Introduction

Within the Australian context, professional boundary violations by clergy have been committed against both minors and adults. Under the auspices of the Catholic Church, the National Committee for Professional Standards (NCPS) was established as a joint sub-committee of the Bishops and Major Superiors (The Leaders of the Catholic Church in Australia). This committee was commissioned to implement a Nine-Point Plan: Towards Healing is a document that establishes uniform policies and procedures to respond to and assist victims of abuse. Integrity in Ministry is a draft document that describes how a church minister should act in a manner that is both faith/*-ful to her/his vocation and maintains important professional standards. Thus when describing mandatory ways of behaving it explicitly incorporates a Code of Conduct.

In the first section of this paper, Part A, a narrative describes how these processes have developed and continue to unfold.

The second section of this paper, Part B, describes the clinical services offered to people who require treatment for psychosexual problems, in particular professional boundary violations. This program, known as Encompass Australasia, was established by the NCPS but functions as an independent, multidisciplinary mental health service.

In the third part of this paper, Part C, clinical trends for 51 clergy with professional boundary violations are discussed. The clinical discussion reports on a comprehensive assessment, scores on standard psychometric tests, and presents clinical formulations from a psychodynamic perspective.

PART A: A Review of the Pastoral Response to Victims.

Historical Context

The Catholic Church in Australia like the Catholic Church in the United States and other countries has been confronted by a sexual abuse crisis that has shocked both the community of the Church as well as the general community.

Australians tend to use the United States as a benchmark to identify the trends, issues and problems that will eventually become endemic in our country. In some cases, we are able to learn from the US experience in solving oncoming problems. However, what was once a five to ten year time lag is narrowing significantly with the ready access to and speed of communication technology. Australia is having to learn faster!

When reports of sexual abuse within the Church hit the US media networks and then the international networks over a decade ago, Church personnel in Australia began to ask questions about sexual abuse within the Australian Church. Naively, some said the Church was witnessing an exclusively American problem. Others highlighted the adversarial position taken by some Church authorities in the US and observed the damage to victims and to the

credibility of the Church, even when the legal system failed to find a sufficient case against the Church. The danger of allowing a legal framework to dictate the Church's response, separate from the normally espoused pastoral values of the Church, was observed.

However, before much could be done to educate the Church in Australia about the sexual abuse crisis and to learn from overseas experiences, victims began to come forward in considerable numbers. The media, in turn, gave coverage to the betrayal of trust in relationships between some clergy and adults and children in their care. It appeared as if new revelations of sexual abuse were coming into the public forum on a daily basis.

Initially, many Church leaders reacted to these revelations with both shock and denial. There was also a view that if the Church did have a problem in this area it was a 'small problem', and, while acutely embarrassing, it could be immediately rectified. As has been noted in other churches and "power-institutions" (such as the military), ignorance of the psychology of sexual abuse and a misguided commitment to protect the institutions' reputation meant that some of the accused were simply transferred to other parishes or other duties where they continued to offend.

At this early stage, the quality of responses by Church leaders to complaints of sexual abuse and professional boundary violations was solely dependent on the commitment of individual Church leaders to practice accountability, justice, openness and due process. Consequently, complainants were subjected to something akin to a roulette type game of chance in obtaining an appropriate response from a Church leader.

In 1988, in an attempt to introduce some minimum standards and common process in responding to complaints, the bishops and religious leaders of the Catholic Church in Australia produced a set of procedures to respond to sexual abuse. Although this was a significant beginning, these procedures were kept confidential amongst the bishops and religious leaders of the Church; complainants and victims had no access to them. Clearly, it was still "early days" in trying to break through the denial of sexual abuse in the Church. Consequently, in this initial phase, the procedures were used with a mixture of success and failure in addressing the needs of complainants of child sexual abuse and adult boundary violations.

Looking back on the late 1980s and early 1990s reveals a great struggle within the Church in its grappling with the reality of sexual abuse and adult boundary violations and, in particular, the task of remaining open to the needs of victims and the predicaments of offenders. For many in the Church, as well as in broader society, there was still a significant lack of openness and willingness to squarely face issues of sexual abuse.

