Towards Healing:

An Australian Approach to the Problem of Professional Boundary Violations by clergy and religious that encompasses both victim and offender.

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Paper presented at 4th International Conference on Sexual Misconduct by Psychotherapists, Other Health Care Professionals, and Clergy, at Boston College, Boston. MA, on October 4th, 1998.

Encompass Australasia is the independent, professional body established by the Leaders of Religious Institutes and the Bishops of Australia in an attempt to ensure that there are "no more victims." Australian Church Leaders are convinced that treatment of the offender is a necessary preventative strategy. Effective treatment enables an individual to take responsibility for problematic behaviours and for their management and thus is a proactive strategy that serves to limit the risk of continued harm to established or new victims of known offenders.

ROLE OF ENCOMPASS AUSTRALASIA

The role of Encompass Australasia is threefold:

- To provide comprehensive assessment, treatment and a continuum of care for individuals with psychosexual disorders.

- To promote prevention through education. Education initiatives inform both the selection and training of candidates for Religious Life and the priesthood, and promotes the development of a healthy sexuality and lifestyle amongst clergy and religious. As a readiness develops, similar initiatives will be offered to other professional groups.

- To initiate empirical research that will inform effective clinical praxis with individuals with psychosexual disorders and will further advance the prevention of the abuse of power by professionals.

CLIENTELE

Encompass Australasia provides psychological services to

- clergy and religious men and women of diverse denominations
- professionals who engage in fiduciary relationships with clients
- individuals from the broader community

Referrals:

- Clients who are referred because their problematic behaviours have come to the attention of a competent authority i.e. Bishop, Superior, Medical Board etc.
- Clients who have been adjudicated and seek treatment for a psychosexual problem
- Self-referrals

Encompass Australasia does not conduct forensic evaluations. Assessment is not a form of investigation and is not meant to determine whether or not an individual is guilty of an alleged offense. An assessment will however, reliably gauge the risk that an individual poses to him/herself and/or to others. An assessment is not conducted without the cooperation of the client.

PSYCHOSEXUAL DISORDERS:

Individuals seek treatment for a broad spectrum of psychosexual and associated disorders which include professional boundary violations, child sexual abuse, sexual orientation issues, other psychosexual disorders, and other problematic behaviours that may have an underlying sexual etiology.

- **Professional boundary violations (sexual);** sexual exploitation (physical contact or exposure that was intended to sexually arouse either one or both of the personal involved, or verbal requests for sexual contact) between an adult person who is in a position of authority over another adult;

- **Child sexual abuse:**
  Pedophilia: having acted on or being markedly distressed by recurrent, intense sexual urges and sexually arousing fantasies of at least six months duration, involving sexual activity with a child generally aged 13 or younger.
  Ephebophilia: having acted on or being markedly distressed by recurrent, intense sexual urges and sexually arousing fantasies of at least six months duration, involving sexual activity with a pubescent or post-pubescent minor.

- **Sexual orientation issues:** Individuals struggling with guilt, shame and remorse over their sexual orientation and how their orientation has been explored during adolescence and adulthood.

- **Other psychosexual disorders:**
  Compulsive sexuality: Distress about a pattern of repeated sexual conquests or other forms of non-paraphilic sexual behaviours, involving a succession of people who exist only as things to be used.
  Gender Identity Disorders: Distress and/or confusion related to gender identity issues.
  Other paraphilias: Paraphilias are sexual disorders characterized by specialized sexual fantasies and intense sexual urges and behaviours that are usually repetitive in nature, "generally involving non-human objects, the suffering or humiliation of oneself or one's partner, or children or other non-consenting persons" (DSM-IV, p. 523). The most common presenting paraphilias include voyeurism, exhibitionism and sado-masochism.

- **Professional boundary violations (physical abuse):** physical abuse of another adult or child by an adult person who has authority over the other person, where the development of the abusive behaviour is linked to a psychosexual problem (e.g. childhood sexual abuse or a psychosexual conflict).

ASSESSMENT

Correct diagnosis of sexual disorders and effective recommendations for treatment require a multidimensional approach to assessment.

Conte (1986, p. 155) noted that:

> Human sexuality is compressed of an amalgam of biopsychosocial behaviours, and the more multi- dimensional the assessment, the greater the likelihood for correct diagnosis and recommendation for treatment.

