1485 accused persons (88.9%), information about their age at the time of the alleged first abuse offense was available. The mean age was 42.6 years (SD = 11.4 years, 95% confidence interval [CI]: [42.0; 43.1]), with a range of 20 to 82 years.

In 472 of the accused clergy (28.3%), evidence of sexual abuse of at least two minors aged 13 years or younger and of abuse occurrences over a period of more than six months was identified. At the time of the first offense, these 472 clergy were significantly younger (aged between 20 and 39 years) compared to those not showing this constellation ($\chi^2 = 14.284$; $p < 0.001$). According to the personnel records, a criminal complaint was filed in 38.3% of cases. A separate analysis of the criminal files found that 67.1% of criminal proceedings were discontinued, largely because of limitation. Only in one of the cases with final judgment made by a court, the person charged was acquitted.

During the analysis period, the number of accused clergy peaked in the 1960s to 1980s, but new first accusation were noted up to the end of the analysis period in 2014. At the same time, it should be noted that the absolute number of clergy has significantly declined in recent years.

Affected persons

Altogether 3677 sexually abused minors could be linked to the accused persons. In 706 (42.3%) of the 1670 accused, evidence of alleged sexual abuse offenses involving more than one minor was identified ("accused persons with multiple allegations"). For 902 accused clergy (54.0%), evidence of a single abused minor in each case was found ("accused persons with one allegation"). In 62 accused persons (3.6%), the number of affected persons in each case could not be determined.

The mean number of victims of abuse among all accused persons was 2.5 (SD = 3.5 affected persons; 95% CI: [2.4; 2.7]). Among the 706 accused persons with multiple allegations, the mean number of affected persons per accused person was 4.7 (SD = 4.5 affected persons; 95% CI: [4.4; 5.0]).

Of the 3677 sexually abused persons identified in total, 2309 were male (62.8%) and 1284 female (34.9%). For 84 affected persons (2.3%), no information about their sex was available.

For 2847 affected persons (77.4%), data on the age at the time of first sexual abuse was available; the mean age was 12.0 years (SD = 3.1 years; 95% CI: [11.9; 12.2]). Two-thirds of those affected were aged 13 years or younger at the time of first sexual abuse ($n = 1899$; 66.7%) (*Table 2*). There was no difference with regard to the sex ratio of one-third female to two-thirds male affected persons between the two age groups.

For 2993 affected persons (81.4%), information were available about the year the abuse started and the year it ended or about the fact that a single abuse event occurred. From these data, an estimate of the duration of the abuse period was calculated. The calculated mean duration of individual abuse courses was 1.3 years (SD = 2.3 years; 95% CI: [1.3; 1.5]).

Abusive acts

In 3388 affected persons (92.1%), information about the type of abusive act was available (*Table 3*). Here, multiple responses were allowed. In at least 582 cases, the abusive act was genital or manual penetration (15.8% of all affected persons or 17.2% of affected persons with information about the type). In 1360 cases, some kind of masturbation act occurred (37.0% of all affected persons or 40.1% of affected persons with information about the type).

Consequences of the abusive acts

Table 4 shows the range of potential health consequences. In at least 244 affected persons (6.6% of all affected persons or 23.7% of affected persons with information about health consequences), the clustering of items indicates a symptom pattern in line with posttraumatic stress disorder. Because no standardized survey and documentation of the findings was carried out in the context of this study, it was not possible to establish a valid clinical diagnosis.

In 890 affected persons (24.3%), information about problems in social functioning was available. The documented problems included relationship problems (53.1%), sex-life problems (43.0%), career problems (34.2%), problems related to social participation (32.5%).

In addition, it was noted that 144 affected persons (3.9%) left the church. At least 626 affected persons (17.0%) received psychiatric or psychotherapeutic treatment for consequences of the abusive acts. Given the non-standardized nature of the documentation, it can be assumed that the actual treatment prevalence is higher.

