Professional Boundary Violations and Mentalizing in the Clergy

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Increasing attention has been focused on mental health problems of clergy in light of long work hours, extraordinary demands, and diversity of tasks. In this communication we report findings from the psychiatric evaluation of 70 Episcopal priests. We describe psychiatric diagnoses, but our focus is on two common themes that emerged: difficulties maintaining professional boundaries and problems with mentalizing, i.e., imagining the impact of their behavior and words on others. Recommendations for education and prevention are addressed.

In a recent New York Times article (Vitello, 2010), clergy stressors were described as contributing to burnout, health problems, and stress. The demands placed on clergy are becoming increasingly distressing to religious organizations, and resulting emotional, physical, and financial burdens are being brought to light in the media. Those who are called to a career in the clergy face numerous stressors. They are often required to be available all hours of the day and night. They may be called upon to function as pastor, marriage counselor, individual psychotherapist, “CEO” of a complex church organization, mediator of disputes between divisive groups in the congregation, accountant, friend, and surrogate parent. It comes as little surprise that many clergy develop symptoms of psychiatric disorders and are sent for evaluation or seek help on their own initiative. Much has been written about burnout in clergy (for example: Doolittle, 2007; Grosch and Olsen, 2000; Maslach, 2003; Lehr, 2005; Weaver, Larson, Flannelly, Stapleton and Koenig, 2002). After tirelessly ministering to the myriad concerns of their flock, pastors may begin to feel they are operating on automatic pilot. They may feel a loss of passion for their work, a sense of going through the motions, and often an existential crisis where they think to themselves, “What’s the point?”

A variety of psychiatric disorders may underlie this feeling that one’s sense of calling has evaporated—e.g., depression, anxiety, and substance abuse. Among the consequences of this loss of purpose are professional boundary violations. Priests in this situation may become more concerned about gratifying their own needs than looking after the needs of others in their congregation. In the most egregious of these transgressions, priests may become sexually involved with their parishioners. The power

differential between the clergyperson and the congregant is ignored or denied, and the emotional and sexual needs of the priest take precedence over the obligation to the parishioner. Nonsexual boundary violations are common as well, either as forerunners of the sexual boundary violations or as problematic transgressions in their own right that stop short of sex. Clergy may mismanage designated church funds to their advantage, disclose their own personal problems to an excessive degree, profess their love and neediness to one of their flock, become intimate friends to the point where the priestly role is lost and others feel excluded, or borrow money from someone they see in pastoral counseling.

Those who transgress professional boundaries do so for complex and diverse reasons. It is facile, and in some ways more satisfying, to view them as simply bad pastors (Shupe et al., 2000). In this way other clergy and distressed congregants can dismiss the problem as simply one of "bad" character and ignore the complexity of the interplay among pre-existing personality characteristics, the presence of psychiatric disorders, the disinhibiting influence of alcohol or drugs, systemic problems in the congregation or the church hierarchy, overwork, adult developmental crises, stressors involving spouse/partner, and incomplete preventive education about power differentials, professional boundaries, and idealization.

Sexual boundary violations in various professional relationships have been well-documented in the existing literature (Gabbard, 1989; Fortune, 1989 and 2009, Gutheil and Brodsky, 2008; Gabbard and Lester, 2003; Celenza, 2007). Clergy boundary violations have much in common with other professional boundary violations. To be sure, some who engage in sexual relationships are "bad" in the sense that they are predators of questionable moral character and are frequently diagnosed with severe narcissistic or even antisocial personality disorders. They are without remorse and are clever enough to conceal what they have done for extended periods of time.

Others are highly moral individuals who are driven to strive for perfection. They are always available to those who need them, conscientious to a fault, perhaps a bit omnipotent in their rescue fantasies, and often regard themselves as indispensable. Like many physicians and therapists who transgress sexual boundaries, they may feel that they have lived a life of great self-sacrifice, and in a dark moment of midlife despair, they may rationalize that they have earned one small self-indulgence as a reward for their altruism (Myers and Gabbard, 2008;Gabbard and Lester, 2003).

