THE RESPONSE FROM DIOCESES AND RELIGIOUS COMMUNITIES

5.1 INTRODUCTION TO THE REPORTING OF CHILD SEXUAL ABUSE

Every published empirical study on the disclosure of child sexual abuse indicates that a high percentage of those child sexual abuse victims who report their abuse to authorities delay disclosure of their abuse, and that a significant number of children do not disclose the abuse at all[1]. The delay between the initial occurrence and the subsequent disclosure of the abuse varies, depending on a number of factors such as the abused child's age at the time of abuse, the relationship between the perpetrator and the child, the gender of the child, the severity of the abuse, developmental and cognitive variables related to the abused, and the likely consequences of the disclosure.

Consequently, child sexual abuse is significantly underreported. When victims do report that they were abused, they often do so years after the abuse occurred. Adult retrospective studies of childhood sexual abuse underline the delay in disclosure. In a study of 228 adult female victims of childhood incest who were predominantly abused by males, Roesler and Weissmann-Wind found that the average age of first abuse was 6 years, and the abuse lasted on average 7.6 years. Only one-third of the subjects in this sample disclosed the abuse before the age of 18, and the average age of disclosure was 25.9.[2] Arata found that only 41% of the 204 female participants in her study, whose average age at the time of victimization was 8.5, disclosed the abuse at the time it occurred.[3] Lawson and Chaffin found that only 43% of their child subjects disclosed their abuse when they were initially interviewed.[4] Lamb and Edgar-Smith conducted a study with 45 adult female and 12 adult male victims of childhood sexual abuse, and they found that although the average age at the time of victimization was 10, 64% of the victims disclosed their abuse in adulthood.[5] In a study of childhood rape of girls, Smith, Letourneau, and Saunders found that approximately half of the women waited more than eight years to disclose the abuse. [6]

If abuse is reported years after it occurred, there may be errors in the accuracy of the report due to "telescoping", or the likelihood that an individual will report the event as happening earlier or later than it actually occurred.7 Several social science studies have tested the telescoping phenomenon. Several studies found that forward-telescoping, or recalling an event that occurred prior to the reporting period in question, is more prevalent than backward telescoping.8 One study showed that memory disorientations, such as telescoping, occur more often in survey respondents 55 years or older than respondents less than 55 years of age.9 Another study portrayed survey participants as showing a tendency to forward-telescope events that were prominent in their lives.10 In other words, these survey respondents showed a higher likelihood of recalling significant life events, such as crime victimization, as occurring more recently in time than the event actually did. Yet another study examined the existence of telescoping in crime victimization surveys, and found that non-reported incidents were

telescoped by respondents to a slightly greater extent than incidents reported to the police.[11] This notion reveals a propensity for crime victims to telescope forward victimizations from their past, particularly if the crime was never reported to the police or criminal justice officials. Though telescoping has consistently been an issue in temporal reporting of a variety of abuses[12], no empirical studies have examined this problem specifically with sexual abuse disclosure.

The process of disclosing childhood sexual abuse varies, though it is often described within two axes: as purposeful or accidental and as spontaneous or prompted.[13] DeVoe and Coulborn-Faller found that child subjects in their study required assistance with disclosure.[14] Sorenson and Snow noted that accidental disclosure was more common in preschool children, whereas purposeful disclosure was more common in adolescents. They also found four stages of disclosure in their retrospective study of 630 subjects who were aged three to 17 at the time of abuse: denial, disclosure (tentative and active), recantation and reaffirmation. These researchers also found that 72% of their subjects originally denied the abuse; 78% of the subjects who tentatively revealed their abuse progressed to active disclosure; 22% recanted their reports, and of those who recanted 93% later reaffirmed the original report.[15] Lawson and Chaffin found that a significant factor in the disclosure process was the belief of the caretaker in the veracity of the disclosure.[16] Bradley and Wood's research also supported the notion that the role of the caretaker is essential. Although recantations of disclosure were rare in their sample, they found that 50% of children who recanted did so under pressure from a caretaker. [17]

