EXPECTATIONS OF TREATMENT FOR CHILD MOLESTERS

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Introduction

In the last decade child molestation has emerged as a major societal concern. In the context of the Church this destructive behavior evokes intense feelings and discussion from an array of perspectives. These include law enforcement, child protective services, victim's rights, civil liability, canonical process, pastoral care, candidate assessment, morale of priests and the faithful and on an on. If this article on the "reasonable expectations of treatment" is to have any coherence and substance, an important question must be faced squarely. In what way is pedophilia (or any form of child molestation) an illness?

Even in physical medicine the definition and classification of diseases is more complex than what might be implied by a simple dictionary definition of the word. Diseases might be classified by the organ system affected such as cardio-vascular, endocrine, pulmonary, neurologic and so forth. If the emphasis is on a known etiologic agent disease definition takes a different slant and may be called viral, bacterial, toxic, hereditary, etc. Consideration of the disease process itself leads to yet another naming scheme: infectious, neoplastic, developmental, degenerative, auto-immune to name a few.

Psychiatric diagnosis must deal with all of these complexities plus a few more. The human brain might well be one of the most complex structures on earth. Although its anatomy, cell types and neuronal pathways are well known, scientific understanding of its physiology and function is primitive compared to what is understood about many other organs. Moreover, theories of mind and personality development abound and what is defined as abnormal is contingent on what is viewed as normative. Lastly, what gets labelled as psychiatric illness, particularly when that illness has behavioral manifestations, is conditioned by cultural practices and values.

That psychiatric diagnoses continue to evolve is evidenced by the successive editions of the Diagnostic and Statistical Manual (DSM) IV. This publication of the American Psychiatric Association contains official diagnostic nomenclature used by mental health professionals. New editions have attempted to be more precise and specific in presenting criteria sufficient to make a given diagnosis.

Advancement in psychiatric understanding of sexual behavior disorders is reflected by changes in the DSM. The second edition coded pedophilia as a manifestation of an anti-social personality. In the DSM IV, as in DSM III-R, pedophilia is accorded a specific diagnosis as a sub-type of the broader category of Paraphilias. The latter is defined as having the following essential features "... Recurrent, intensive sexually arousing fantasies, sexual urges or behaviors generally involving 1) non-human objects; 2) the suffering or humiliation of oneself or one's partner, or 3) children or other non-consenting person, that occur over a period of at least six months." Additional features addressing subjective

symptoms and types of impairment are described. In diagnosing pedophilia, the DSM IV specifies that the child victim is pre-pubescent which is generally understood as age 13 or less.

Facilities with a significant experience in treating priest and religious child molesters have come to recognize that these individuals much more commonly abuse adolescents rather than pre-pubescent children. A ratio of 4 to 1 is commonly cited. Thus, in the majority of cases the criteria for pedophilia are not met. Most clinicians, however, recognizing that it is not normative for adults to experience "...Recurrent, intense sexual arousing fantasies, sexual urges or behaviors" towards adolescents, code these conditions as paraphilias.

The normative outcome of the genetic, pre-natal, psychological and cultural/experiential processes that is called psycho-sexual development is sexual interest in and behavior with opposite sex partners of roughly the same age. What appeals to us is a matter of discovery not choice. How we act in response to that appeal obviously moves us into the realm of personal responsibility and morality. It would appear that sexual object preference, i.e., sexual orientation, once established, is not amenable to change. Some would argue this point and can cite a number of individual cases where a change of orientation has apparently occurred. This possibility does not have acceptance among most mental health clinicians.

For a most unfortunate few their sexual object preference turns out to be children. For pedophile/ephebophile individuals the sexual allure of children varies widely in its intensity, exclusivity, gender orientation and behavioral expression. Regardless of this variability it is clear that sexual attraction to children is a formidable human burden from which most of us are spared.

In no way is a medical/psychiatric understanding of pedophilia a substitute for a moral perspective. It is not a contrived variant of "the insanity defense" for very destructive, felonious behavior. On the other hand, viewing pedophilia and ephebophilia as definable, diagnosable psychiatric disorders had led to the development and application of a number of therapeutic strategies. These in turn have yielded more consistent behavioral change than criminal prosecution alone. Sincere repentance would imply the use of available, licit means to prevent the repetition of immoral acts.