In addition to certain similarities with other helping professionals, the clergy also have some unique features in their setting (Hulme, 1989; Celenza, 2007). The tendency of parishioners to idealize their pastor to the point of expecting godlike qualities intensifies the power differential that is present in all relationships between helping professionals and those they help. Moreover, the psychodynamic concept of transference is highly relevant to these interactions. As children, we all internalize images of our parents and throughout our lives transfer those mental representations onto other authority figures, imbuing them with maternal or paternal qualities that may or may not fit. Transference is particularly relevant in the context of relationships between parishioner and pastor because parental expectations are readily transferred onto God and onto the person of the pastor. In addition, of course, Godlike qualities are attributed to the minister.

Though we acknowledge that the gender balance is changing in ordained church leadership as the number of female clergy increases, in many venues, church work continues to have a gender imbalance: ministers are predominantly male and church volunteers largely female (Hulme, 1989). Clergy may also assume a special protection by virtue of their work—because of their relationship with God and their overall good

intentions, they may view themselves as exceptions to rules that apply to others. In addition, they are often working in a setting where there is no supervision. Special systems issues also operate in the church setting. Benyei (1998) writes about the interface of individual dynamics and religious systems in the context of boundary violations. She attempts to identify some of the ways that congregations function as families, and how projection and scapegoating play a role in these violations.

In many years of evaluating and treating clergy for the Episcopal Church, we have seen a great many priests and bishops who have been sent for psychiatric evaluation for a variety of reasons. Though the data in this paper focuses on Episcopal clergy, the issues addressed apply universally across denominations. In fact, when we have evaluated clergy from other faith traditions, we have been struck by the similarities to the Episcopal clergy discussed in this communication. Professional boundary problems are often part of the picture. Our experience has taught us that the causes for these difficulties are indeed multiple and cannot be boiled down to one simple formula. Nevertheless, we are impressed at how often certain difficulties in thinking about oneself and others are at the core of these situations. In particular, many who are referred to us have problems with *mentalizing.* This concept grows out of attachment theory and has a growing body of research associated with it (Allen, Fonagy, and Bateman, 2008). In brief, mentalization is the capacity to place one's mind in the mind of another and imagine their perspective. It refers to the capacity to understand that one's own and others thinking is representational in nature and that one's own and others' behavior is motivated by internal states, such as feelings and long-held assumptions. One's own subjectivity is, of course, colored by parental models, cultural background, biases and childhood experiences. The ability to mentalize is often referred to as having a "theory of mind". In other words, one is aware that each person has a separate subjectivity that is unique. Impairments of mentalizing, which are not confined to only one type of personality or psychiatric condition, may affect one's ability to relate smoothly in interpersonal situation. Clergypersons who have problems in this area also have difficulty understanding how they come across to others.

In this communication, we review 70 cases of Episcopal clergy who came for psychiatric evaluation with the mental health team of one of the co-authors (GOG) over the past twenty years. Our examination of these cases illustrates the diverse reasons for evaluation, the common psychiatric problems leading to referral, the variations on professional boundary violations that are involved, and the role played by problems with mentalizing.

Method

One of the authors (GOG) began conducting psychiatric evaluations of Episcopal clergy in the early 90s at the Menninger Clinic in Topeka Kansas.). Since the author relocated to the Baylor Psychiatric Clinic at the Baylor College of Medicine in 2001, those evaluations have continued in Houston. These assessments are conducted over a three-day period and are multidisciplinary in nature. Three or four psychiatrists interview the clergyperson who has been referred, and a psychologist administers a battery of psychological tests. A social worker interviews family members or significant others. Extensive collateral information is obtained from the referral source.

The research team reviewed the records from 70 consecutive evaluations of clergy, limiting the sample to those who were in the Episcopal Church.