For 348 affected persons (9.5%), information about the severity of the consequences of the abusive act on health and social functioning was available, but no standardized criteria were used for severity classification. In the majority of cases, the consequences of the offence were assessed as severe (*Table 5*).

TABLE 1

Number of accused clergy

Clergy status	Number of screened records	Number of accused persons	Proportion of accused persons among clergy with screened records
Diocesan priests	28 208	1429	5.1%
Deacons, full-time	2356	24	1.0%
Priests within religious orders	7534	159	2.1%
Unknown	Not stated	58	0.2%
Total	38 156	1670	4.4%

TABLE 2

Age of affected persons at the time of first sexual abuse

Age	Number of affected persons	Proportion of all affected persons (n = 3677)	Proportion of affected persons with record of age (n = 2847)
≤ 13 years	1899	51.6%	66.7%
≥ 14 years	948	25.8%	33.3%
Unknown	830	22.6%	Not stated
Total	3677	100%	100%

Discussion

There were methodological limitations with regard to standardization, validity, and reliability of the data. It can be assumed that the full extent of the sexual abuse offenses by clergy was not captured. Not all sexual abuse offenses were documented and an unknown number of personnel records were no longer available or no longer complete when the study began. On the one hand, this results in an underestimation of the number of accused clergy and minor victims of sexual abuse. On the other hand, there was a multitude of missing information on individual aspects in the data sheets which were recorded as such. All information was shared in anonymized form with the research consortium for analysis; consequently, the assessments of the investigators could not be reviewed. Since the personnel records were analyzed by review teams of the dioceses, neither a conflict of interest, nor incomplete sharing of the available information can be excluded. It is not possible to provide a quantitative estimation of this bias. A point to note here is that in 50% of abuse cases considered as plausible by the Catholic Church itself, no corresponding information was found in the personnel records or other documents. Despite of this limitation, we were able to analyze a very large sample and an abundance of so far unknown empirical data was compiled.

The figure of 1670 clergy accused of sexual abuse of minors as well as the figure of 3677 affected

persons allegedly abused by these accused persons during the period from 1946 to 2014 should be regarded as lower estimates of the actual sexual abuse that has happened. While it cannot be excluded that some clergy have been wrongly accused, it can be assumed, based on the insights from research into unreported abuse cases, that a lower number of potentially wrong accusations is more than offset by a significantly higher number of undiscovered cases (11). A recent review has shown that studies on the frequency of false allegations do not allow robust prevalence estimates and that the vast majority of accusations is true (12). The insights from the MHG study can help to establish professional access for the health system to dealing with sexual abuse in an institutional setting (13). Besides general mechanisms promoting sexual abuse in institutions (for example, asymmetrical power relations or a closed system), high-risk constellations specific to the Catholic Church should also be taken into consideration. These include the abuse of clerical power, restrictive Catholic sexual morals, a problematic attitude toward homosexuality and a problematic way of dealing with celibacy and secrecy of confession (14). Whether there are specific risk constellations for child sexual abuse in the Protestant Church or other institutions, has as yet not been studied comprehensively. Striking is the—compared to other institutions—very high share of abused boys in the area of responsibility of the Catholic Church.

TABLE 3

Type and number of abusive acts (multiple items allowed)