Encompass Australasia offers a five-day comprehensive assessment protocol that takes into account the form, duration, chronicity, intensity, frequency and compulsivity of the problematic sexual behaviours. The protocol includes traditional psychometric testing and psychological evaluations, and ascertains the presence of comorbid non-sexual diagnoses such as biochemical disturbances, personality disorders, depression, psychosis, alcohol and substance dependence etc. This information provides a multi-faceted perspective for understanding each individual in the treatment program.

Assessment Venue:
The Encompass facilities are located within the grounds of Wesley Private Hospital and staff from both organizations form the multidisciplinary team. The assessments are generally inpatient assessments. The underlying presumption is that the intensity of the evaluation process together with the structured milieu will both raise anxiety levels and contain them in the service of penetrating denial and disarming other psychological defenses.

Typically, clients referred for a comprehensive assessment present with high levels of anxiety. Many have recently been confronted by allegations of sexual abuse and, in accordance with the Towards Healing Protocol, these clients may also have been removed from active ministry and from familiar social networks and support systems. Since Encompass attracts clients from all over Australia and from the Pacific Rim, effective management of client anxiety and procedures for ensuring their safety are paramount. For these reasons, most clients are admitted to Wesley Private Hospital for the five day assessment and nursing staff are acquainted with sufficient details related to the presenting issues to ensure effective management. The hospital environment provides a client with a safe and private setting.

Confidentiality:
Prior to the assessment, the client's rights to confidentiality are explained and the client is informed of any circumstances which may cause an exception to the agreed upon confidentiality. The client provides written consent for the referring agent to attend a verbal feedback session and/or to receive a written report. At the feedback session, the assessment data is explained to the client in non-technical language, and questions and comments from the client are welcomed. The written consent of the client is kept on file and is valid for one year unless the client revokes the consent in writing.

MULTIDISCIPLINARY ASSESSMENT PROTOCOL

The assessment protocol is comprised of the following core elements:

Collateral Data: prior to the assessment the referring agent is asked to forward any collateral data available. Suggested data includes police reports, behavioural observations, diocesan records, medical reports, incident reports etc.

Psychosocial History: The client is guided through an extensive semi-structured interview that reviews the client's history with particular focus on the development of the presenting problem. The client, before the assessment, fills out a Personal Profile Questionnaire that begins to orient the client to the detail required by the psychosocial historian.

Psychological Assessment: The client participates in a structured psychological interview and completes standard psychological tests including the MMPI-2, the MCMI-III and the MIPS.

Medical Assessment: The client undergoes a complete physical examination, a comprehensive blood chemistry screen, chest x-ray and ECG. Specialist consultations and procedures are conducted when indicated.

Psychiatric Assessment: The client participates in a psychiatric assessment with the admitting psychiatrist. The assessment determines any current or past symptomatology and charts psychiatric history.

Neuropsychological Assessment: The client's gross brain functioning, general level of intellectual functioning, memory and motor abilities are assessed. Where deficits are noted, an attempt is made to determine in what ways the neuropsychological issues are related to the presenting psychological problem. This assessment is crucial in assessing any organic impairment that may impact on the management and/or progression of problematic behaviours.

Spiritual Assessment: The client's spiritual health is assessed in order to determine how the client's spirituality (religious attitudes and/or beliefs) contribute to cognitions that support problematic behaviours.

Assessment Team Meeting: At the end of the assessment week, the members of the assessment team meet to discuss the client data, to determine clinical diagnoses and to make recommendations.

Feedback Session: Following the team meeting, the members of the assessment team meet with the client and the referring agent to share the findings and recommendations in an integrated style that involves the use of non-technical language. The aim of the feedback session is to convey data to a client in a manner that both enables and encourages the client to assume responsibility for on-going treatment and/or personal development.

Assessment Report: An assessment report that summarizes the data conveyed at the verbal feedback session is completed within two weeks of the assessment and is generally between 10 and 14 pages in length. The report summarizes each of the individual components of the assessment – medical, psychosocial/psychosexual, neuropsychological, psychiatric, psychological and spiritual, and contains diagnoses and recommendations. The report is sent to the client and, with written permission, to the referring agent.