Using a checklist that we had devised, we recorded the following demographic characteristics: gender, age, marital status, ethnicity, position held, work status, and referral source. We also recorded the psychiatric diagnoses and the presence or absence of substance abuse from the findings of the evaluation. For purposes of

reporting our findings, we broke these down into three categories: substance abuse, Axis I psychiatric syndromes, and Axis II personality disorders or traits based on the DSM-IV system.

Finally, since the focus of our research was specific, we recorded in detail whether there were boundary violations present, either as part of the complaint or as phenomena that emerged in the course of the evaluation. We evaluated the presence of both sexual boundary violations as well as those that were nonsexual in nature. We specifically extracted signs of mentalization problems, either noted specifically by the evaluating team, or those that were easily inferred from the interpersonal problems described. While there are research measures of mentalization that are more rigorous (Allen, Fonagy, and Bateman 2008), we did not have the capability of administering those retrospectively. Hence our identification of mentalizing problems was purely clinical. In addition to our interest in professional boundary problems and mentalization difficulties, we also recorded the reasons listed for referral of the clergyperson for evaluation.

Results

The demographic characteristics of the population evaluated are presented in Table 1.

Table 1. Demographic Characteristics

		N	%
Gender	Male	57	81.4%
	Female	13	18.6%
Mean age	51.39		
Married/partnered	Yes	56	80%
	No	14	20%
Ethnicity	Caucasian	64	91.4%
	Black	5	7.1%
	Hispanic	1	1.4%
Position	Priest	59	84.3%
	Bishop	11	15.7%
Work Status	Working	22	31.4%
	Disability	18	25.7%
	Not working*	30	42.9%
Referral Source	Diocese	30	42.9%
	Pension fund	26	37.1%
	Presiding Bishop	10	14.3%
	Psychiatrist/therapist	2	2.9%
	Self	1	1.4%
	Seminary	1	1.4%

*Reasons for not working include: leave of absence, retired, suspended, inhibited, resigned, or fired

As Table 1 indicates, the majority of clergy evaluated were male (81.4%), while only 18.6% were female. Even though there was a range of ages represented, for the most part there was a clustering around the midlife period with a mean age of 51.4. The clergy evaluated were predominantly Caucasian. Eleven of the 70 subjects were bishops.

The work status of the clergy varied considerably. Thirty-one point four percent of those in the sample were working at the time of the evaluation, and 25.7% were already on disability. Forty-two point seven percent were not working. This latter figure contains a number of different situations that reflect diverse reasons for referral. In some cases,

the clergyperson involved was retired or had resigned. Sometimes the individual had been placed on leave of absence while the evaluation was taking place. In some cases, formal disciplinary action had already taken place, and the clergyperson had been suspended, inhibited, or fired prior to coming for the assessment. In still other cases, the clergyperson had resigned, often under pressure to do so.

Referral sources vary considerably. Forty-two percent of the subjects were referred by their local diocese after complaints had reached the office of the bishop. In many cases, the Church Pension Fund in New York City had initiated an evaluation because of concerns about disability or other related work issues. Many cases involving bishops came directly from the Office of the Presiding Bishop of the Episcopal Church of America. As Table 1 indicates, two subjects were referred by mental health professionals treating the clergyperson, one was self-referred, and one came from a seminary setting.

Reasons for referral were diverse. Because of various behaviors observed in the work setting, some were referred for straightforward psychiatric diagnosis and treatment recommendations. Many of these also involved requests for an evaluation of the clergyperson's fitness for duty. A common theme was the question of disability. The referral source wanted to know if the individual being referred was capable of working in the current position or if another work setting would be better. If the clergyperson was deemed disabled, the evaluation team was often asked if it would be possible for them to work in a secular setting or if the disability were pervasive and no employment was reasonable. Other common reasons for referral included an assessment of the nature of the professional boundary violations and what psychological factors contributed to them. These included allegations of inappropriate sexual relationships with coworkers or parishioners. A variety of problems with interpersonal skills also contributed to conflicts in the work setting, and these were frequently mentioned as reasons for referral.