The media coverage of sexual abuse in the Catholic Church in Australia, while not always balanced and accurate, became pivotal in prompting, if not forcing, the Church to confront the reality of sexual abuse, the general inadequacy of many previous responses by Church leaders to complaints,

and the demand for change from an increasingly sceptical and cynical community.

A Nine-Point Plan

The Woods Royal Commission was established to investigate the New South Wales Police Service, and in the process of this investigation alighted upon serious incidents relating to the protection of pedophiles in the community. The focus of the media and this Royal Commission, together with a call from many in the Church for more appropriate responses from leaders, culminated in a public pastoral statement in April 1996 from the Bishops and Religious Leaders regarding sexual abuse within the Church.

The bishops and religious leaders of the Catholic Church in Australia collectively implemented their pastoral statement, often termed the 'Nine-Point Plan', through the establishment of a National Committee for Professional Standards. This National Committee of the Church falls jointly under the auspices of the Australian Catholic Bishops Conference and the Australian Conference of Leaders of Religious Institutes.

Part of this Nine-Point Plan was the development of more effective principles and procedures in responding to complaints of sexual abuse against personnel of the Catholic Church in Australia. Further key decisions related to the development of a Code of Conduct for clergy and religious; and the establishment of a treatment program for clergy and religious with psychosexual difficulties, known as Encompass Australasia.

The document of principles and procedures is titled Towards Healing; it is not a confidential document like the 1988 procedures but rather a public document, and is available to clergy, religious, victims of abuse, and any interested person, free of charge.

In the introduction (1996, 1) to the document it states:

> We recognise that in itself this document is nothing more than words on paper. It will become credible only to the extent that it is actually put into effect. At the same time, it is a public document that establishes public criteria according to which the community may judge the resolve of Church leaders to address sexual abuse within the Church. If we do not follow the principles and procedures of this document, we have failed according to our own criteria'.

This is a powerful statement for an institution to make. In the process of reform the Church continues to struggle in being faithful to these publicly espoused principles and procedures.

Towards Healing now applies not only to sexual abuse, but also to physical and psychological abuse. The structures set up to respond to complaints are dealing with an increasing number of boundary violations between clergy and

adults in their pastoral care. It is interesting to note that as the number of child sexual abuse complaints decreases, the number of adult boundary violation complaints is increasing. In Part C of this paper, it is noted that the incidence of adult boundary violations compared to child abuse is in the ratio of 2:1.

The Towards Healing document is a national document. One religious order and one diocese of the Church have opted for their own procedures. Towards Healing principles and procedures cover over 80% of the Catholic clergy and religious in Australia, as well as employed personnel and volunteers within Church structures.

The principles in Towards Healing espouse the principles of truth, humility, healing for victims, assistance to other persons affected; an effective response to those who are accused and those who are guilty of abuse; and prevention of abuse.

The procedures in Towards Healing are implemented and "over-sighted" by the National Committee for Professional Standards. The National Committee has established a network of Professional Standards Resource Groups made up of personnel, both Catholic and non-Catholic, usually from professional backgrounds with some expertise in the area of sexual abuse and boundary violations. These Professional Standards Resource Groups cover the various regions of the Church and operate out of every Capital City of Australia.

In their turn they have established a network of Contact Persons in urban and rural Australia whose names are well publicised and accessible to people who wish to make a complaint. Complainants are interviewed and statements taken. If the complaint is about a criminal matter, the complainant is referred to the Police for an investigation. Procedures are very clear about not interfering in criminal proceedings by interviewing individuals and inadvertently corrupting evidence. This explicit procedure resulted from painful learnings of the past.

If the Professional Standards Resource Group is satisfied that a particular complaint is not one that requires referral to the police, two assessors are appointed to investigate the complaint, interview whom they wish to interview and provide a report with recommendations to the responsible Church authority. The assessors operate independently from the particular Church authority. The procedures indicate that the accused should be stood down by the appropriate Church Authority during this process if the complaint is of a serious nature or where there is potential harm to others.

The procedures also allow for a review of process, a type of appeals process if the complainant is not happy with the implementation of the process. The review of process is undertaken by an independent person, usually a non-Catholic person. A written report of the review of process is given both to the Church Authority and to the complainant.