One model of child sexual abuse, the Child Sexual Abuse Accommodation Syndrome, is intended to help explain the hindrance to disclosure (Summit, 1983). This syndrome is not intended to be diagnostic, but rather as a clinical tool to assist in putting abuse victim behavior in context. It consists of five components: secrecy (the abuse occurs when the victim and perpetrator are alone, and the perpetrator encourages the victim to maintain secrecy); helplessness (children are obedient to adults and will usually obey the perpetrator who encourages secrecy); entrapment and accommodation (once the child is helplessly entrenched in the abusive situation, he or she assumes responsibility for the abuse and begins to dissociate from it); delayed disclosure (because the victims who report child sexual abuse often wait long periods of time to disclose, their disclosures are subsequently questioned); and retraction (as in the recantation stage described by Sorenson and Snow, the victims may retract their disclosures of abuse after facing disbelief and lack of support after their disclosure).[18] Of course, not all victims react in predicted ways, but some broad patterns can be discerned.

FACTORS INFLUENCING DISCLOSURE

VICTIM'S RELATIONSHIP TO THE PERPETRATOR

If the perpetrator is a relative or acquaintance, victims of child sexual abuse are less likely to report the offense, or they are likely to disclose the abuse after a delay.[19]

In Arata's study, 73% of the victims did not disclose the abuse when the perpetrator was a relative or stepparent, and 70% did not disclose when the perpetrator was an acquaintance.[20] Goodman-Brown, Edelstein, and Goodman found that those children who felt responsible for the abuse, often because the abuse occurred within the family, took longer to report the abuse.[21] Wyatt and Newcomb found that the women who did not disclose their abuse to

anyone were likely to have been closely related to the perpetrator and abused in close proximity to their home.[22]

Severity of sexual abuse

Research results vary in regard to disclosure of abuse in relation to the severity of that abuse. Arata found that child victims who experienced more severe levels of sexual abuse were less likely to disclose this type of abuse.[23] This is consistent with the findings of Gries, Goh, and Cavanaugh, who reported that fondling was reported by 80% of their subjects who disclosed.[24] In contrast, however, Hanson found that of their 341 adult females who were victims of childhood rape, the more severe assaults were likely to be reported.[25] DiPietro et al (1998) also found that contact sexual offenses were those most commonly reported in their sample of 76 children.[26]

Developmental and cognitive variables

Lamb and Edgar-Smith speculate that "more astute" children may not disclose because they may "anticipate unsupportive reactions".[27] They also maintain that such children may wait until adulthood to disclose when they can choose appropriate people to tell. White et al (1986), as cited in Campis et al (1993), found that older victims of child sexual abuse were less likely to disclose than their younger counterparts and noted that the knowledge of social consequences was a significant hindrance to disclosure.[28] Keary and Fitzpatrick concluded that children over the age of five, who had previously disclosed sexual abuse, were more likely to disclose this information during formal assessment, but the converse was true for children under five.[29] Similarly, DiPietro (2003:140) found that "developmental maturation clearly facilitates" disclosure.[30]

Fear of negative consequences

Sorenson and Snow found that fear of further harm had an impact on a child's motivation to disclose abuse and that child victims often only felt safe enough to disclose after the departure of the perpetrator.[31] Berliner and Conte also noted that the fear about perceived reactions of others prevent some children from disclosing sexual abuse.[32] Roesler and Weissmann-Wind found that 33.3% of their subjects did not disclose their abuse during childhood because they feared for their safety. They also found that 32.9% of their subjects did not report their abuse during childhood because they felt guilt or shame as a result of the abuse.[33]

Gender differences

DeVoe and Coulborn-Faller; Gries, Goh, and Cavanaugh; Lamb and Edgar-Smith; and Walrath, Ybarra, and Holden all found that girls are more likely to report abuse than boys.[34] Reinhart found that sexual abuse of males was more likely to be disclosed by a third party.[35] There are no methodologically sound empirical studies that indicate that males disclose at a higher rate than females. Gender does not appear to be as important, however, as victim-perpetrator relationship in disclosure of abuse (Paine and Hanson, 2002).

