# Will Priests Sexually Abuse After Treatment?

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Every bishop who has sent one of his priests to a hospital or clinic for psychiatric treatment related to sexual abuse faces a moment of crucial decision making when the patient is discharged. The simple but difficult question he must ask himself is "What do I do with him now?" The professionals who provided the institutional care can assist the bishop by reassuring him that the priest, having complied well with the treatment program and demonstrated that he has benefited from the services rendered, is now ready to return to the diocese. They can advise the bishop about what he can do to contribute to the success of their patient's "aftercare" program, and they can recommend that the bishop not reassign the priest to ministry that will place him in contact with children or adolescents if his diagnosis was either pedophilia or ephebophilia.

What the bishop will never hear from the treatment team is that the priest in their care has been "cured". Most often, what will be reported to him is that the patient is "in recovery", and that he will stay so (just as a successfully treated alcoholic is considered to remain) for the rest of his life. One of the implications of this message is that there will always be some chance that the sexual offender will revert to his former misbehavior, since the possibility of recidivism can never be completely ruled out. This absence of a guarantee inevitably leaves the bishop in a state of uncertainty as he contemplates the risk he faces in considering what assignment, if any, to give the priest whose therapy-supported self-confidence is likely to exceed the bishop's

degree of certitude that reassignment is a good idea at the present time.

The question bishops are certain to ask at such a moment is "What are the chances of this priest repeating his abusive behavior?" A statistical probability is what they are seeking; only this can logically determine their degree of confidence in the choice they make. But statistics related to the recidivism rate of priests treated professionally as sexual abusers are not readily available. This fact was discovered with some surprise and disappointment when the bishops' Ad Hoc Committee on Sexual Abuse began its fact-finding work this past year. Published scientific literature deals with recidivism among the general population of sexual offenders, but not specifically among priests. Moreover, the reports available usually fail to distinguish between the relapse rate among pedophiles and that among ephebophiles, a deficiency that is regrettable in view of the fact that the majority of priest-offenders are currently being diagnosed as ephebophiles.

Search for Useful Information

Aware of the fact that in some dioceses bishops who are reluctant to gamble on assigning post-treatment priests have provoked resentment among the unassigned as well as their colleagues and friends (who regard them as "warehoused"), the Ad Hoc Committee sought a way to provide decision-making bishops more help than they can get from published scientific literature. The Committee believed that this could be accomplished by turning to the institutions that offer treatment for priests, and asking for information about recidivism among their satisfactorily treated and discharged patients. A consultant to the Committee was assigned to obtain this

information from a representative sample of treatment centers. His plan was to contact by phone the director, researcher or clinician who could report whether follow-up studies have been done at that center to determine the recidivism rate among Catholic clergy. Eighteen hospitals, clinics and other treatment centers were selected, with the intention of arranging on-site visits for in-depth conversation about their clinical experience with priests, if such visits seemed warranted.

The phone conversations took place during February and March of the present year. Unfortunately, these yielded the generally disappointing information that very little record keeping and research is currently being done on priest-recidivists. Spokespersons for several of the centers contacted gave helpful replies, and a few sent by mail some statistical data that supported what they reported by phone. The harvest of available information, however, was so sparse that no on-site visits appeared warranted. But it should be noted that those who shared with the inquirer the limited data they possessed were uniformly generous with their time, observations, clinical expertise and ideas about the projects the Ad Hoc Committee is undertaking.

Ultimately, most respondents agreed that it would be useful for treatment centers along with bishops to know more than is currently understood about recidivism among priests treated for sexual problems. The research that would provide this data, many said, would be time-consuming and rather expensive. Moreover, they suggested, it would be best accomplished through collaboration among the largest and most experienced treatment centers, which could pool their data bases and then make widely available a body of potentially very useful information about relapse rates among priests diagnosed as either pedophiles or ephebophiles.