Recommendations for treatment include:

- Day Hospital Program
- Partial Day Hospital Program
- Outpatient Treatment
- Referral to another agency when appropriate

ENCOMPASS THERAPY PROGRAM

Sex offenders and individuals with psychosexual problems are a heterogeneous group. This group cannot be equated with any single personality disorder or psychiatric disorder. While there may be overlapping disorders and a dual diagnosis, there is no single psychiatric classification for the sex offender and/or individuals with psychosexual problems. Consequently, an effective program for sex offenders and individuals with psychosexual problems will have core components that will be supplemented with individualized treatment plans.

OVERVIEW OF THE PROGRAM

The Encompass Day Hospital Program is designed as a 24 week continuous program. The model allows for participants in the program to be in various stages of treatment and recovery, encouraging a more fertile possibility for supportive and confrontative peer group interaction.

The program proceeds in three broad phases and incorporates the ethical standards and principles for the management of sexual abusers as endorsed by the American Association for the Treatment of Sexual Abusers (1997).

Phase 1: Intense identification of problematic sexual attitudes, beliefs, practices. Confrontation of defenses.

Phase 2: Working through unresolved trauma, victim empathy, irrational core beliefs, education.

Phase 3:- Relapse Prevention, transition, accountability and supervision.

CORE COMPONENTS OF THE THERAPY PROGRAM

- Psychoeducational Modules
- Therapeutic Modalities
- Medical Assessment / Supervision
- Living Environment

- Continuing Care Program

PSYCHOEDUCATIONAL MODULES

Introduction to Treatment
Healthy Sexuality
Disordered Sexuality
Cognitive Restructuring
Childhood Trauma
Victim Empathy
Alcohol & Substance Abuse Ed.
Family Dynamics
Anger Management
Life Skills
Emotional Differentiation
Relapse Prevention
Stress Management

THERAPEUTIC MODALITIES

Individual Therapy
Small Group Therapy
Large Group Therapy
Art Therapy
Psychodrama
Behaviour Log
Peer Evaluation
Patient Staff Conference
Spiritual Direction
Body Therapies

LIVING ENVIRONMENT

During treatment some clients are required to live in structured, supervised communities that promote accountability and open communication. A part of the assessment protocol involves a risk assessment of each client, and recommendations regarding accommodation are related to risk assessment as well other therapeutic considerations. For the client these communities can provide an opportunity to practise the type of lifestyle necessary for maintaining a healthy sexuality.

CONTINUING CARE COMPONENT:

The Continuing Care Program is designed to assist the client in transitioning from treatment to post-treatment and to help in maintaining recovery. Prior to discharge, a Continuing Care Contract is prepared and is discussed with the Major Superior/ Bishop or representative. In addition, the client usually prepares a list of behaviours that has been identified as a precursor to relapse. Clients arrange for outpatient therapy and spiritual direction and make contact with these professionals before the termination of treatment so as to ensure continuity of aftercare. Prior to termination a support group of individuals with whom the client will have regular contact is identified and arrangements are made for a re-entry workshop that will resource these individuals to support the on-going recovery of the client. The educative re-entry workshop typically takes place about 6-8 weeks after the client leaves treatment.

PART C: CLINICAL TRENDS

Part C of this paper reviews the assessment profiles of 51 clergy and religious with psychosexual and related disorders.

DEMOGRAPHICS

1. SUBJECTS

The subjects for this study were 51 male, Roman Catholic clergy evaluated by the staff at Encompass – Sydney. All were diagnosed according to the DSM-IV Fourth Edition, International version with ICD –10 Codes (1995).

The subjects were homogeneous on various demographic variables which include gender, marital status, socio-economic status, education, faith affiliation and occupation.

For purposes of this study the sample is presented in the four clinical groups by diagnosis of pedophilia, ephebophilia, boundary violations (opposite-sex), boundary violations (same-sex).

Two clients who presented for a comprehensive assessment were not given a sexual diagnosis that reflected problematic sexual behaviours. One client was profoundly distressed about his sexual orientation and suffered from an associated Major Depressive Disorder. The other presented for assessment following allegations that he had abused minors. However, although he was not given a paraphilic diagnosis his sexuality was found to be so repressed that he was given the diagnosis of Sexual Disorder NOS with unintegrated features. These two subjects were not members of the four groups.