[1] For a comprehensive review of the literature on disclosure of childhood sexual abuse, see Paine, M.L. and Hansen D.J. (2002) Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review*. 22: 271-295.
[2] Roesler, T.A., & Weisssmann-Wind, T.A. "Telling the Secret: Adult Women Describe Their Disclosures of Incest," *Journal of Interpersonal Violence* 9 (3, 1994): 327-338.

[3] Arata, C M. "To Tell or Not to Tell: Current Functioning of Child Sexual Abuse Survivors who Disclosed Their Victimization," *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children* 3 (1, 1998): 63-71.

[4] Lawson, L., & Chaffin, M. "False Negatives in Sexual Abuse Disclosure Interviews: Incidence and Influence of Caretaker's Belief in Abuse in Cases of Accidental Abuse Discovery by Diagnosis of STD," *Journal of Interpersonal Violence* 7 (4, 1992): 532-542.

[5] Lamb, S., & Edgar-Smith, S. "Aspects of Disclosure: Mediators of Outcome of Childhood Sexual Abuse," *Journal of Interpersonal Violence* 9 (3, 1994): 307-326.

[6] Smith, D.W., Letourneau, E.J., & Saunders, B.E. "Delay in Disclosure of Childhood Rape: Results From a National Survey," *Child Abuse & Neglect* 24 (2, 2000): 273-287.

7 Sudman & Bradburn, (1973), as cited in Schneider, Anne L. & Sumi, David. "Patterns of Forgetting and Telescoping." *Criminology*. Vol. 19, No. 3. (November 1981): p. 401.
8 Schneider et al., (1978); NRC, (1976), as cited in Schneider, Anne L. & Sumi, David. "Patterns of Forgetting and Telescoping." *Criminology*. Vol. 19, No. 3. (November 1981): p. 401. This article discusses telescoping patterns as well as the Portland Forward Records Check.
9 Sudman & Bradburn (1974), as cited in Gottfredson, Michael R. & Hindelang, Michael J. "A Consideration of Telescoping and Memory Decay Biases in Victimization Surveys." Journal of Criminal Justice. Vol. 5. (1977): p. 206. This article describes characteristics and tendencies of telescoping commonly found in social science research.
10 Neter & Waksberg, (1964), as cited in Gottfredson, Michael R. & Hindelang, Michael J. "A Consideration of Telescoping and Memory Decay Biases in Victimization Surveys." Journal of Criminal Justice. Vol. 5. (1977): p. 206. This article describes characteristics and tendencies of telescoping commonly found in social science research.
11 Schneider et al., (1978); NRC, (1976), as cited in Schneider, Anne L. & Sumi, David. "Patterns of Forgetting and Telescoping." Criminology. Vol. 19, No. 3. (November 1981): p. 409. This article discusses telescoping patterns as well as the Portland Forward Records Check.
12 Skogan, (1975), as cited in Levine, James P. "The Potential for Crime Overreporting in Criminal Victimization Surveys." Criminology. Vol. 14, No. 3. (November 1976): p. 318; Schneider et al., (1978), as cited in Schneider, Anne L. & Sumi, David. "Patterns of Forgetting and Telescoping." Criminology. Vol. 19, No. 3. (November 1981): p. 402.
[13] Devoe, E.R., & Coulborn-Faller, K. "The Characteristics of Disclosure Among Children who May Have Been Sexually Abused," *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children* 4 (3, 1999): 217-227; Reinhart, M.A. "Sexually Abused Boys," *Child Abuse & Neglect* 11 (2, 1987): 229-235; and Sorenson, T., & Snow, B. "How Children Tell: The Process of Disclosure in Child Sexual Abuse," *Child Welfare* 70 (1, 1991):

[14]Devoe & Coulborn-Faller, p#
[15] Sorenson and Snow, p # 4.
[16] Lawson and Chaffin, p#
[17] Bradley, A.R., & Wood, J.M. "How Do Children Tell? The Disclosure Process in Child Sexual Abuse," *Child Abuse & Neglect* 20 (9, 1996): 881-891

[18] Summit, R.C. "The Child Sexual Abuse Accommodation Syndrome," *Child Abuse & Neglect* 7 (2, 1983): 177-193.