The victim of sexual abuse is provided with the options of immediate counselling and support. At the end of the process and in the event of proven culpability, whether through admission, through the finding of a Court or through a PSRG assessment, the Church Authority responds to the needs of the victim in the context of the recommendations of the assessment report. Those needs may include the payment of professional counselling with a counsellor, psychologist or psychiatrist of the victim's choice. The response to the needs of the victim usually include a formal apology to the victim. Responses may also include some form of financial compensation. If financial compensation is agreed to, the legal counsel of the Church authority and that of the victim are involved to place such compensation within a legal framework. As the policy and procedure continues to develop, some PSRG's are initiating professional independent conciliation processes to attend to the issue of just renumeration. To the victim, this is experienced as less traumatic that a civil litigation process. For the Church, this process offers greater opportunities for the response to be pastoral.

The procedure directs that any meeting between a victim and a Church Authority be a facilitated meeting in order to address the issue of power imbalance in such an encounter.

As well as this process, Church Leaders need to face issues such as:

> What treatment or therapy is necessary for offenders?
> Whether offenders should be removed from all ministry or placed under some form of supervision?
> Under what circumstances can an offender return to ministry?

These questions need to be asked in all cases whether the Church is dealing with a child sexual offender or an adult professional boundary violator. There seem to be more similarities than differences in these two types of sexual abuse.

While the structure outlined may appear straightforward, its implementation is frequently complex and often needs to be adapted to the peculiarities of each complaint. A unique geographical challenge involves the resourcing of the variety of dioceses and communities in Australia. In the city of Sydney, there are three dioceses: each has access to an array of services to support the Towards Healing process. On the other extreme, some rural diocese may have a handful of priests and yet be spread over an area larger than most countries. Resources are limited and spead thin is such settings.

Mistakes continue to be made and some Church leaders are still resistant to proper process. However, the Towards Healing program, now operational for the last 18 months is displaying a robustness and acceptance by a wide range of people. Even within the media there seems to be a sense that the principles and procedures of the Church in responding to sexual abuse issues are basically credible.

Professional Boundary Violations

The area of professional boundary violations is demanding more time and attention from the Professional Standards Resource Groups in Australia. Over the last few years Church personnel have gradually become educated and well informed about child sexual abuse and its aetiology. Adult professional boundary violations brings with it a set of different issues with witch the Church must grapple. Quite often the issue of 'consenting adults' seems to muddy the waters with not only those accused but also some Church leaders and many victims as well, viewing consent as reducing or nullifying responsibility.

Unlike many other professions, clergy need to deal with what is often termed dual relationships. A clergy person can be a pastor to a parishioner, providing some pastoral care in circumstances of grief; he can work with the same person on a liturgy committee of the Church in organising a major parish celebration; and he can accept an invitation to dinner in the person's family home as someone who has become a friend over the years as well as being the person's parish priest. This dual professional/personal relationship requires specific skills on the part of clergy to ensure a clarity of boundaries is maintained.

In the professional boundary cases already before the Professional Standards Resource Groups in Australia, many of the clergy involved see the sexualising of a pastoral relationship as a private moral issue and not one of public and professional accountability. These clergy indicate that the breaking of vows of celibacy and chastity can be dealt with in the confessional. The so-called 'consent' of the participating adult person indicates to the clergy person that a private and personal friendship rather than pastoral relationship now dominates the dual relationship. The concept of professional misconduct and public accountability in ministry is missing in an analysis of their own behaviour. This is an alarming situation and reflects badly upon the effectiveness of the Church's selection, formation and ongoing educative processes.

The experience of the initial stage of operation of Towards Healing has already focused attention on areas that need to be confronted including the false understanding that some clergy have between a vocation and a profession. The issue for the Church member to clarify focuses on a sense of vocation (seen as a calling from God with the unstated and automatic dispensation from secular boundaries) and of profession (seen in negative terms as about distance, aloofness and limited commitment to people in need of boundaries such as strict working hours). The issue of more adequate formation for a celibate lifestyle is also an important area for ongoing dialogue.