2. AGE

The average age of the group was 53.4 years: 5 were in their thirties; 15 in their forties; 17 in their fifties; 9 in their sixties and 5 in their seventies. The age of the sample ranged from 30 to 78 years. The average age of the clients by diagnosis group revealed no significant difference. When the average age of the clients was compared by their affiliation, again, no difference was noted: Diocesan priests were aged 51.85, Religious order priests were aged 54.91; Religious brothers – 55.35 years; and the two seminarians – 48 years.

Table 1: AGE RANGE OF CLIENTS.

Age Range	Number of Clients
20 – 29	0
30 – 39	5
40 – 49	15
50 – 59	17

60 – 69	9
70 – 79	9
Average Age	**52.5**

While over two-thirds of the sample presented for assessment in their 40s and 50s, all except one client reported that problematic sexual behaviours began in their late 20s or early 30s. Typically, clients reported that their problematic sexual behaviours began immediately prior to their Diaconate Ordination or within two years of their ordination to the priesthood. For the group of religious brothers, a similar phenomenon was reported in that brothers tended to act out just prior to or within two years of leaving the formation house.

An explanation of this phenomenon is, no doubt, multidimensional. Until recently (and perhaps to date) poor or non-existing screening procedures allowed for the selection of candidates who were relatively immature psychosexually and psychologically. Furthermore, formation systems were typically characterized by rigid, formal, hierarchical relationships that inhibited healthy psychological development and precluded opportunities for healthy psychosexual development. In such systems, candidates were deprived to a large extent of the opportunity for responsible decision making. The system rewarded compliance and the inhibition of both aggression and libidinal energy; encouraged repression and dependence; and promoted a preoccupation with short-term goals, namely ordination or Final Profession. When a candidate transitioned from the rigid, formal structure to a more open system, and when there were no longer any external goals or structures, some clergy found that they lacked the internal resources for self-direction, self-monitoring and self-maintenance.

3. AFFILIATION

Of the 51 clients, 20 were diocesan priests, 22 were religious order priests, 17 were religious brothers and 2 were seminarians. Four clients were not given a sexual diagnosis as their primary diagnosis. Their sexual diagnosis was secondary to another diagnosis such as Alzeheimer's Disease, Asperger's Syndrome and Major Depressive Disorders.

Table 2: AFFILIATION OF CLIENTS

Affiliation	Number of Clients
Diocesan Clergy	20
Religious Clergy	12

Religious Brother	17
Seminarian	2

Table 2b: AFFILIATION BY DIAGNOSIS

Diagnosis	Number	Affiliation
Pedophile	6	Diocesan = 1 Rel. Clergy = 0 Rel. Brother = 5
Ephebophile	10	Diocesan = 4 Rel. Clergy = 0 Rel. Brother = 5 Seminarian = 1
Boundary Violations	32	Diocesan = 14 Rel. Clergy = 11 **OS=23** Rel. Brother= 6 **SS= 9** Seminarian = 1

Pedophile Group: Six clients formed the pedophile group. Five of these were brothers and one was a diocesan priest.
Ephebophile Group: Ten clients formed the ephebophile group; 4 diocesan priests, 5 brothers and 1 seminarian.
Boundary Violations: Of the 51 clients, 32 admitted sexual boundary violations with adults – 22 with women victims and 9 with same sex victims.

Of the child molesters, 62% (N=10 of 15) were religious brothers.
Brothers formed 1/3 of the overall sample (N=17 of 51).
Of the adult boundary violation group 75% (N=24 of 32) were priests. 1 was a seminarian.

4. NEUROPSYCHOLOGICAL ASSESSMENT TRENDS

All clients are routinely assessed using a battery of neuropsychological instruments. The tools used for each assessment include: Wechsler Adult Intelligence Scale – Third Edition; National Adult Reading Test; Wechsler Memory Scale – Revised; Rey Auditory Verbal Learning Test; Rey-Osterrieth Complex Figure Test; Trail Making Test; Benton Controlled Oral Word Association Test; Free Drawing Tests; and the Wisconsin Card Sorting Test.

For the whole sample Full Scale I.Q. was 110.8, Verbal Quotient 113.8 and Performance Quotient 104.8. When I.Q. was investigated by affiliation and by diagnosis group, no difference was found.