Type of act	Number of affected persons	Proportion of all affected persons (n = 3677)	Proportion of affected persons with abusive act stated (n = 3388)
Inappropriate touching of affected persons outside of clothing	1084	29.5%	32.0%
Touching of primary genital area of affected persons under clothing	826	22.5%	24.4%
Touching of affected persons under clothing	701	19.1%	20.7%
Kisses on the mouth of affected persons	421	11.4%	12.4%
Verbal approach of affected persons with sexual content	420	11.4%	12.4%
Touching of primary genital area of affected persons outside of clothing	414	11.3%	12.2%
Genital penetration of affected persons	412	11.2%	12.2%
Masturbation on affected persons by accused person	408	11.1%	12.0%
Undressing of affected persons by accused person	407	11.1%	12.0%
Touching of affected persons after undressing without further sexual activities	359	9.8%	10.6%
Asking affected persons to undress	340	9.2%	10.0%
Masturbation of accused person in front of affected person	334	9.1%	9.9%
Masturbation of affected persons in front of accused person	330	9.0%	9.7%
Independent undressing of accused person in front of affected persons	272	7.4%	8.0%
Humiliation, corporal punishment	234	6.4%	6.9%
Touching of secondary sexual characteristics outside of clothing	229	6.2%	6.8%
Touching of secondary sexual characteristics under clothing	227	6.2%	6.7%
Oral sex on accused person	211	5.7%	6.2%
Mutual masturbation	181	4.9%	5.3%
Independent undressing of affected persons in front of accused person	176	4.8%	5.2%
Kissing of other body parts than the mouth	168	4.6%	5.0%
Age-inappropriate sex education	167	4.5%	4.9%
Oral sex on affected person	156	4.2%	4.6%
Inappropriate hygiene-related acts	150	4.1%	4.4%
Affected person's touching of accused person under clothing	150	4.1%	4.4%
Finger penetration on affected persons	125	3.4%	3.7%
Taking nude photos of affected persons	114	3.1%	3.4%
Showing pornographic images or videos	114	3.1%	3.4%
Undressing of accused person by affected persons	35	1.0%	1.0%
Genital penetration of accused person	29	0.8%	0.9%
Making of nude videos or pornographic videos of affected persons	23	0.6%	0.7%
Unknown, not stated	289	7.9%	Not stated

This raises questions regarding the significance of Catholic sexual morals and the Catholic Church's statements on homosexuality. Doctors should have an understanding of general and specific risk constellations for the problem of institutional sexual abuse of children, as they can be contacts for affected persons, for persons inclined to commit sexual abuse, and for perpetrators. In addition, medical expertise may be

needed in prevention programs or with interventions directly aimed at protecting a child at risk.

In the group of the affected persons, the results of our study show a wide range of adverse effects on health and social functioning. However, in the absence of a control group, it cannot be proven that the experienced sexual abuse caused the health and social problems of the affected persons. Because the

TABLE 4

Health problems of affected persons (multiple items allowed)

Health problems of sexually abused persons	Number of affected persons	Proportion of all affected persons (n = 3677)	Proportion of affected persons with consequences stated (n = 1028)
Fears	436	11.9%	42.4%
Depression	435	11.8%	42.3%
Distrust	295	8.0%	28.7%
Sexual problems	294	8.0%	28.6%
Contact difficulties	292	7.9%	28.4%
Nightmares	247	6.7%	24.0%
Difficulty sleeping	203	5.5%	19.7%
Physical consequences	191	5.2%	18.6%
Flashbacks	175	4.8%	17.0%
Suicidal ideation	157	4.3%	15.3%
Panic attacks	133	3.6%	12.9%
Mood swings	128	3.5%	12.5%
Poor concentration	109	3.0%	10.6%
Suicide attempt	96	2.6%	9.3%
Pain	91	2.5%	8.9%
Excessive alcohol consumption	91	2.5%	8.9%
Restlessness	80	2.2%	7.8%
Irritability	65	1.8%	6.3%
Self-harm	50	1.4%	4.9%
Impaired memory	42	1.1%	4.1%
Drug consumption	42	1.1%	4.1%
Easily startled	39	1.1%	3.8%
Bulimia	28	0.8%	2.7%
Anorexia	23	0.6%	2.2%
Misuse of prescription drugs	20	0.5%	1.9%
Severe obesity	16	0.4%	1.6%
Not stated	2649	72%	Not stated