In confronting improper understandings of professional boundary violations and the use of 'consent' as a mitigating circumstance, the Towards Healing document (1996, 2) states:

> Any attempt to sexualise a pastoral relationship is a breach of trust, an abuse of authority and professional misconduct. Such abuse may take the form of suggestive comments, unnecessary questions or physical contact. Failure by the other person to reject such conduct does not necessarily imply meaningful consent. Even when the other person concerned is the one who seeks to sexualise the relationship, it is the professional responsibility of clergy or religious to guard the boundary against sexual contact.

The National Committee for Professional Standards of the Catholic Church in Australia recently reinforced and affirmed this statement when it noted the succinct and excellent statement made by the US National Organisation for Continuing Education of Roman Catholic Clergy Inc. in their video resource guide, 'Priestly Relationships: Freedom through Boundaries'. The study guide (p.14 no.6) states:

> It is an abuse of ministerial responsibility and a violation of boundaries for a priest to sexualise a relationship with a parishioner or someone under his care, even if it appears that the other person is aware, consenting, or even initiating the further level of intimacy.

In affirming and implementing this policy statement the Church must present professional boundaries in a way that is both positive and life giving to ministry, and not something negative and restrictive of effective pastoral ministry.

A set of ethical standards for all Church workers

It is this issue along with many others that is being addressed in the development of a Code of Conduct for clergy and religious in Australia. A draft document titled Integrity in Ministry: A Document of Ethical Standards for Catholic Clergy and Religious in Australia, is currently the subject of a year long consultation phase amongst clergy, religious and lay people in Australia.

Prompted by the sexual abuse crisis within the broad society as well as the Churches, an increasingly critical and sceptical Australian community is demanding transparent accountability processes in place for a wide range of professions; all religious organisations are very much central to this process.

As well, Integrity in Ministry is attempting to minimise the risk of complaints and abuse and to provide clergy and religious with a protective structure in which to operate as pastoral ministers. As the old saying goes: "$1 of prevention is worth $10 of treatment" once a sexual disorder has developed in a minister.

The document is being hotly debated throughout this year. A second draft will be published in the early part of next year (1999). The consultation is deliberately a long one. The Church is very aware that any Code of Conduct or ethical standards needs to be owned by the people who will work within it.

The aim is for the consultation period to be an educative process in order to bring people on board with the need for the document and to get their assent to its broad areas of content.

Integrity in Ministry attempts to face the issue that pastoral ministry is a public ministry and necessitates a level of public accountability that is acceptable and transparent to the community. It also asserts that pastoral ministry is both a vocation and a profession with professional responsibilities. The document is much more than a list of do's and don'ts. It covers a wide range of roles and functions in ministry as well as addressing the need for self care and support mechanisms.

The current consultation process also asks questions about sanctions. The National Committee for Professional Standards and its Code of Conduct Advisory Committee (mandated with the responsibility to draft the document) realise that without a formal process to deal with complaints and without formal sanctions in place, the credibility of any code of conduct or ethical standards is seriously diminished. The consultation document (1997, 18-19) lists the possible range of sanctions as:

> advice and counselling; formal caution; direction to undertake special training; direction to seek specialised assistance; restrictions of ministry, privileges and /or residence; suspension of certain faculties; suspension from active ministry; dismissal from the clerical state or from religious life.

The responsibility of Church authorities would be to match the seriousness of the offence with the appropriate sanction, realising that the more serious sanctions, using the Church's Cannon law, can only be imposed by authorities in the Roman Curia. The mechanism to respond to a complaint in terms of a code of conduct may well be the already established Professional Standards Resource Groups. The Code of Conduct would apply to Church leaders as well; to bishops and the leaders of the religious institutes of Australia.

Both the Integrity in Ministry document and the Towards Healing document attempt to interact with a Church culture where, in the main, formal and structured accountability processes are lacking and have never been significant. Supervision as a concept and in practice is foreign to the pastoral ministry of a large number of clergy and religious in Australia. Blend this culture with a high stress ministry in which dual relationships are commonplace; the fact that many clergy and religious operate in isolation from one another and from support structures; confusion regarding contemporary identity, meaning and purpose of ministry; an inadequate formation for some; inadequate psychosexual development in some, and you have a potent mixture for potential professional boundary violations.
The Towards Healing process is attempting to respond appropriately to complaints of sexual abuse of children and adult professional boundary violations. The process was purposely named "Towards" Healing, well aware that what has been put in place so far is only a beginning. Viewed as a

process, a lot of learning from mistakes and successes is occurring along the way.