Given the small sample size (N=51), it is difficult to statistically analyze neuropsychological trends for this population. However one interesting trend seems to be emerging in the results so far. It is apparent that patients assessed have shown relatively lower scores on tests measuring executive functioning. This observation is particularly relevant to scores on the Wisconsin Card Sorting Test. It would seem that an emerging trend is that the clergy sample find it difficult to both maintain and shift mental set. This observation and its possible diagnostic and functional implications should provide the subject of future research in this area.

5. DIAGNOSTIC TRENDS: AXIS I DIAGNOSES

All but one of the clients received a sexual disorder diagnosis and 9 received two distinct sexual diagnoses. The number of Axis I diagnoses ranged from 1 through 7 with an average of 3 diagnoses per client.

Table 3: AXIS I DIAGNOSES

Diagnosis	Frequency	Comment
Sexual	50	19 Paraphilias 9 = 2 distinct diagnoses
Alcohol/Substance	13	4 Polysubstance
Depression	23	13 Major Depression 4 Bi-polar 6 Dysthymic Disorder
Anxiety	20	
Impulse	2	Eating Disorders
Cognitive	7	
Conversion	3	

Of the 19 subjects who received a Paraphilic diagnosis, 16 were ephebophiles and 6 were pedophiles. The next most common Paraphilic diagnoses were Voyeurism, Exhibitionism and Sado-Masochism. Of those with two sexual diagnosis, all were ephebophiles or pedophiles with an accompanying diagnosis of Voyeurism or Exhibitionism.

One quarter of the sample received an alcohol /substance diagnosis and four were polysubstance abusers. To date, none of the clergy have presented with dependence on or abuse of narcotics.

6. DIAGNOSTIC TRENDS: AXIS II DIAGNOSES

Of the sample, 40 clients received a Personality Disorder Diagnosis. 17 of the 40 received a specific Personality Diagnosis while 23 were given the mixed Personality Disorder; Not Otherwise Specified.

Table 4: PERSONALITY DISORDER DIAGNOSES

Personality Disorder	Frequency
Schizoid	6
Borderline	1
Histrionic	2
Dependent	4
Obsessive-Compulsive	4
Disorder NOS	23

Further investigation revealed that the prominent traits for this sample of clergy presenting with problematic sexual behaviours were dependent, narcissistic, schizoid and obsessive-compulsive and avoidant as indicated in the table below.

Table 5: AXIS II PERSONALITY TRAITS

Paranoid	1
Schizoid	17
Schizotypal	0
Antisocial	8
Borderline	3
Histrionic	7
Narcissistic	20
Avoidant	18
Dependent	20
Obsessive – Compulsive	19

7. DIAGNOSTIC TRENDS: AXIS III DIAGNOSES

While 4 clients received no Axis III diagnoses, the sample averaged 3.7 diagnoses each, with one client receiving 13 medical diagnoses.

Of the 51 clients, 47 received one or more Axis III diagnoses that were previously undiagnosed. Previously undiagnosed medical conditions included 5 sexually transmitted diseases, 4 cases of diabetes, 13 medical conditions secondary to alcohol abuse, 9 prostate (PSA) elevations. An alarming percentage of the clients 68.5% (35 of the 51) clients presented with high coronary risk factors.

Table 6: AXIS III DIAGNOSES

Sexually Transmitted Disease	5
Coronary Risk Factors	35
Malaria	6
Diabetes	4
Alcohol – secondary	13
Prostate	10

PSYCHOMETRIC TESTING

8. CLINICAL TRENDS: MMPI-2

MMPI-2 Validity, Clinical and selected Supplementary Scale Sample Mean Scores are presented in Table 7.

Table 7: MMPI-2 SAMPLE SCORES

Scale	Mean	>= 65
L	53.0	7
F	48.8	7
K	55.0	10
Hypochondriasis	56.2	12
Depression	**59.1**	**20**
Hysteria	**57.7**	**15**
Psychopathic Deviate	**58.2**	**17**
Masculinity/Femininity	56.1	7
Paranoia	**57.9**	**13**
Psychasthenia	**57.2**	**13**
Schizophrenia	**57.4**	**13**
Hypomania	49.7	2
Social Introversion	**53.5**	**13**
Addiction Potential	51.1	4
Overcontrolled Hostility	**57.0**	**10**

When group mean scores are investigated no clinical elevations are found. However, 39.2% of the sample were clinically elevated on the Depression scale. As noted earlier, 23 clients received a depression diagnosis. One-third of the sample were clinically elevated on the Psychopathic Deviate Scale. While the sample size is small, this proportion of elevated Pd scores in this Australian sample seems quite different to other clergy samples (Robinson et al, 1994., Stumpf et al, 1995., Taylor et al, 1996., and Mendola et al, 1998). This trend could be further investigated.

