

T RESTORING T **TRUST**

A Pastoral Response to Sexual Abuse

Document

Bishops' Ad Hoc Committee on Sexual Abuse

November 1984



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November 14, 1994

National Conference of Catholic Bishops
Annual General Meeting
Omni Shoreham Hotel
2500 Calvert Street, N.W.
Washington, D.C. 20008

Dear Brother Bishops:

Ever since its inception during the June 1993 general meeting of the Conference, your Ad Hoc Committee on Sexual Abuse has been meeting bimonthly with staff and various consultants to develop resource material to assist you and your staff in dealing with the difficult challenge of child sexual abuse by clergy your own diocese.

This binder contains the first material approved by the Committee:

1. A review of the 157 policies received, together with highlighted sections and a commentary.
2. A report on ten Evaluation/Treatment Centers.
3. Articles on selected topics in different areas by authors with experience in the field. These are the first of approximately eleven articles which we have commissioned especially for your use.

Many people with expertise in different areas of this problem have willingly contributed their time and knowledge in the development of this material.

The Committee intends to continue developing, approving, and passing on to you, additional resource material for your binder as it becomes available.

We hope that this material will be of assistance in keeping you, and all those working with you in your dioceses, up to date in the most effective ways to deal with the problem of child sexual abuse.

If there are areas you would like to see covered in future materials or articles, please contact a member of the Committee or staff.

With kind personal regards, I remain,

Sincerely yours,

Most Reverend John F. Kinney
Chairman, Bishops' Ad Hoc Committee
on Sexual Abuse

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INTRODUCTION

RESTORING TRUST

A PASTORAL RESPONSE TO SEXUAL ABUSE

Because of instantaneous media coverage, or possibly direct experience, virtually all corners of this country are responding to the sexual abuse phenomenon. The spiritual, physical, and emotional harm caused by the actions of a few have affected the well being of many, most especially the victims, their families, and their communities.

Whenever someone is wounded by the betrayal of another member of the human family, restoring trust becomes the paramount need for the one offended. In the context of sexual abuse in the church, this need is recognized individually in the many diocesan policies and programs in place throughout the country, and collectively in the past statements and guidance offered by the NCCB. One of the instruments currently assisting the conference in this regard is its Ad Hoc Committee on Sexual Abuse.

The Ad Hoc Committee is pleased to offer this first installment of resource materials to help NCCB members respond to the need for restoring trust in this extremely sensitive and challenging area of sexual abuse by members of the church and in society at large. Responding to the pastoral needs of the diocesan church comes within the purview of the local bishop. Therefore the comments or suggestions made by the Ad Hoc Committee in any of its reports are to be seen in this context, and are in no way binding for local implementation.

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AD HOC COMMITTEE ON SEXUAL ABUSE

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PREAMBLE

In the workplan for the Ad Hoc Committee on Sexual Abuse the first objective set related to diocesan policies on sexual abuse. The intent was to review the policies in place, share with all NCCB members their general character, and offer comments and proposals that might be considered in the evolution of policies as experience indicates possible improvements.

The response to the request to the dioceses to supply copies of their policies was most encouraging for the committee: out of 188 dioceses, 178 replies, and 157 policies. Thirteen dioceses indicated that they had no policy, and eight informed the committee that they were working on one and would send it in when completed.

Of the 157 policies reviewed, 41 deal with clergy only, while 116 apply to diocesan employees (and often volunteers) as well. Whereas 39 address sexual abuse of minors exclusively, 118 cover that, plus sexual harassment, sexual exploitation, and sometimes neglect as well.

Many policies are in what has been termed the "second generation" category, that is, a revision of what had been developed in the mid to late 1980's. Obviously it is not the prerogative of the committee to judge the adequacy of any of the policies reviewed, first and foremost because it has no mandate to do so, but especially because what is paramount is the quality and competence of those implementing them at the diocesan level. That being said, it is noted that policies play a critical role in assuring a consistent approach to the phenomenon they are intended to regulate.

In submitting this report on diocesan policies in place in mid 1994, the committee has chosen a two-pronged approach: offering a selection of what the policies themselves say in key areas, followed by some commentary and suggestions for consideration.

The bishops on the committee are mindful of the evolutionary nature of diocesan policies and trust that this report will be found useful as NCCB members continue to review their local situations.