[19] Arata, p#; Elisabeth Kahl, Desmond K. Runyan, and Doren D. Fredrickson, "Predictors of Disclosure During Medical Evaluations for Suspected Sexual Abuse," *Journal of Child Sexual Abuse* 6 (1, 2003): 133-142; Rochelle F. Hanson, Heidi S. Saunders, Benjamin E. Saunders, Dean G. Kilpatrick, and Connie Best, "Factors Related to the Reporting of Childhood Rape," *Child Abuse & Neglect* 23 (6, 1999): 559-569; Smith Letourneau and Saunders, p#; and Wyatt, G.E., & Newcomb, M.D. "Internal and External Mediators of Women's Sexual Abuse in Childhood," *Journal of Consulting & Clinical Psychology* 58 (6, 1990): 758-767.

[20] Arata, p#
[21] Goodman-Brown, T.B., Edelstein, R.S., & Goodman, G.S. "Why Children Tell: A Model of Children's Disclosure of Sexual Abuse," *Child Abuse & Neglect* 27 (5, 2003): 525-540.

[22] Wyatt & Newcomb, p#
[23] Arata, p#

[24] Gries, L.T., Goh, D.S., & Cavanaugh, J. "Factors Associated With Disclosure During Child Sexual Abuse Assessment," *Journal of Child Sexual Abuse* 5 (3, 1996): 1-20.

[25] DiPietro, P#

[26] Hanson, 566

[27] Lamb & Edgar Smith, 321.

[28] Campis, L.B., Hebden-Curtis, J., & DeMaso, D.R. "Developmental Differences in Detection and Disclosure of Sexual Abuse," *Journal of the American Academy of Child & Adolescent Psychiatry* 32 (5, 1993): 920-924.

[29] Keary, K., & Fitzpatrick, C. "Children's Disclosure of Sexual Abuse During Formal Investigation," *Child Abuse & Neglect* 18 (7, 1994): 543-548.

[30] Dipietro 2003 p. 140

[31] Sorenson & Snow, P#
[32] Berliner, L., & Conte, J.R. "The Effects of Disclosure and Intervention On Sexually Abused Children," *Child Abuse & Neglect* 19 (3, 1995): 371-384.

[33] Roesler & Weissmann-Wind, P#
[34] Walrath, C., Ybarra, M., & Holden, E.W. "Children With Reported Histories of Sexual Abuse: Utilizing Multiple Perspectives to Understand Clinical and Psychosocial Profiles," *Child Abuse & Neglect* 27 (5, 2003): 509-524.

[35] ReinHart, P#

5.2 REPORTING OF ALLEGATIONS OF SEXUAL ABUSE

The shape of the distribution of incidents of alleged abuse, as was shown in Figure 2.3.1 in Part Two of this report, follows a regular curve, rising steadily from 1950 to its height in the mid-1970s and then steadily decreases until the end of the study period. Although the reporting of child sexual abuse follows a completely different pattern, as is shown in Figure 5.2.1, the distribution of abuse allegations over time that are reported in the peak year 2002, are not different from the overall pattern of events. As Figure 5.2.2 shows, the curve is very similar to that shown for all allegations.