TABLE 5

Severity of health-related or social consequences of abuse

Severity of consequences of abuse	Number of affected persons	Proportion of all affected persons (n = 3677)	Proportion of affected persons with severity stated (n = 348)
Mild	57	1.6%	16.4%
Moderate	56	1.5%	16.1%
Severe	235	6.4%	67.5%
Unknown, not stated	3329	90.5%	Not stated
Total	3677	100%	100%

TABLE 6

Overview of selected study findings

Reference	Country of study	Prevalence period	Total number of offenders	Overall prevalence rate of offenders	Number of affected persons
Royal Commission into Institutional Responses to Child Sexual Abuse, 2017 [21]	Australia	1980–2015	2410 ^{*1}	7.0%	6875 (64.3% male; 35.4% female; 0.1% other; 0.2% unknown)
John Jay College of Criminal Justice, 2004 [22]	USA	1950–2002	4392 priests	4.0% ^{*2}	10 667 (81.0% male; 19.0% female)
Deelman et al., 2011 [23]	Netherlands	1945–2010	approx. 800 clergy and Church staff	Not stated	774 (82.0% male; 16.5% female), prevalence rate: 9.7%
Office of the Attorney General Commonwealth of Massachusetts, 2003 [24]	USA	1940–2003	250 priests und Church staff	Not stated	789 (sex not stated)
Holliane of German Bishops' Conference for victims of sexual abuse 2013 [25]	Germany	until 2011	753 ^{*3,*4}	Not stated	381 (66.4% male; 33.6% female)
Ryan, 2009 [26]	Ireland	1936–2009	434 offenders from testimonies of the victim hearing	Not stated	381 (66.4% male; 33.6% female)

^{*1} 1880 Diocesan priests, priests within religious orders, monks, nuns, lay associates, voluntary roles; 530 unknown offenders

^{*2} Based on estimates of the dioceses and orders; breakdown of clergy who worked in dioceses or religious orders: 4.3% of all diocesan priests and 2.7% of all priests within religious orders

^{*3} 479 priests, 122 priests within religious orders, 79 nuns, 62 Church lay associates, 11 monks

^{*4} No distinction between sexual abuse and psychological violence

information was not obtained from medical or psychological reports, but personnel records of clergy, no diagnoses according to ICD-10 (ICD, International Statistical Classification of Diseases and Related Health Problems) could be established. However, in contrast to the German general population where a recent study found a prevalence of depression of only 6.4% (15), the fraction of depressed persons—if this information was available—among victims of sexual abuse and among the entire group of affected persons was 42.4% and 11.9%, respectively. Likewise, a considerably higher prevalence of symptoms of posttraumatic stress disorder was found in the group of affected persons. This amounted to 23.7% of the affected persons with corresponding information and to 6.6% in the entire group of affected persons. For the German general population, a prevalence of posttraumatic stress disorder of 2.9% was reported (16). It is noteworthy that in the records analyzed in our study information about health-related and social consequences of the abuse was documented for only just under one-third of the affected persons. However, it cannot be deduced from this that there were no negative consequences, but only that no corresponding information was available.

Children and adolescents in closed institutional systems are frequently victims of sexualized violence (17, 18). It is an important responsibility of physicians to be aware of the possibility that a patient could suffer from consequences of abuse and to detect and diagnose potential traumatic events by taking a careful medical history and to initiate further steps, if necessary.

There are a variety of ways how a physician obtains information about the fact that an act of sexual abuse had occurred. This information can, for example, be provided by the child itself or its caregivers. It is also conceivable that a physician suspects sexual abuse because of unspecific symptoms in a minor. Examples of such unspecific symptoms in children include anxiety, aggressiveness, drop in achievements at school, withdrawal tendencies, or psychosomatic symptoms (7). Under certain circumstances, information about sexual abuse can be made available to a physician anonymously. In cases where there is strong suspicion of sexual abuse, a safe environment should be provided as an emergency measure. The individual treatment requirements should then be immediately assessed by a child and adolescent psychiatrist (7). It should, however, be remembered that many affected persons do not, or only decades later, report that they were sexually abused, while suffering from a variety of mental and physical symptoms after the traumatic event(s). Therefore, the possibility that a patient experienced sexual abuse in the context of the Catholic Church