DISCUSSION

The MMPI-2 Group Profile suggests quite a broad range of significant scale elevations, including hysteria, depression, psychopathic deviance, paranoia, psychasthenia, schizophrenia, and over-controlled hostility. In addition, the validity scale profile suggests a uniform tendency to deny psychological discomfort and distress, and a concomitant presentation of the self in an overly positive and idealized manner.

The data suggests that a significant number of the clients responded in a manner that produced fake good responses. Reflecting on this validity scale configuration of faking good responses, most of our clients, in terms of their presenting self pathology, have an inflated self concept that masks a shame laden and hungry self representation. Identification with, and a strong allegiance to an archaic, idealized self-concept serves to protect the self from a painful and possibly fragmenting awareness of inner deficiency and a sense of unlovableness. Another useful way to view this idealized self concept is in terms of the introjection of desirable aspects of others which are then claimed as belonging to the self, while, through the mechanism of projective identification, undesirable and unacceptable aspects are deposited on to others. It is interesting to note that within our patient population, authority figures frequently serve as receptacles for the split off and disowned aspects of the self. In particular, the aggressive and hostile impulses of the clients are often deposited into the salient, usually male, authority figure. In these clients, the dynamic (of inflating the good sense of self and denying what seems "bad") may be culturally reinforced when parishes and communities collude with this distortion. Placed on a pedestal, such a man may appear as a "cultural icon", but unfortunately, like all statues, are not "en-fleshed" and shatter when toppled.

Elevation on the hysteria Clinical scale confirms the above tendency to deny psychological and emotional problems, with a resultant conversion of inner turmoil into other symptomatic behaviours. In particular, this sample of clients exhibit a marked tendency to react to stress by developing physical symptoms. As noted earlier we refer to the plethora of previously undiagnosed medical conditions that are diagnosed in the majority of clients during the initial assessment. Furthermore, many complain of pervasive and enduring physical anomalies that are not rooted in any clear medical pathology. In these cases, a physical symptom seems to represent an emotional ailment.

It may be valuable to view this phenomena as connected to Winnicott's (1949,1960) powerful notion of a true and false self dichotomy, where the sensation and affect based aspects of experience (including early experience) remain with the body, while the mind functions as an over-adapted and often intellectualized false self. This functioning of the false self as a "mind object" further illuminates how these patients are able to dissociate from the true nature of their affective experience, as a critical means of self preservation.

However, such a distortion leaves them vulnerable to hurting a victim and not fully grasping the impact of their actions on the victim.

While our clients frequently score within the elevated region on the psychopathic deviance scale, it should be noted that this is not, in most cases, aligned with a diagnosis of anti-social personality disorder. Rather, it is indicative of a tendency to act out as a form of need gratification, as well as indicative of an omnipotent and exploitative use of others in the service of the self.

The perverse or sexual aspects of this use of the object has been particularly well described by Masud Khan (1968), who, in his classic work on perversions, noted how the pervert's omnipotent and ruthless use of others serves as a potent denial of any dependence since its recognition and ownership would imply vulnerability to love, separation and what others have to offer. Hence relationships remain predominately shallow and superficial, with the primary interest being in how others can be used. Indeed this conceptualization of repetitive sexual behaviour characterized by the depersonalization and objectification of the other is clearly reminiscent of the DSM-IV description of compulsive sexuality – a prevalent phenomenon among our sample in that 35% of our clients present with this problematic sexual behaviour pattern. It is curious that for celibates, the choice to act-out involves an excursion into what is "most forbidden". In many cases, these clients seem to have been incapable of negotiating an authentic celibate lifestyle: vulnerability, connection and growth as a person within the context of non-sexual intimacy was attempted at too early an age, with too few resources. It could be argued that Khan's notion of omnipotence may be a defense against the terribly barren loneliness that this has evoked.