Figure 5.2..1 YEAR OF ABUSE REPORT

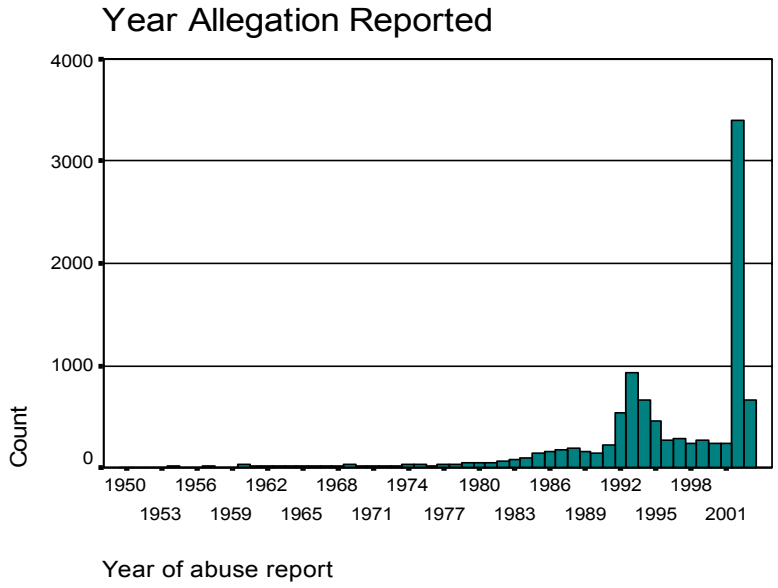


Figure 5.2..2 CASES REPORTED IN 2002, BY BEGIN DATE

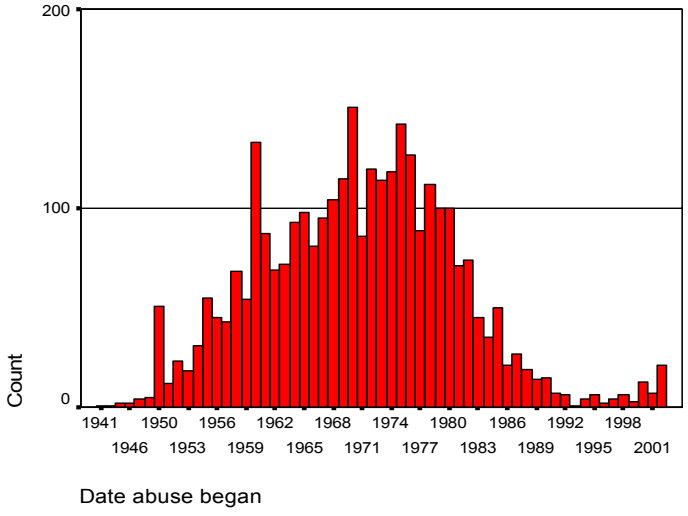


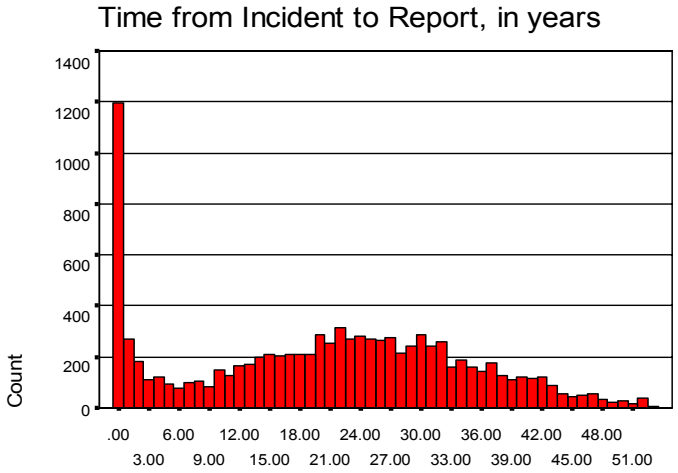
Table 5.2.1 INCIDENT BEGIN DATES REPORTED IN 2002 COMPARED TO ALL INCIDENTS

Decade	***Overall Count***	***Percent***	***Percent in 2002***
1950 - 1959s	939	9.7%	416 / 13.3%
1960 - 1969s	2533	26.1%	966 / 30.7%
1970 - 1979s	3445	35.5%	1196 / 36%
1980s - 1989	2074	20.6%	473 / 15%
1990s - 2003	603	6.2%	95 / 2.8%
Total	9714		

Table 5.2.2 ABUSE REPORTS BY DECADE

Decade	***Overall Count***	***Percent***
1950s	53	.5%
1960s	190	1.8%
1970s	266	2.6%
1980s	1146	11.2%
1990s	4022	39.4%
2000 - 2002	4533	44.4%
Total	10, 210	100%

Figure 5.2.2 TIME FROM INCIDENT TO REPORT



Half of the incidents of abuse were reported by individuals who experienced the victimization. Attorneys reported one in five incidents, followed by family members, who reported approximately 17%.