Table 2 summarizes the diagnostic assessments of the subjects as a result of the multidisciplinary evaluations

Table 2. Psychiatric Diagnoses and Substance Abuse

		N	%
Substance abuse	Yes	12	17.1%
	No	58	82.9%
Axis I diagnosis	Yes	58	82.9%
	No	12	17.1%
Specific Axis I diagnoses	% of total sample with mood disorders	39	55.7%
	% of total sample with anxiety disorders	8	11.4%%
	% of total sample with cognitive disorders	8	11.4%
	% of total samples with sexual disorders	2	2.9%
Axis II personality disorders	Yes	30	42.9%
	No	7	10%
	Personality traits that fall short of a true disorder	33	47.1%
	% of total sample with personality disorder not otherwise specified (mixed)	22	31.4%
Specific personality disorders	% of total sample with narcissistic personality disorder	7	10%
	% of total sample with obsessive-compulsive personality disorder	1	1.4%

As the table notes, the majority of the referrals to the evaluating team did not have substance abuse disorders (82.9%). The Axis I diagnoses, which focus on clear psychiatric syndromes, were common, with mood disorders being the most frequently diagnosed disorder at 55.7%. While major depression or depression not otherwise specialized were most common, there were some cases that involved bipolar illness or variants thereof. Anxiety disorders and cognitive disorders were less common (11.4% for both conditions). Among the anxiety disorders were generalized anxiety disorder, panic disorder, post-traumatic stress disorder, and anxiety disorder not otherwise specified. The cognitive disorders included variants of dementia and cognitive disorder not otherwise specified, meaning there were difficulties with memory, attention, or executive functioning, but the cause could not be determined.

Axis II diagnoses reflect longstanding personality disorders and personality traits that do not reach the level of true personality disorder. These traits may significantly influence the clergy member's functioning in the work setting and in personal relationships. Of those evaluated, 42.9% had a diagnosable personality disorder, 47.1% had significant personality traits, and only 10% had neither a personality disorder nor detectable traits. Of those who had a diagnosable personality disorder, a mixed diagnostic category was most common. In the DSM-IV language, the term "personality disorder not otherwise specified" is used for situations where there is a mixture of personality characteristics rather than a pure diagnostic entity. The specific personality disorder most common was narcissistic personality disorder (10%), and 1% had obsessive-compulsive personality disorder. With 42.9% having a personality disorder and 47.1% having personality traits, it is clear that longstanding characterological features play a key role in the referral of clergy to assessments.

Table 3 records the presence of boundary violations and mentalizing problems.

Table 3. Boundary Violations and Mentalization Problems

		N	%
Boundary violation	Yes	31	44.3%
	No	39	55.7%
Mentalization problem	Yes	51	72.9%
	No	19	27.1%

Boundary violations were present in 44.3% of the cases. This figure encompasses both sexual and nonsexual boundary violations. The sexual boundary violations noted included those in which the clergyperson was sexually involved with a congregant or with a coworker. Nonsexual boundary violations were highly varied, but common ones included inappropriate physical or emotional relationships with parishioners or coworkers involving intimate emails, phone calls, hugging, and kissing, as well as violations of confidentiality. Financial violations, such as the blurring of personal and professional use of church money, were also common. Mentalizing problems were frequently noted among the subjects of this study. Seventy-two point nine percent had problems in which they had great difficulty in understanding how their behavior or comments affected other people. There were many instances of conflicts with parishioners or coworkers where comments were perceived as demeaning, arrogant, aggressive, or threatening. Similarly, there was often obliviousness to the power differential and the transference issues that accompany a clergyperson's relationship to parishioners.

Discussion

The data garnered from this review reflect the fact that there are diverse reasons for referring Episcopal clergy for evaluation. Nearly half had some form of professional boundary transgression that contributed to the referral. As noted above, boundary violations have multiple causes and occur in individuals with a variety of different pre-existing psychiatric problems and who are beleaguered by a host of different external situations within the church setting. Mood disorders, specifically depression, were the most common Axis I condition. A typical scenario is a middle-aged male parish priest, whom we will call Rev. Adams, who finds himself struggling with a developmental crisis of adult life. He approached his vocation with alacrity as a young man. He wanted to be of service to his flock and fulfill his calling by offering his parishioners a contemporary interpretation of the Gospel—one that would strike them as relevant to the challenges of living in a confusing and frightening era.