Some Available Data

Several of the institutions contacted have already begun to research the issues inquired about by phone, and several others are hoping to share their own clinical data with these centers. Published already (in 1991) by psychiatrist-researcher Fred Berlin, M.D., and discussed with him by phone recently, is a report presenting data about recidivism among pedophiles treated at the Johns Hopkins University Clinic. Among a group of 173 patients who had molested minors, undergone three years of treatment, and were then discharged from the Clinic as "treatment compliant", and after an average period of 3.19 years post-discharge, only 1.2 percent had become recidivists, that is, had become involved in criminal sexual behavior again. In a related article (also published in 1991) on "Media Distortion of the Public's Perception of Recidivism and Psychiatric Rehabilitation", Berlin reported that "criminal sexual recidivism for treatment-compliant pedophiles has been less than 3 percent."

For the sake of comparison, it should be noted that another study, reported by Marshall and Barber (1990), found recidivism to occur at a rate of 17.9 percent and 13.3 percent at four year follow-up for treated heterosexual and homosexual pedophiles respectively. These researchers also used "official plus unofficial sources" to establish the relapse rate among untreated sexual abusers of minors at a significantly higher 42.9 percent.

None of the studies just mentioned made any distinction between offenders who were pedophiles (their sexual arousal is to prepubescent children) and those who

were ephebophiles (their sexual arousal is to postpubescent teenagers). All the patients in each study were labeled as "pedophiles" and given similar treatment. Members of the clergy who might have been among those patients were not studied or reported as a separate sub-group.

A small number of treatment centers contacted by phone reported keeping track of priests treated and recidivism rates among them when the condition for which they were institutionalized was either pedophilia or ephebophilia. One of these, a hospital, quoted a recidivism rate of only 1 percent after discharge that had occurred one to four years before the study. Another hospital reported success in its treatment of priests by keeping the recidivism rate down to less than 3 percent, measuring back as far as eight years from the time of collecting its data. (They had treated about the same number of pedophiles as ephebophiles during the years studied). Other centers said they had been treating at least four times as many ephebophiles as pedophiles in recent years.

## Additional Information Obtained

Among the interesting pieces of information collected by phone from the treatment centers contacted were the following

- clinicians believe that both self-reports by patients and clinical opinions of therapists will underestimate the incidence rate of recidivism
- some clinicians believe there is no great risk in assigning to ministry most treated priests who are compliant with their treatment and aftercare programs, as long as they are not assigned to work near teenagers or children

- priests who are "warehoused" after discharge from a treatment center are likely to experience isolation, depression and anger which can precipitate regression into sexual misbehavior
- some priests who have been treated for abuse of minors are active sexually after discharge, but only with adults
- several clinicians say that in their experience the vast majority of recidivists are pedophiles, not ephebophiles
- in some centers where priests are treated, the diagnosis (sexual abuser) has been disguised; as a result, accurate statistics are impossible to obtain there
- many of the centers contacted by phone have treated too few priest-molesters to develop significant statistics
- in some centers, the sexual abusers of minors are not separated out statistically from other types of sexual offenders, such as exhibitionists
- no center has at the present time adequate data to determine which type of treatment is most effective with which type of sexual abuser
- a number of the centers contacted by phone do not treat priests who have sexually abused minors (they refer them to other centers)
- most of the centers contacted have simply not collected data on recidivism, research not being an active element within their institutional program
- a very high rate of treatment success is found where the priest is an ephebophile, has molested only once or twice, and acknowledges his sexual misbehavior
- the most successful centers are those with comprehensive programs and the best trained and experienced staffs in treating sexual offenders
- some of the centers contacted have not been treating priests long enough to