The depression Clinical scale needs to be viewed in tandem with another markedly elevated scale in these patients: overcontrolled-hostility. An outstanding feature in our clinical population is a capacity to sequester aggression away from appropriate external expression, with resultant self directed attacks against the libidinal, vulnerable and dependant child-self (within). This would explain the emergence of strong depressive features: in short, anger and rage are converted into depression.

Returning to Winnicott's notion of the true and false self, we have observed how aggression that should have been available for adaptation, frequently leaves our patients with an ingratiating and/or compliant false self to negotiate relations in the world, with aggression turned inward.

A tendency towards paranoid ideation in our sample also ties in well with a picture of overcontrolled hostility. Anger and rage that is muted and is turned towards the self also finds, as another avenue for expression, the possibility for projection onto others, who are then perceived as malevolent and persecutory.

Endorsement of psychasthenia items points to a general conglomerate of fears, and self-doubts, as well as obsessive thinking and compulsive

behaviour. In our sample, compulsivity has been a particularly noticeable trend, dovetailing with the conforming and compliant false self orientation and evoking a powerful defensive structure protecting the self from unacceptable impulses that threaten its cohesiveness. Internal and external ambiguity threatens the idealised self structure and opens these patients up to the frightening world of a shame laden and deficient real self.

High scores on the schizophrenia subscale, while not referring to a clinically diagnosable psychotic disorder, have, in our sample, pointed mainly to social alienation, sexual concerns, difficulties in impulse control and concentration, and generalised fears, worries, and dissatisfactions. These would be the kinds of areas expected to have been highlighted given the structural deficits to the self noted above.

9. CLINICAL TRENDS: MCMI-III

The MCMI-III Validity, Personality, Severe Pathology and Clinical Syndrome Scale Mean Sample Scores are presented in Table 8.

Table 8: MCMI-III SAMPLE SCORES

MCMI-III	MEAN	>= 75	>=85
Disclosure	40.8	2	0
Desirability	**65.7**	**13**	**3**
Debasement	35.9	2	2
Schizoid	**53.9**	**13**	**4**
Avoidant	**44.6**	**14**	**0**
Depressive	**40.2**	**9**	**4**
Dependent	**49.7**	**13**	**4**
Histrionic	47.0	3	1
Narcissistic	**54.9**	**8**	**1**
Antisocial	31.6	1	0
Aggressive Sadistic	25.1	1	0
Compulsive	56.2	3	0
Passive Aggressive	29.2	6	0
Self-defeating	39.6	9	2
Schizotypal	24.7	0	0
Borderline	26.7	1	0
Paranoid	29.3	1	0
Anxiety	**45.3**	**20**	**8**

Inflation on the Validity Scale - Desirability as compared to deflated scores on the Validity - Debasement scale is a strong trend.

As noted with the MMPI-2, variability within the sample is often "washed out" by the mean scores. However, on several MCMI-III scales, clinical trends emerged.

DISCUSSION

The MCMI-III Group Profile highlights a significant elevation on the desirability component of the validity scale (reinforcing our finding on the MMPI-2). On the MCMI-III the specific personality disorders and salient traits endemic to our patient population are the schizoid, dependent, narcissistic and compulsive traits. While the utility of a compulsive defense and personality style has already been discussed in terms of its ability to ward off impulses or affects that are incompatible with the self representation, some comment is required around the schizoid, dependent and narcissistic patterns.

Firstly, it has been interesting to note that, while quite a number of clients have revealed themselves to have schizoid traits on the Millon, very few have met the DSM IV criteria for this characterological pattern, or, indeed, have exhibited a classically detached and isolated interpersonal mode of being. A tendency to withdraw (as a response to and protection against narcissistic injury), flattened affectivity and a general severance of intellectual and emotional functions (false self-pathology) have, however, been strong schizoid characteristics of this client sample.

Prominent Dependent Personality Traits in these clients also reveals some characteristic permutations. We have found that a dependent style amongst our clergy sample is inextricably bound up with a selfless syndrome, whereby there is often a total submergence of the self to the whims and desires of others, particularly to authority figures. Abdication of autonomous functioning serves to protect against abandonment and rejection that is intrapsychically equated with self-assertive behaviour. Thus it can be seen again how the dependent style links up with the false self compliance and acquiescence discussed earlier, this hiding a deeply anxious self that is in desperate need of acceptance, approval, nurturance and support.