As he became immersed in parish life, he learned that many were not interested in what he had to say. They criticized him for not being more available (even though he worked 12 hour days), for being too sympathetic to progressive trends in the Church, and for not being more effective in bringing in new families to the congregation. People came to him for counseling but didn't take his advice. Rev. Adams rarely saw his wife because the demands of the parish consumed him. His children were chronically angry because the Church kept moving him to new locations just when they had formed friendships and became involved in scouting and athletics in the community. After 15 years of living this way, Rev. Adams and his wife became increasingly distant from one another and rarely had any meaningful communication. The priest worked harder as the congregation grew. Eventually he felt he was chronically exceeding his limits and soon was burning out to the point where he was clinically depressed. He found it difficult to get up and go to work, but he did so anyway. He felt he couldn't take time off because he was indispensable to keep the congregation on track for their fund-raising campaign.

One day a young divorcee in the parish came to him for counseling. She told him he looked sad. He started self-disclosing to her about his domestic situation, and she hugged him at the end of the counseling session. It felt so good to have someone who concerned herself with his feelings and his needs for a change. After she left, he went over to her home for a "pastoral visit" and asked her if she would go to dinner with him before they attended a church meeting together. She hesitated but accepted his invitation. When they went to dinner, she seemed to appreciate the attention, but she told him that she felt it wasn't right to date her pastor. He asked why she accepted his invitation, and she replied, "It's kind of difficult to say 'no' to your priest."

She later complained to the bishop of the diocese, and the priest was called in for a meeting with the bishop. He was clearly depressed, and the bishop suggested that he have a psychiatric evaluation. He explained to the bishop that he placed no pressure on the parishioner to go out with him, but the bishop explained that by virtue of the power differential between priest and parishioner, it was hard to give consent. The priest was taken aback by this idea because he felt he was totally without power.

Clearly, Rev. Adams was unable to mentalize the internal experience of the woman in his parish. He thought he was making a friendly gesture to take her to dinner. She felt he was attempting a seduction. The impact of his invitation on the congregant was quite different than his intent in asking her to dinner. This failure to see the difference between intent and impact is pervasive in professional boundary violations (Gutheil and Gabbard, 1993). The priest must make a conscious effort to imagine how his words and/or behavior can be construed differently by the parishioner based on her distinct

perspective. He was operating out of his own needs in his beleaguered state and did not take her point of view into account.

While the above example illustrates a priest whose depression, burn-out, marital stressors, and loneliness may have led to mentalization problems and boundary violations, there are other situations in which difficulties in understanding one's impact on others is not situational in nature. Some clergy have longstanding personality organizations that make them largely oblivious to how they are coming across to others and somewhat insensitive to what others may be seeking from them.

Consider Rev. Jones, a 37 year-old priest who transitioned to a new congregation. He had been serving a smaller parish, and felt optimistic about the transition as he believed himself more suited to a larger parish and more capable of putting his talents to good use. Since he was ordained, he felt that he was called to be "God's messenger" in the church. During the first year at the new congregation, he felt that things went very well, and he received a great deal of positive feedback on his sermons. People told him how riveting his sermons were and how profound his teaching was. After the first year, he noticed that the quality of the feedback from his congregants was declining. Rev. Jones received emails complaining that his sermons were too long with too many quotations from theologians. The head of the vestry pulled him aside and sheepishly told him that his sermons tended to focus too much on himself. He also said that other congregants were put off by his use of many personal anecdotes. The head of the vestry quickly clarified that this view was not his own—he was simply passing on what others had said. He vehemently disagreed, believing that what he preached in his sermons was of vital importance and that his interpretations of theology were divinely inspired. He summarized his view by emphasizing to the head of the vestry, "I KNOW I am a good preacher."