Table 5.2.3 SOURCE OF ABUSE REPORT

Who reported?	Count	Percent
Victim	5327	51.6%
Teacher	36	.3%
Cleric	278	2.&%
Parent/Guardian	1450	14.1%
Police Officer	174	1.7%
Lay Person	202	2%
Doctor	28	.3%
Attorney	2165	21%
Self-report	174	1.7%
Other	104	1%
Siblings/Other family	328	3.2%
Anonymous	12	.1
Counselor/Therapist	40	.4
Total	10318	100%

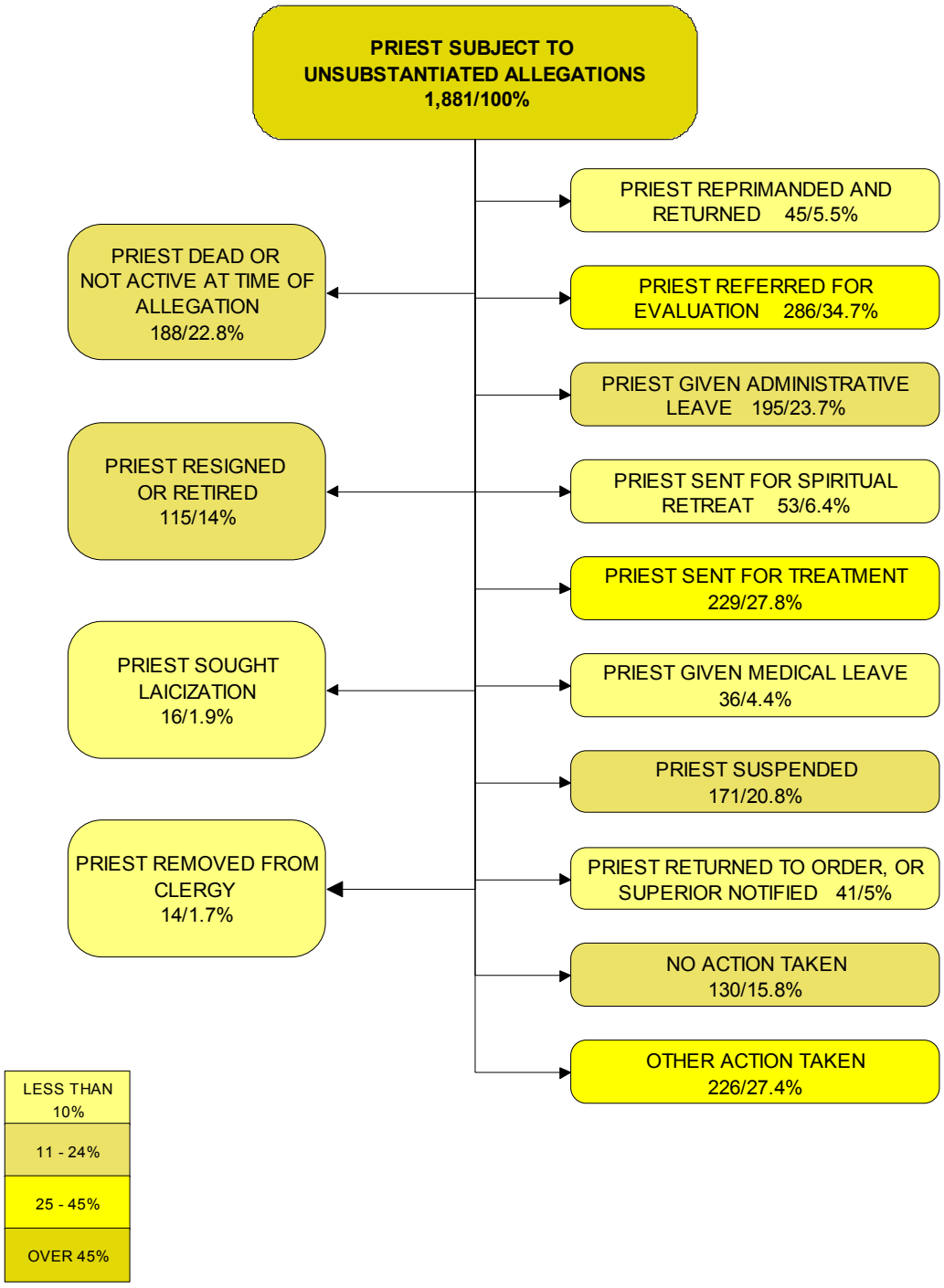
The reports of abuse came to the Church in many and varied ways. Phone calls and letters were the most commons forms of contact, followed by a legal filing by an attorney.