If sexual object preference is unchangeable it is unreasonable to expect treatment to effect a cure. Acceptance of this clinical reality has led to the development of treatment approaches that focus on management. This is analogous to what is done for any number of uncurable maladies such as diabetes, epilepsy, hypertension and alcoholism. The concepts of sexual addiction, relapse prevention, and empathy training as well as pharmacologic approaches have all contributed to a therapeutic optimism that a child molester can be helped. Cure is not possible, but recovery is.

Evaluation

Rational and effective treatment pre-supposes a careful and comprehensive assessment. This evaluation must be sufficiently comprehensive to:

a. Accurately diagnose primary and concomitant illnesses. An evaluation is typically precipitated by official reception of an allegation of child sexual abuse. As a clinical process, an evaluation cannot be relied upon to determine if a particular act did or did not occur. Within this limitation, it should be able to trace the history of the individual's psycho-sexual development. A clinical history taken by experienced evaluators, appropriate psychological testing and the careful review of collateral information, permit a fairly reliable diagnostic conclusion in the majority of cases.
The assessment process must be broad enough to detect concomitant illnesses such as chemical dependency, mood disorders or personality diagnoses. The comorbidity of such disorders with paraphilias is significant.

b. Identify risk factors and pre-disposing conditions. Although the cause of pedophilia cannot and may never be completely understood, a significant list of risk factors has been accumulating. These include chromosomal abnormalities, congenital defects, developmental trauma, early and/or extensive sexual activity, unusual repression of sexual awareness, hormonal abnormalities, neuro-psychological deficits and a history of being sexually abused. Some of these risk-factors can be directly addressed in treatment, others can be mitigated through the learning of compensatory strategies.

d. Acknowledge, at least in broad outline, extrinsic factors that may impinge on the recovery process (number of victims and extent of harm, court matters - criminal and civil, reporting obligations, media publicity, family and personal resources.)
The referring official can reasonably expect a substantive report of the results of the evaluation. These results should be presented in lay language and in sufficient detail to support diagnostic conclusions and treatment recommendations.

Goals of Treatment

The effectiveness of the treatment of child molestation is measured by the achievement of goals. The essential, non-negotiable goal is the reliable, consistent arrest of harmful behavior. Although essential, this goal is a negative one and purely from an emotional perspective represents a loss to the pedophile. Recovery is supported and enhanced by other therapeutic goals involving the physical, psychological and spiritual healing of the abusing individual.

Pedophiles often have distorted body images. Their dislike of their physical selves may lead to bodily neglect or physical problems related to unhealthy life styles. Obesity, poor-conditioning or poor cooperation with medical management of physical illness are common.

Psychological damage may include low self-esteem, a deep sense of victimhood, immaturity, particularly as it affects peer relationships, authority conflicts, and little empathic understanding of others.

The perceptual distortions and cognitive rigidities and peculiarities that are associated with the denial so characteristic of child molesters limit spiritual development too. Pietism and spiritualizing are sometimes used to shield the pedophile from the serious behavioral changes they must make. The outward observance of a spiritual discipline may obscure the lack of a true relationship with a transforming God. An enduring recovery includes spiritual conversion.

The Process of Treatment

The structure and form of treatment for pedophilia/ephebophilia must be intense and comprehensive. Intense, both, because denial and minimization are such common features of these illnesses and because the consequences of treatment failure are so dire. It must be comprehensive to deal with all the identified risk factors and to insure as much personal growth as possible for the individual so that sexual sobriety is experienced as not only attainable but also highly rewarding.

Treatment must feature confrontation and support. The child molester must be pressured to look directly at what they have spent years avoiding. Yet they must be supported so that this self-inspection is not self-destroying. When denial crumbles and rationalizations fade and the pedophile/ephebophile faces the destructive lustfulness inherent in their abuse they are shamed and saddened. They are at risk for a major depression and suicide is a realistic concern.

The necessary combination of confrontation and support is best accomplished in a group setting. It is difficult to "con a con" so peer confrontation is invaluable for realistic self-appraisal. Moreover, seeing the progress of peers in achieving personal honesty and successful behavioral control is a major incentive for participation in treatment.