He found himself in further conflict later, when in meetings, he laid out a course of action without asking for input and processing the options with his vestry. When others questioned or criticized his decisions, he could barely contain his contempt, and on one occasion he yelled, "Why did you choose me to lead this congregation and then expect me to stand by while you make bad decisions?" The vestry was shamed into dead silence, but after he left the church, the members of the vestry stood in the parking lot for nearly an hour talking about what they should do. Rev. Jones believed that he was ordained by God to lead and that he knew what was best for the church. He received complaints that when he was teaching, he did not answer questions but tended to present a monologue.

He became increasingly defiant in the face of these complaints. He took money out of the pastor's discretionary fund for a plane ticket to pay for a weekend trip to a spa to rejuvenate himself. When he was asked about his use of the funds, he replied. "It's a discretionary fund. That means I use it at my discretion." He felt he deserved it for how hard he had been working with so little encouragement and support.

One weekend, there was a congregational picnic and sports day, with softball, horseshoes, and volleyball. He played in the softball game. At one point, he became enraged at the umpire when he was called out at second base. In front of the congregation, he shouted at the umpire, "What the hell are you talking about? I was safe by a mile. Did you leave your glasses at home?" While everybody watched in silence (and a few laughed nervously), he continued to argue until the umpire, a congregant, changed the call.

A church elder later approached him about the incident and said that some members of the parish were embarrassed by his behavior. He replied, "Why? I wasn't being the priest; I was just being a regular guy playing baseball." Several members of the vestry

complained to the Bishop who called him in for a meeting. The bishop said he now had a file folder filled with emails and letters complaining about Rev. Jones. He suggested that the priest have a psychiatric evaluation to address his behavior and how it contributed to conflict in the congregation.

In the evaluation, it was clear that he needed assistance looking at the impact of his yelling on the congregants as this had occurred both in meetings and at the game. The priest was not able to see the transference that the parishioners had to him, namely, "God" does not blow his top. The congregants were concerned that he was not interested in their perspectives. They viewed him as self-interested rather than passionate about serving the needs of the congregation. The way that he yelled in meetings and dismissed the views of others was experienced by others as demeaning and demoralizing. He said to the Bishop, "I was just expressing my frustration, like a regular person." He needed help understanding that he could not take off the priestly mantle on the baseball field or in the church meeting room. The transference to him as a pastor and an authority figure led to high expectations that were independent of location or context. From a mentalizing perspective, clergy need to recognize that their parishioners view them as Godlike and parental 24 hours a day regardless of context. The pastor will never be "just be a regular guy".

Rev. Jones' view of himself as divinely inspired and at the right hand of God may have set him up for an injury to his self-esteem when the reality of congregational conflict and differing expectations became clear. He longed to be idealized and was shocked when his congregation confronted him with criticisms and complaints. His inability to see the perspective of others through mentalizing left him trapped by his own narrow views which were largely self-centered. This incapacity to empathize with how others were feeling and what others sought from him led to paralyzing conflict and dissent within the church. It rendered him incapable of leading because no one would follow.

These two examples illustrate the linkage between mentalizing difficulties and professional boundary violations. Rev. Adams asked a parishioner he was counseling out to dinner without thinking of how his invitation would look to her. Rev. Jones used church funds to finance his trip to a spa. His sense of entitlement led him to be unaware of the impact of his behavior on others. While neither of these case examples evolved into a sexual boundary violation, the scenario involving Rev. Adams might well have gone in that direction if his counselee had responded differently. To her credit, she was able to bring up her concerns to Rev. Adams. Someone like Rev. Jones, who has pre-existing personality traits that lead him to feel that the rules don't apply to him, could also resort to seeking the idealization of a woman in the parish to comfort him. Hence, sexual boundary violations could be part of that clinical picture as well. The loving, sexual response of a parishioner might be a way that he could feel appreciated instead of criticized.