5.2.4 FORM OF ABUSE REPORT

How was the abuse reported?	Count	Percent
Called Parish	290	2.7
Signed letter to parish	97	.9
Anon. letter to parish	6	.1
In person/parish	189	1.8
Told trusted cleric	658	6.2
Media	114	1.1
Called diocese	3216	30.2
Signed letter to diocese	2433	22.8
Anon. Letter to diocese	107	1.0
In person/diocese	709	6.6
Called P/MS	299	2.8
Signed letter to P/MS	171	1.6
Anon. Letter to P/MS	13	.1
Legal filing	1118	10.5
Other	281	2.6
Diocese contacted victim	10	.1
Other unrelated adult	35	.3
Cleric self-reported	86	.8
Police/any CRJ	246	2.3
SNAP, victim hotline	34	.3
School representative	33	.3
Total	10144	95.1

5.3 ACTIONS OF DIOCESES AND RELIGIOUS COMMUNIES FOR PRIESTS WITH UNSUBSTANTIATED ALLEGATIONS

Figure 5.3.2 outlines the unsubstantiated complaints of child sexual abusers.



5.4 SEX OFFENDER TREATMENT

Although the majority of the priests and deacons accused of child sex abuse have only one allegation, there were two types of who had inspired more concern – those priests who had more than multiple victims and those who abused one victim for a lenghty period of time. The aims and types of treatment for sexual offenders have changed significantly throughout the past century, which is important when understanding the types of treatment clergy have undergone since the 1950s. In the early 20th century, psychologists thought sexual offending was the result of individual psychological conflicts. As a result, many of the first treatments were psychoanalytic in nature. They were based upon a model which implied that offending was out of the individual's control. Early psychoanalysts believed that if treatment were to occur it would have to be lengthy in order to adequately address and resolve the problem. [1]

In the 1950s, psychological methods of treatment for sexual offenders began to change.[2] Many researchers at this time believed that deviant sexual practices resulted from deviant sexual arousal, and therapeutic practices were developed to modify deviant fantasies. They took various forms, such as operant conditioning,[3] aversion therapy,[4] orgasmic reconditioning,[5] and shaping.[6] The focus was not only on modifying serious sexual fantasies, such as those about children, but also on eliminating homosexual desires.

The first behavioral treatment programs were limited in scope and concentrated upon single elements of deviant behavior. Some researchers then expanded upon these and made the programs multi-modal in nature. Through the addition of treatment components, such as social skills training, clinicians attempted to address the many factors shown by research to be associated with offending behavior. Treatment providers such as Abel recognized that sex offenders evidenced a high prevalence of cognitive distortions, or thought processes that allowed the offenders to neutralize their feelings of guilt and shame. He and other treatment providers began to modify behavioral treatment programs so that they were cognitive-behavioral in nature in order to address these distortions.[7] In the 1980s, the cognitive behavioral treatment programs were further expanded to include the therapeutic technique of relapse prevention, which is a strategy for maintaining treatment-induced changes through self-management. This was originally developed as a model for controlling substance abuse and was later adapted by Pithers et al. to address deviant sexual behavior. Relapse prevention is said to be one of the most important developments for sex offender research of that decade since offenders were finally trained to recognize and manage their own fantasies and behavior.[8] Other developments in the 1980s involved cognitive restructuring, victim empathy training, the refinement of sexual arousal monitoring, and an increased validity of phallometric testing (a measure of arousal assessment).[9] The most significant addition to treatment in the 1990s was the use of the polygraph. Though polygraph results are generally not admissible trials of guilt or innocence, the polygraph does produce usable information about deception and gives treatment providers deeper insight into the acts committed by offenders and shows whether they are being truthful during the treatment programs.