The concept of sexual addiction only received clinical attention in the early 1980s. It has not become an accepted official diagnosis. Nonetheless, it has yielded much of value to those struggling with sexual behavior problems. It has been especially helpful in providing a comprehensive structure and method of operation for support groups.

Aside from the "official diagnosis" issue, one thing is abundantly clear. Sexual behavior disorders behave like addictions in the following manner. They thrive in an atmosphere of isolation and secrecy. They wither with disclosure and healthy relationships. Thus the treatment process must promote openness. As an abstract value, the affirmation of openness does little for recovery. What is needed is repetitive practice of self-disclosure. The treating community must facilitate the experience of healing which truth-telling occasions. The subjective signs of this healing are feelings of confidence, peacefulness and an increase of self-esteem. The outward manifestations include acknowledgement of harm done and a more collaborative relationship with superiors.

Denial is nurtured by naivete and ignorance. Good treatment includes a strong educational component. Knowledge is needed about normal human sexuality, addictive processes, family dynamics, stress management and a variety of physical and mental health issues.

The educational component of effective treatment should include detailed instruction about the harmful effects of sexual molestation. Individuals with sexual behavior problems talk much more comfortably about the motivations for their behavior than its effects. Treatment must bring about a change in perspective so that the consequences of one's behavior is accepted as a crucial issue.

The quest for insight and understanding is very seductive and in a heady, highly educated treatment population it can be a therapeutic dead end. Paraphilias are primarily behavior disorders and successful treatment presupposes behavioral change. Why one performs a destructive act may be interesting but what is needed is to stop doing it.

In a schematic way, treatment addresses thinking, feeling and actions: the cognitive, affective and behavioral realms of human experience. In a clerical population, verbal facility is often over-learned. In restoring some kind of balance and assisting the individual in identifying and dealing with feelings, non-verbal therapies are valuable. Expressive therapy using art materials, psychodrama, bio-energetics, movement therapy and massage are among the techniques employed. Individuals respond variably to these methods but the application of one or more of them is commonly crucial to therapeutic breakthroughs.

Successful treatment brings clarity to the abuser about the "process nature" of their behavioral troubles. In the mind of the child molester the destructive act is often bracketed in the flow of his cognitive and affective life. He usually has a poor grasp of the behaviors, attitudes and circumstances leading up to the abuse and even less awareness of the consequences. The grabbing of unknown youngsters for quick, brutal sexual gratification is very rare among clergy molesters. What is much more typical is a sequence of behaviors,

based on inadequately examined attitudes and feelings, that eventually lead to the betrayal of sexual abuse. The basic plot outline of this tragic drama, this modus operandi, might be called a "seduction ritual" or "grooming behavior". The treatment process should be able to define it as a "relapse scenario" and assist the individual to identify the specifics of their own pattern.

Child molesters undergoing treatment have enormous pastoral needs. Even though some have long maintained a certain devotional discipline, their spiritual development is typically arrested. Given the extent of denial in their lives, their detachment from significant areas of affectivity and their relational impoverishment, how can their spirituality be healthy? There is a deep spirituality embedded in the process of 12-step recovery. In paraphilias, psychological healing is often accompanied by a spiritual conversion as well. Opportunity can be given for a guided examination of how the development of one's behavioral difficulties interacted with spiritual development and distorted one's relationship with God.

Medications have a useful role in the treatment of paraphilias. They work best as a component of an overall program and should not be regarded as an alternative to a comprehensive approach. Depo-Provera has been used for many years as an adjunct in the treatment of child abusers. It consistently lowers blood levels of testosterone and may have other effects on the brain itself. An individual taking this drug usually notices a diminution in sexual interest and reactivity. Physiologic responses to sexual stimuli are reduced and patients report a sense of comfort and control which they sometimes describe as a kind of freedom.

With doses in the 200 to 300 milligram range, given by weekly injections, the profile of side effects is very low. It is most helpful when taken voluntarily as a clearly understood component of an overall management and recovery plan. Clinically it is very useful to observe how a patient processes a recommendation that he take Depo-Provera. It is a powerful drug with significant effects both physically and psychologically. Abrupt refusal to consider its use raises questions about the abuser's commitment to healing. Knee-jerk acceptance may betray a superficial compliance that is unlikely to produce long term behavioral change. Grappling with the decision and cultivating a knowledge of and desire for expected benefits is consistent with a serious commitment to recovery.