should be considered in adults too and, in case of unclear etiology, it should be cautiously explored. Here, the physician can first point out that the present symptoms can be caused in some patients by experiences of abuse. Subject to the response of the patient, potential abuse situations can then be explored by asking biographical questions. The art of medical interviewing lies in ability to obtain specific information, while keeping in mind a potential reactualization of post-traumatic symptoms and avoiding to provoke false memories by asking suggestive questions.

With regard to the accused clergy, one should be aware that physicians may come into professional contact with this group of persons too; potentially at a time when the clergy is only inclined to commit an offense, but has not yet committed it. Here, prevention can set in: For example, physicians may detect potential high-risk constellations early when taking a comprehensive sexual history and then initiate specific sex therapy interventions. Here, the prevention network “Kein Täter werden“ (Don’t offend) is a suitable contact. Physicians are advised to always see themselves in the diagnosis, intervention, and prevention of cases of sexual abuse as a partner in an interdisciplinary team and to involve the justice system, government agencies, and counselling services, too.

Because of the methodology used in our study, it is in the majority of cases not possible to reliably diagnose the accused clergy; therefore, extreme caution is advised when considering the motivation and typology of the offender. In clinical practice, it can be helpful to assume a continuum of offenders and persons inclined to commit an offense. This continuum extends from a fixed type with pedophilic preference disorder to regressive offenders or persons inclined to commit an offense who, for example, have immature or narcissistic personality problems.

The Catholic Church has now responded in all dioceses to the abuse scandal by implementing prevention and protection plans. However, there is significant heterogeneity in their implementation. Until now, the preventive work has been lacking a focus on the specific risk constellations of sexual abuse by clergy (19). If evaluation studies were conducted, they mainly found an effect of the respective intervention program in favor of the intervention group (20). An evaluation of the prevention activities by the Church which satisfies scientific criteria still needs to be performed.

Prevalences of accused clergy comparable with the 4.4% in the MHG study were found in the US (4%) and Australia (7%) (Table 6).

The similar prevalences highlight the fact that sexual abuse by Catholic clergy is a global phenomenon which needs to be addressed by the regional healthcare systems.

Funding

The study was funded by the German Bishops’ Conference and the Association of German Dioceses (VDD, Verband der Diözesen Deutschlands).

Key messages

- The study included 38 156 personnel records of clergy who worked in the 27 dioceses in Germany between 1946 and 2014.
- Significant differences in the prevalence of abuse were found between diocesan priests (5.1%) and full-time deacons (1.0%).
- International studies have shown that sexual abuse by Catholic clergy is a global problem.
- The minors affected by sexual abuse are primarily male, in contrast to children in other settings. The majority of those affected is aged 13 years or younger at the time of the first abusive act.
- The personnel records showed that the health consequences suffered by the victims of sexual abuse have been severe.

Conflict of interest statement

All authors received study support and reimbursement of travel expenses from the VDD and the German Bishops’ Conference.

Manuscript received on 12 December 2018; revised version accepted on 28 March 2019

Translated from the original German by Ralf Thoene, MD.

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Cite this as:

Dreßing H, Dölling D, Hermann D, Kruse A, Schmitt E, Bannenberg B, Hoell A, Voss E, Salize HJ: Sexual abuse at the hands of Catholic clergy—a retrospective cohort study of its extent and health consequences for affected minors (the MHG Study). *Dtsch Arztebl Int* 2019; 116: 389–96. DOI: 10.3238/arztebl.2019.0389

► Supplementary material

eMethods:

www.aerzteblatt-international.de/19m0389

Supplementary material to:

Sexual Abuse at the Hands of Catholic clergy

A Retrospective Cohort Study of Its Extent and Health Consequences for Affected Minors (the MHG Study)

by Harald Dreßing, Dieter Dölling, Dieter Hermann, Andreas Kruse, Eric Schmitt, Britta Bannenberg, Andreas Hoell, Elke Voss, and Hans Joachim Salize

Dtsch Arztebl Int 2019; 116: 389–96. DOI: 10.3238/arztebl.2019.0389

eMETHODS

Supplementary methodology information

This study reports epidemiological data obtained by analyzing personnel records of clergy. The study population comprised all active or retired Catholic priests (“diocesan priests”), full-time deacons and priests within religious orders who are governed by “Gestellungsverträge” (a contract conferring a form of stipend), i.e. priests of Catholic orders who, temporarily or permanently, exercised priest functions in the area of responsibility of the German Bishops’ Conference (Deutsche Bischofskonferenz, DBK), as well as their minor victims of sexual abuse. The analysis period extended from 1946 to 2014. The examination of the women’s orders was not part of the study contract. Therefore, the question whether or not girls, for example in a convent boarding school, have been at risk for sexual abuse by nuns, and the level of such a risk, if any, cannot be answered.

For the analysis, all relevant personnel records of the dioceses were screened for pertinent evidence of abuse, or allegations of abuse, for the defined study population. For reasons of data protection, the screening of the personnel records was not performed by scientific staff of the research consortium, but by staff specially hired, instructed and trained for this task by the dioceses. At least one member of the respective teams of the dioceses had to be qualified to act as a judge.

For extracting the pertinent information from the personnel records, the consortium developed data collection sheets which were pre-tested under real-world conditions in collaboration with 3 dioceses. With this approach, we wanted to increase content validity and promote the use of a standardized procedure. Furthermore, the research consortium prepared comprehensive instructions for the methodological procedure and provided a dedicated hotline for all diocesan review teams. All evidence of sexual abuse of minors and relevant further information were extracted from the personnel records in the corresponding data collection sheets for accused persons and affected persons, respectively. The study was designed as a retrospective epidemiological study and not as a criminal investigation. Therefore, verification or falsification of individual offences, cases or involved persons by the research consortium was explicitly excluded. For this

reason, the term “accused person” is used for all persons where a plausible allegation of sexual abuse of minors was identified in the corresponding files or in other documents of the DBK’s dioceses. The term “affected person” was used for all persons who were minors, as defined by applicable law, and in whom it was considered plausible that they suffered sexual abuse or who reported sexual abuse. The definition of sexual abuse was fundamentally based on the facts of the Crimes Against Sexual Self-determination regulated in Chapter 13 of the German Penal Code (StGB); however, it also took into account the broader definition of the term ‘sexual abuse’ detailed in the guideline for dealing with sexual abuse of minor and adult dependents by clergy, religious and others in the service of the Church in the area of responsibility of the German Bishop’s Conference. The latter represent acts below the threshold of criminal acts which represent a violation of boundaries or a sexual assault.

In 1028 affected persons (28.0%), information about sexual abuse-related health problems was identified. For the majority of affected persons (72.0%), this type of information was missing. As health problems, all relevant problems had to be reported that were documented in the original files as related to the abusive acts. It was not distinguished between subjective information provided by the affected person and objective evaluation by a third person. Moreover, a professional confirmation by a physician, therapist or other experts was not compulsory.

The duration of occurrence (chronic, short-term, or one-time) or the interval between the abusive act and the onset of health problems were irrelevant for the information reported in our article. Multiple items were allowed.

Continuous variables were described as mean value with standard deviation (SD) and 95% confidence interval [95% CI], whereas dichotomous or categorical variables were described as number (N) and percent value (%). For statistical testing to assess group differences, either the χ^2 test, the two-sided t-test, or the bootstrapping method ($n = 1000$) was used. The explorative data analysis was performed using SPSS Version 24 for Windows (SPSS Inc., Chicago, IL). The significance level was set at $p \leq 0.05$.