Although it is clear that there is no cure for sex offenders, certain treatment regimes appear to be successful at reducing rates of recidivism for certain types of offenders.

Unfortunately, it is not possible to present definitive statistics on the reduction of recidivism due to the numerous methodological problems associated with sex offender treatment

Table 5.4.1. TYPE OF SEX OFFENDER TREATMENT

Type of Treatment	Count	Percent
Specialized program for clergy sex offenders	666	41
Specialized program for sex offenders	212	13.1
General treatment/program	283	17.4
Individual psychological counseling	679	41.8
Psychotherapy	412	25.4
Relapse prevention program	170	10.5
Evaluation,but not treatment	293	18.0
Spiritual counseling	224	13.8
Other	97	6.0
Total	3036	186.9

Individual priests often received multiple forms of treatment either simultaneously or consecutively. This table describes 3,036 treatments/evaluations of 1,624 Priests.

Table 5.4.4. TREATMENT FACILITY

Facility	*Count*	*Percent*
BMI-Atlanta, GA	8	.6
IRC-Chicago, IL	50	3.6
JHM-Baltimore, MD	10	.7
PCS-Cincinnati, OH	5	.4
SLI-Suitland, MD	465	33.4
SP-St. Louis, MO	115	8.2
SCI-Splendora, TX	23	1.6
S-Ontario, CAN	113	8.1
SP-Jemez Springs, NM	197	14.1
SP-Albuquer Villa, NM	36	2.6
SLCS-St. Louis, MO	61	4.4
IL-Hartford, CT	99	7.1
MC-Topeka, KS	4	.3
NLC-Middleburg, VA	8	.6
VSJV-Dowington, PA	138	9.9
Other	337	24.2
Total	1669	119.7

This table represents 1,669 treatments of 1,394 Priests. Some individuals received treatment at more than one treatment facility or returned to the same facility for a second treatment.

[1] Organic, or medical, treatments for sexual offenders surfaced in the 1940s. These treatment approaches are not discussed at length here because they have rarely been used for clergy abusers. The first hormonal treatment in the 1940s was an estrogen called which proved to be fairly successful at reducing deviant sexual behavior. Despite its benefits, it was not widely used because of its side effects which included vomiting, nausea and feminization. The idea that sexual offending was a medical problem continued through the 1950s and the 1960s, with the introduction of medical treatments such as medroxyprogesterone acetate (MPA), which is still used today with "chemical castration" (more commonly referred to as Depo Provera).

[2] It was Eysenck's criticism of traditional psychotherapy that facilitated the move towards behavioral therapy as the preferred form of psychological treatment (Marshall et al, 1999).

[3] B.F. Skinner. *Science and Human Behavior* (New York, NY: The Free Press, 1953).

[4] R. McGuire and M. Vallance. "Aversion Therapy by Electric Shock: A Simple Technique," *British Medical Journal* 2 (1964): 594-597.

[5] John N. Marquis, "Orgasmic Reconditioning: Changing Sexual Object Choice Through Controlling Masturbation Fantasies," *Journal of Behavior Therapy & Experimental Psychiatry*, 1(1970): 263-271.

[6] John Bancroft. "The Application of Psychophysiological Measures to the Assessment and Modification of Sexual Behavior," *Behavior Research and Therapy* 9 (1971):119-130.

[7] Gene G. Abel. "Behavioral Treatment of Child Molesters," in *Eating, Sleeping, and Sex: Perspectives in Behavioral Medicine*, ed. Albert J. Stunkard and Andrew Baum (Hillsdale, NJ: Lawrence Erlbaum Associates, 1989): 223-242.

[8] William L. Marshall, "Assessment, Treatment, and Theorizing about Sex Offenders: Developments During the Past Twenty Years and Future Directions," *Criminal Justice and Behavior* 23(1996):162-199.