Severe diabetes, significant cardio-vascular disease, advanced age and poorly controlled hypertension are among the medical contraindictions for Depo-Provera use. It is also of limited value when the child molester has a low level of sexual drive and a history of few sexual acts spaced years apart. For such an individual there is little subjective sense of benefit. It is undoubtedly a useful drug overall, but its value for a given individual varies widely. Its prescription should be a careful clinical discernment and consent to use it should be thoroughly informed.

A variety of anti-depressants have value in treating paraphilias. Sometimes these are used specifically to ameliorate a co-existing mood disorder. Some of the drugs in this class moderate anxiety and some have been approved for treatment of obsessive-compulsive disorders. A sub-set of the child molester population features a great deal of obsessive, ruminative mental activity. In these individuals anti-depressants, particularly those in the serotonin influencing group, can be very helpful. Some individuals report significant improvement in behavioral control with drugs in this class. This effect is variable and not as specific and reliable as that produced by Depo-Provera.

The need for treatment to be both intensive and comprehensive makes a residential setting the most reliable format. Arguments can be made for and against a specialized treatment for priests and religious. When clerical patients are treated together the defensive use of ministerial role to disidentify with one's fellow patients becomes irrelevant. The sharing of faith assumptions can facilitate a certain relational base with the treatment team. On the other hand, a more varied treatment group can bring different challenges and perspectives to the therapeutic task. Pooling of experience and measurement of outcomes will be needed to answer more persuasively the question of how important specialized treatment is.

The scope of treatment sketched above gives some understanding of why competent residential treatment is so costly. Before committing to paying for such a venture, a religious superior has several reasonable expectations. The evaluation process should yield not only good diagnostic validity but some statement as to the pedophile/ephebophile capacity to benefit from the recommended treatment. Such feedback is best given in a face to face meeting among the assessing agency, the patient and his superior. In those situations where there is doubt about an individual's treatability, a trial period can be proposed with an agreed upon time frame for re-appraisal.

It is important that a religious superior be a working partner in the treatment process. They are entitled to regular reports describing progress in treatment. By providing new information about the patient to the treatment team, they can facilitate the therapy. Two way communication regarding administrative decisions affecting treatment are also desirable. Confidentiality is an important value in psychiatric care. The complexity of sexual behavior problems and their impact on others besides the perpetrator and victim requires suitable modifications about how the value of confidentiality should be served. An agreement on this point should be based on open discussion and clear agreement among patient, treating agency and responsible superior.

Continuing Care

The chronic nature of sexual behavior disorders requires that an organized continuing care program be a part of their management. Recovery that may appear solid in a residential treatment setting must prove its durability in a real world environment. If residential treatment has been successful then the recovering person should be an active participant in designing their continuing care plan. They should have a working knowledge of their risk factors, budding signs and support requirements.

In the wisdom of 12-step recovery there is a saying "We get sick alone, we recover together." A hallmark of sexual sobriety is a new kind of relatedness. It is expressed not as a clinging dependency but as a deeply felt need for involvement with others and a willingness to express that need in appropriate ways. It includes a reciprocal awareness of the rights and needs of others.

This awareness of the need for others finds concrete expression when a support group includes members of the major dimensions of the recovering persons day to day life. For a recovering priest this might include a personnel director or other hierarchical representative. A co-worker, a long term friend, a family member, a 12-step fellowship sponsor, a pastor or other person with whom one lives would all be good choices for members of a support group. Once they are selected and they accept membership they should be apprised in some detail of the recovering person's problem, his recovery plans and what he is asking of them to support that plan. Free communication among support groups members should be negotiated as well as a clear understanding of what they should do if concerns arise.

An effective support group takes effort. Guidance in its assembly and function can usually be provided by a treating agency. It has a vital role both in promoting personal growth in the individual and in providing early warning signals if movement towards relapse starts to occur. A major factor in good support group function is the commitment of the individual to his own recovery. On the other hand, the practical love expressed by support group membership enhances resolve when the recovering person encounters times of struggle.

Accountability is a key concept in recovery. One expression of willingness to be accountable is coming to periodic continuing care workshops. Residential centers typically require some sort of scheduled return to the place of treatment to formally review the experience of recovery in one's home setting. This practice helps to reinforce the fact that recovery is a long term process. It is not a task, like a course of study, that can be finished and left behind.