DEFINITIONS

The policies reviewed indicate that the topic covered is broadening considerably from the pedophilia context. While mindful of differences that may be indicated by state laws, the committee offers the following quotation from a diocesan policy which gives a succinct description of most of the terms found in the many of the policies examined.

The terms "ministry-related sexual misconduct" and "sexual misconduct," as used throughout this statement, refer to three related forms of misconduct. The first, which is sexual contact between a church leader and a minor or vulnerable adult, is often called "sexual abuse." The second, which is sexual contact between a church leader and a person who is receiving pastoral care from the church leader, is often called "sexual exploitation." The third, which is unwanted sexualized conduct or language between co-workers in the church work setting, is often called "sexual harassment." All three are addressed here together because they have this in common: usually each involves an abuse of power or authority. State statutes give legal definitions of each of these.

Many other dioceses have picked up almost verbatim this description of terms.

THE FIVE PRINCIPLES

Throughout much of this report you will see many quotations from diocesan policies that have been approved by individual bishops. However, there is a collective position taken by NCCB members that obviously has had great influence on the evolution of the policies, namely, the five principles that came out of the November 1992 General Meeting. To recall:

- * **Respond promptly to all allegations of abuse where there is reasonable belief that abuse has occurred.**
- * **If such an allegation is supported by sufficient evidence, relieve the alleged offender promptly of his ministerial duties and refer him for appropriate medical evaluation and intervention.**
- * **Comply with the obligations of civil law as regards reporting of the incident and cooperating with the investigation.**
- * **Reach out to the victims and their families and communicate sincere commitment to their spiritual and emotional well-being.**
- * **Within the confines of respect for privacy of the individuals involved, deal as openly as possible with the members of the community.**

1. GENERAL GUIDELINES

Here is a sample of some general guidelines found usually in the introduction of selected policies, or in the presentation of the document by the bishop.

Every society esteems its children. In their innocence a society recognizes its own innate goodness and its calling to build a better world. In their incompleteness a society understands that hope for a fuller life and second chances is never extinguished. This is no less true for the Church.

...the common mission of all of us is to be holy. A holy people will not allow one of its members to be a victim of sexual misconduct.

All human suffering as well as the weaknesses and imperfections of human beings deserve a response rooted in love, compassion, and concern.

As bishop ..., my obligations regarding this issue are numerous and complex. I am morally obligated to address the issue openly and honestly. I am legally obligated not to be negligent. I am financially obligated to act responsibly. I am obligated to uphold the image of the Catholic Church in working with the news media while at the same time respecting the confidentiality of victims and showing compassion for the accused.

The symbolic role of the bishop cannot be delegated.

Pastoral ministers are to maintain the integrity of the ministerial relationship at all times. Sexual contact between pastoral ministers and those in their care is a violation of the ministerial relationship and is never permissible.

Sexual misconduct by a priest with a minor violates human dignity, priestly commitment and the mission of the church.

The church in dealing with such tragedies can help the entire community to grow and develop, especially assisting it in combating the scourge of sexually abusive conduct. The spiritual well-being of all persons affected by sexual misconduct with a minor is of primary concern - "The salvation of souls is the supreme law" (c.1752)

As disciples of Jesus Christ, all persons directly or indirectly involved with incidents of child abuse are to act with honesty, charity and confidence in the Lord's power to forgive and to heal."

There is a need for the entire church to create an atmosphere where silence, ignorance and minimization are overcome by understanding, Christian love, and mutual respect.

Any sexual misconduct by church personnel, volunteers, and clergy of the diocese is contrary to Christian morals and principles and is obviously outside the scope of the duties of church ministry and employment for all personnel.

The diocese is committed to dealing with issues of sexual misconduct within its ranks in an open and straightforward manner. Officials will speak the truth. We will reach out to the injured. We will promote and protect the safety of children and families, women and men. We will stand by priests and deacons and employees of the church while upholding the right of the people to be safe and secure from risk and harm. We will promote healing where it is needed, guidance when it is called for, with firm justice and mercy towards all and a determination to do what is needed to correct and prevent sexual misconduct.