All boundary violations are not secondary to mentalizing problems. Not all clergy who have difficulties with mentalization engage in boundary violations. The two phenomena often overlap but may exist independently as well. Similarly, the types of psychopathology reflected in Table 2 do not necessarily lead to problems in either area. While some studies (Allen, Fonagy, and Bateman, 2008) link mentalizing with specific types of psychiatric disorders, we all can lose the capacity to imagine another's perspective in the throes of strong emotions. In addition, some clergy with severe narcissistic and antisocial tendencies that we have seen can mentalize very well, but use that capacity in the service of exploiting others. They can read the faces of their parishioners and figure out what they need to do or say to manipulate them.

Recommendations

What are the implications of these findings for educating, preventing, and responding to problems of this nature? Space considerations necessitate brevity. The cornerstone of prevention is education. Seminaries must systematically teach the concept of professional boundaries in the priesthood, the nature of transference in the pastor/parishioner relationship, the power differential inherent in the interaction between the clergy and their congregations, and the nonsexual boundary violations that may lead to sexual misconduct. In addition, we recommend seminars that focus on identifying and empathizing with the other person's point of view. The role of education must transcend the walls of the seminary and continue throughout the pastor's career. Probably the most important preventive measure is the avoidance of professional isolation. Those clergy who attempt to solve all problems arising in the parish on their own are at particularly high risk for engaging in boundary violations. As we noted in the introduction, too many clergy work in the absence of supervision. In some cases, consulting with a trusted colleague, even one outside one's own denomination, may be vital to maintaining the objectivity one needs to address complex interpersonal problems that occur in every church. In some cases small groups of clergy may serve as a support system for one another. Common problems encountered can be shared in a setting of like-minded peers who have a good deal of empathy for the pastor's struggles.

When prevention fails, churches ought to respond in constructive ways that address both the needs of the priest and the needs of those who have been victimized by boundary violations. Serious boundary violations can devastate a congregation to the point where people leave the church and those who remain are frozen with indecision and shame. Scapegoating of the priest as a "bad pastor" can be problematic, but colluding by doing nothing is equally harmful. Similarly, scapegoating of the victim of the boundary violations by disbelieving, discrediting, or blaming the victim, is also a common maladaptive response. Support from the Diocese is generally the first step, where one has the advantage of consulting with those who are once-removed from the turmoil of the congregation and may see things more clearly. When necessary, psychiatric evaluation conducted by professionals who are expert in this area is indispensable.

Recommendations that may emerge from the evaluation of the priest include such things as specialized forms of psychotherapy, couples therapy, treatment of any primary psychiatric conditions such as depression or anxiety, addiction treatment, structural changes in the work setting or changes involving the type of work the priest is doing, education regarding mentalization and boundary violations, or insight into traits in their personality that may cause them difficulty. Rigorous research indicates that mentalizing problems are improved by specific forms of psychotherapy (Bateman and Fonagy, 2006). In some cases, a consultant with organizational expertise may need to sit down with the priest and key members of the congregation to examine and solve systems problems in the church that transcend the individual psychological characteristics of the priest. Finally, as the recent publicity about pedophilia in the Catholic Church underscores, some clergy violations must be dealt with through the criminal justice system and/or expulsion from the clergy.

The occupational hazards of the clergy are multiple. Some can be addressed successfully while others may be intractable. Focusing efforts in the areas of prevention and education that are geared to universal vulnerabilities provides the best hope for staving off problems in advance rather than dealing with them after they occur.

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The Association of Professional Chaplains promotes quality chaplaincy care through advocacy, education, professional standards and service to its members.
Become an APC member
www.professionalchaplains.org


2012 Association Annual Meetings
NAJC January 15-18 Cleveland, Ohio
ACPE February 8-11 Washington, D.C.
CASC/ACSS April 18-21 Sydney, Nova Scotia
AAPC April 19-21 Leesburg, VA
NACC May 19-22 Milwaukee, WI
APC June 21-24 Schaumburg, Il