As in evaluation and intensive treatment the ecclesial superior should be a valued collaborator in continuing care. A vicar for clergy, personnel director, bishop or provincial can provide valuable observations to the treating agency. Conversely, he should be provided ongoing assessment of the quality of the individual's recovery from a clinical perspective.

He should be advised of any modifications of the continuing care plan or of any other changes that impact his role as responsible authority.

Results of Treatment

In achieving the essential goal of treatment, the cessation of molestation, church affiliated centers report very good results. Overall, the relapse rates are much lower than those reported in much of the professional literature. Despite struggle, inconsistencies and media frenzies over some dramatically horrible cases, the fact is, that countless instances of child abuse have been prevented by the Church's activism around treatment of child abusers. All would wish that such activism had begun earlier but it is only in recent years that diagnostic precision and effective treatment approaches have been available.

The impressive success in achieving the essential goal of treatment has not been met in meeting the secondary yet important goals of physical, psychological and spiritual healing. Some child molesters are seriously damaged individuals with limited internal resources to bring to the task of treatment. Such individuals, with great support, may be able to maintain a fragile recovery. Little remains, however, for them to spend outside themselves either in a restricted ministry or some type of meaningful employment. At the other end of a very broad spectrum is a priest whose recovery is so solid that much is left over after basic recovery commitments are met. For some such people their recovery itself may represent an enhancement of the resources they bring to the service of others including ministerial service.

All of these factors bear on any discussion of the possibility of a child abuser returning to ministry. In such a discussion it is important for all parties to stay in role. Ministry assignment is unequivocally the responsibility of the ecclesial authority, be he bishop or provincial. The role of the clinician is to offer opinion to assist the Church authority in making such a weighty decision. The clinician should be able to give some broad assessment of the quality of the individual's recovery - weak, good, excellent and so forth. Along with this assessment is an implicit statement of risk of relapse. Behavioral prediction in the mental health professions has not been impressive. Despite this, a reasonable prognosis can be given, especially if it is conditioned on the meeting of the stipulations of the continuing care plan. To the degree this plan is described in behavioral terms its adherence can be observed by others. To those who say the recovery person can't be watched twenty-four hours a day the reminder is necessary that priest child molesters commonly have a grooming ritual that extends over long periods of time. A properly prepared continuing care plan allows the perception of early warning signals. The workability of this system has been verified many times in instances where movement towards re-offending was recognized and interrupted in a timely way.

Another area where the mental health professional can speak appropriately about return to ministry is assignment fit. By "fit" is meant how the circumstances of a particular assignment

might support a given individual's recovery or how its challenges might pose special threats to a less than robust recovery. To do this the clinician has to have a working understanding of priestly function. This is obviously a situation best served by good three way communication between superior, treating agency and recovering individual. Incidentally, it is supportive of the position that clergy child molesters are best treated in a specialized, church affiliated institution.

The assessment of risk involves the weighing of a number of factors. Some of these pre-date treatment, others emerge in the treatment process. The best predictor of human behavior is past behavior, so good recovery maintained over years is a very favorable prognostic sign. But even here it is not a certainty. The following table describes some basis on which a prognosis can be formed.

Good Prognostic factors	Poor Prognosis
Older victims	Younger victims
Little overt aggression	More overt aggression
Few victims	More victims
Better neuropsychological function	Poorer neuropsychological function
Conflicted about behavior	Little conflict over what was done
Remorse/victim empathy	No remorse/empathy
Improved peer relationships	No improvement in relationships with peers
Active in constructing support for on-going recovery	Passive in constructing post-treatment support

Although treatment provides excellent results in meeting essential goals and variable, but usually good, results in achieving subsidiary goals, success can't be guaranteed. This is cited by some, including victim advocacy groups, as a reason for never allowing a child molester to officially minister. There is a certain stark logic to this position but it dismisses other values such as compassion, forgiveness and redemption.

There is a contagious quality to solid recovery that should not be overlooked. Solid recovery typically augments ministerial effectiveness. There is also a need to honor certain realities. If no risk could be tolerated it isn't just in cases of pedophilia where ministerial assignment would be impossible. What seems more reasonable is to make such decisions with extreme care and prudence using appropriate disclosure to enhance the safety of all.