When Towards Healing was published in December 1996, it was publicly stated from the outset that the document would be reviewed within a few years and updated and more refined procedures put in place. We are conscious that an enormous amount of learning, education and change has still to take place.

Conclusion

Many people within the Church in Australia often ask whether the sexual abuse crisis is nearly over. There is a sense of leaving this pain behind us so that we can get on with the normal life of the past. However, it seems more accurate that responding to issues of sexual abuse and professional standards is now a permanent part of the life of the Church. Through this crisis there has been a type of appropriate shift in values about the exercise of ministry; issues of accountability. Openness and transparency of process are starting to find their way onto ministry agenda in the Church in Australia. This is a sign of hope, for unless the Church consciously and structurally addresses professional standards, credibility and relevance within the community will continue to be eroded. As well, having heard "the cry of the poor" from victims of sexual abuse, the Church needs to stay attentive and continue to move Towards Healing: for the victims firstly, for the perpetrators and for itself and its structures that allowed the abuse of power to go unnoticed.

A further sign of hope in the Towards Healing process in Australia has been the establishment by the bishops and religious leaders of a program called Encompass Australasia.

PART B

The second part of this paper describes Encompass Australasia – 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. For all groups, Verbal I.Q. was superior to Performance I.Q. This finding is not surprising given that most of the subjects were tertiary educated and involved in a profession that requires a high level of articulateness.

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, 10 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

This profile suggests that the clergy in the sample are largely inattentive to basic self care and that they may lack supportive, intimate, personal relationships that promote and support healthy self care.

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 clients' in this sample, 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 this sample, 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, these men may appear as “cultural icons”, 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 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 a proportion of the sample 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 this 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 this 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 the 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 the 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, 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.

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 this client sample 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 the 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 this 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 the sample 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 the clients' needs for others as self objects who provide a mirroring and idealising function, also observed is 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.

While the sample size has been small and the various clinical themes that have been discussed vary within the sample, we could make the following summary. In both standard psychological tests, there seems to be a distinct tendency to deny psychological distress. It seems that the personality defence structures seem to be based on minimisation and a denial. Thus, this sample of sexually troubled clergy seem to be vulnerable to developing a compulsive style in their personality that is rigid and inflexible. When this defense structure does not work, the client has few resources with which to cope with the situation and the way they will act in response in unpredictable. This seems particularly true about repressed erotic impulses or suppressed anger and rageful feelings. As these clients try to live as celibate people, at times and for some of the group pervasively, there seems to be a desperate need to cling to others. Since this is rather primitive and immature, they will feed frustrated and at times angrily clutch onto authorities and at other times, seek to have their desperate need for connection sexually filled by contact with parishioners. The clients experience a push and pull towards relationship. When they do come close, they do not seem confident what to do (when close). As well, for some, a narcissistic self focus seems to emerge. When their defenses are working ineffectively, they are apt to bend the rules. As a result of an inability to successfully resolve these tensions, many of the group are left anxious and depressed.

SUMMARY

In standard psychological tests there seems to be a distinct tendency to avoid disclosing signs of distress, mechanisms of denial and minimisation shielding the self from deep seated feelings of shame and vulnerability. Our sample suggests three distinct patterns of intrapsychic and interpersonal functioning. A strong dependent style manifests itself in a tendency to cling to others and suppress autonomous functioning: a compliant false self sequesters anger away from healthy assertiveness with resultant emergence in depressive affect, psychosomatic disturbances or destructive acting out behaviour that may be sexual in nature. A prominent covert narcissism in our patients highlights difficulties around self esteem and a grandiose self structure that may omnipotently use others in the service of the self. Finally, a marked compulsive trend serves to ward off impulses that are not compatible with the idealised self image. These clients are at particular risk, due to their use of suppression and repression, for developing psychosomatic and affective disorders and to seeking interpersonal gratification where the self can, at all times, remain in control. Inappropriate sexual acting out is aligned with the maintenance of self control, as the object world can be manipulated in accordance with transitory needs states as opposed to the exigencies of sustained intimacy.

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 adult boundary violations to child-molestation 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, typically, 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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