- many centers keep track of their priest-patients and others patients only while the patients are in treatment there; after discharge, they refer their patients back to the care of the therapists who treated them before admission, and there is no further contact with them
- it is a clinical impression, not convincingly established by research, that the longer the period post-discharge the more likely is recidivism to occur
- several clinicians pointed out that the relapse rate would be expected to be different for discharged priests who live in a highly structured and supervised setting (such as a monastery) as compared with that of priests who live alone, in an apartment in a large city, and with no assigned or regular occupation
- the several studies reported by phone were not the type in which matched control groups (untreated) are used for comparison; neither were groups treated in different ways (modalities) compared for recidivism in any one treatment center
- most of the spokespersons for the centers agreed that follow-up studies which have lasted only a few years may be of very limited value

Possible Steps For Bishops

(1) Bishops could be informed that a number of treatment centers have a remarkably low rate of recidivism, especially among ephebophiles. This might result in increased hopefulness about the prospect of giving ministerial assignments to priests who have completed treatment in these centers.

(2) Bishops could encourage and support on-going collaboration in doing research

and sharing data bases among centers where priests are treated for sexual problems.

(3) Bishops could promote and attend meetings in which clinicians and researchers from the leading centers where priests are treated would design research projects that would identify (a) which priests are the best candidates for successful treatment, (b) which treatment modalities are likely to be most successful with which patients, and (c) which aftercare programs are most likely to prevent recidivism.

(4) Encouragement and support could be given by bishops to the establishment and maintenance of an adequate number of long-term residential centers where post-treatment priests who cannot yet be assigned within the diocese can be given a home, spiritual care, psychological support, educational opportunities, fraternal support, etc., in order to prevent frustration, depression and recidivism. A healthy, balanced style of life would be cultivated, and results could be measured in terms of relapse rate over a long period of time.

(5) Bishops could help prevent anger and resentment on the part of unassigned priests, their colleagues, and friends by making it clear that in seeking help in their decision making about post-treatment reassignments, they are not just listening to lawyers and insurance companies. Bishops could make it known that they are consulting the professionals who have treated their priests and are giving consideration to each case uniquely, rather than simply applying general policies. Furthermore, bishops could make public their recognition of the fact that statistics are not nearly as important to consider as the prognosis professionally determined in light

of the individual priest's frequency and manner of sexually abusing, response to treatment, risk factors, strength of motivation, etc.

(6) Bishops could help to inform the laity that many professionals in the field of mental health care are agreed that the majority of priests who have abused minors sexually are able to be treated successfully, and that most are able to be assigned to some form of ministry again -- as long as there is close supervision, together with provisions that will keep them apart from children and teenagers.

(7) Bishops could be informed that many clinicians believe there is a significant difference between pedophiles and ephebophiles, with implications for success in treatment, rate of recidivism, and feasibility of post-treatment assignment. Current clinical experience would seem to indicate that arrested social and psychosexual development that is manifested by most ephebophiles is far more likely to be treated effectively than the severe psychopathology motivating predatory pedophiles.

(8) If bishops or others in their care ask the question, "Does treatment help our priests?" or "Is it worth the cost?" , it may help to remember that it has been reported in the Harvard Mental Health Letter (March 1994): "The recidivism rate for untreated pedophiles is about 50 percent in homosexuals and 35 percent to 40 percent in heterosexuals". By contrast, as mentioned earlier, several centers where priests are treated for sexual misbehavior, including pedophilia, report that they have a lower than 3 percent recidivism rate after treating both homosexual and heterosexual priests.

(9) Bishops could encourage not just treatment centers but government research agencies, such as the National Institute of Mental Health, to use all possible resources to gain a more complete understanding of child sex abuse, its treatment and prevention, and to teach professionals (including priests and seminarians) to recognize and respect sexual boundaries, for their own well-being as well as that of those whom they serve.

(10) Bishops could be told that many of the professionals contacted by phone in the preparation of this paper expressed their appreciation and gratitude for what the Ad Hoc Committee on Sexual Abuse and the N.C.C.B. are doing in order to help solve the problem of sexual abuse, not just as it relates to priests, but to the Church and the American public at large.