Since it would be too threatening for these clients to reveal their libidinal neediness and vulnerability in a way that might permit for real empathic and caretaking responses from others, there is an attempt to give to people what is really desired by the self, combined with a hope that their supplicating behaviour will elicit some of the sought after approval and affection.

It has also been a notable finding that high schizoid and high dependent scores frequently coexist in our sample. In most cases a split off affective life masks deep-seated needs for nurturance and support. A schizoid-dependent personality comprises an intrapsychic "cocktail" of profound ambivalence. The push-pull experienced in interpersonal relations is often excruciating.

Narcissistic Personality Traits represent a marked trend in this sample. This finding is consistent with that of other studies namely Benson, (1994), Irons & Laaser (1994), Steinke (1989), Schoener & Gonsiorek (1989).

While a minority of the sample have comprised the classic exhibitionistic narcissist, more common has been what James Masterson (1989) refers to as the closet narcissistic type who hides his grandiosity. Many of our clients present as shy, humble, anxious or inhibited, underneath which lurks the grandiose self with its manifest need for mirroring and idealisation. The developmental history in these instances usually reveals memories of being devalued or disparaged as a child as well as a pervasive absence of nurturing and affirmative responses from caregivers.

Apart from our patients' needs for others as self objects who provide a mirroring and idealising function we have also observed a narcissistic tendency to use others as transitional objects who serve as transitory or fleeting means of assuaging internal discomfort. It is important to note that, many of these clients' sexual acting out bears the hallmark of transitional object relating: others are omnipotently cathected in an attempt to alleviate painful states of mind and bolster the grandiose false self.

It may be seen that the dependent personality disorder and the narcissistic personality, especially the closet type, share some important characteristics, namely a tendency to present as self effacing, shy or inhibited, and exhibit a strong need for mirroring and affirming responses. The dependent style amongst these clients does, however, reveal itself more as a clinging behaviour with abandonment being the principle fear; whereas a narcissistic style hinges on a need to co-opt objects in a controlling, manipulative or ruthless fashion, with anxiety centering around injuries to self esteem.

CONCLUDING COMMENTS

The Australian Catholic Church has established uniform policies and procedures to respond to victims of sexual abuse as elaborated in the document Towards Healing. The establishment of independent Professional Standard Resource Groups in each State is a feature of this response. The draft document Integrity in Ministry articulates an ethical standard and a Code of Conduct that is espoused by the church as a call to health and focuses on education and prevention.

Encompass Australasia offers comprehensive psychological services for professionals who suffer from psychosexual and associated disorders, especially professional boundary violations. Leaders of the Australian Church believe that the treatment of perpetrators of sexual abuse is a necessary proactive strategy for preventing further victimization of vulnerable individuals in professional relationships. The underlying goal of all therapeutic interventions in the Encompass Program is "no more victims".

Finally, a review of the assessment profiles of 51 clients revealed some interesting clinical trends. The ratio of child-molestation to adult boundary violations was found to be 2:1, with the majority of adult violations perpetrated against females. A significant frequency of comorbid mood and substance abuse disorders were noted. The predominant personality traits found in the

sample were the dependent, narcissistic, schizoid, obsessive-compulsive and avoidant traits. An alarming finding was that over 92% of the sample presented with untreated medical conditions.

These findings raise a disturbing range of questions about the institutional system in which clergy excise their pastoral ministry. Sexual abuse by professionals is always about power inequality and a misuse of power. The study suggests that some clergy have been ill-equipped to deal with the psychological and emotional demands of their calling, and that they lack both the external and internal resources to responsibly manage the authority with which they have been invested. For these 51 clients, problematic sexual behaviours have been expressions of profound intrapsychic dilemmas.

The faith community is the only community that attempts to respond compassionately to both victim and perpetrator. While sexual abuse remains an interpersonal enactment between abuser and victim, it must not be forgotten that this occurs within the ambit of a very particular institutional structure. Thus while the intrapsychic conflicts of individual perpetrators can be addressed, systemic changes within the Church are also essential to reducing the high incidence of abusive behaviour.

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