Since the principal attitudes that shine through many of the policies are compassion and accountability, diocesan policies can be effective public instruments to indicate a responsive and open approach to the matter of sexual abuse within the church. The very tone itself of the document can be an effective means to convey these attitudes. The committee proposes, therefore,

1. That all dioceses consider having a written policy on sexual abuse of minors.
2. That the tone of the diocesan policy, particularly in its introduction, be clearly pastoral, while appropriately dealing with the legal (civil and canonical) and financial obligations of the diocese.
3. That the policy be a public document thereby indicating that the local church is open to the accountability implied in it.
4. That any qualifying statements required in a policy be appropriately presented so that the pastoral tone not be diminished.

In a typical, rather well developed policy there are more than a few technical terms be they legal, medical or otherwise. Therefore, for both educational and interpretative reasons, it is proposed

5. That a glossary be provided of the technical terms used in the policy.

2. PREVENTION - EDUCATION

As one follows the evolution of diocesan policies into the "second generation" (revisions) category, it is evident that more and more attention is being given to matters of education and prevention. Obviously, in this context the use of the word "prevention" does not refer to preventing the development of the disorder pedophilia. It seems this fact has to be pointed out from time to time.

Through the quotations from the policies which follow, readers will get an impression of how the prevention-education topic is presented.

It is most important that those in church leadership become familiar and comfortable with the issues surrounding sexual abuse.

The most important step in dealing with problems associated with our sexuality is prevention. Prevention in turn requires awareness. Accordingly, the policy of this diocese is not avoidance of sexual issues, but rather affirmation of our own humanity as sexual beings. At the same time, as we recognize our essential humanity, we also must reaffirm our commitment to the dominant spiritual values which we have knowingly embraced as the basis for the dedication of our lives to the ministry of Jesus Christ.

Each adult is responsible for his or her own sexual growth and maturity.

Persons working with minors must always avoid the kind of contact that could cause comment on the part of reasonable people.

Priests have a special responsibility to be their brothers' keepers in these matters.

A priest discovering or determining he is having or has had trouble in the area of child abuse is strongly urged to speak with the bishop about these difficulties. In this instance the diocese will assist him to seek the help needed and do everything possible to support him.

Immediate help is offered to any priest who seeks help to control sexual behavior and to act in accordance with his sacramental commitment to celibacy and sexual continence.

The diocese recognizes that in order to more fully address the problem of sexual misconduct by church personnel, it must embark on a comprehensive program of education to create an atmosphere of understanding to help maintain the integrity of the ministerial relationship and prevent the misuse of power and authority.

All who minister to children in the church are to be aware of the causes and signs of child abuse, the steps to take to protect children, and the procedures to follow if abuse is suspected or observed.

All those involved in the appointment, hiring, or retention processes are educated about procedures designed to prevent the exposure of unfit persons to children or others who may be vulnerable.

Pastors are encouraged to provide some form of regular education about sexual issues in ministry for their staff, volunteers, and members.

In-service training and educational programs are offered regularly for priests, deacons, seminarians, employees, and volunteers regarding child sexual abuse and sexual molestation, reporting requirements, and diocesan policies and procedures.

Programs of clergy formation include psychological screening and background checks of prospective candidates. Although no perfect screening method exists, we are committed to using the currently accepted methods and continue working with competent professionals in strengthening that screening.

Applicants for the priesthood or permanent diaconate, priests seeking incardination, priests or religious seeking ministry or residence in the diocese, and employees and volunteers are screened for their fitness to work with minors.

All superiors of religious communities proposing names of individual religious for ministry or residence in parishes or other diocesan institutions, as well as those simply requesting priestly faculties, are required to state clearly in writing that there is no history which would render the individual unsuitable to work with minors.

No pastor, associate pastor, or director of any diocesan institution or facility is permitted to grant residence, or full time or part time or regular weekend ministry to an extern priest or religious without prior written approval from the diocese.

An independent review board meets regularly to review reports of child abuse and all actions taken in response to reports, to insure the integrity of the process, to offer advice regarding investigations, and to provide oversight of the handling of all cases.

The following excerpt makes a point that was emphasized in many different ways throughout the policies examined:

Any agent of the church who has actual knowledge of or who has reasonable cause to suspect an incident of child sexual abuse shall comply with any applicable reporting or other requirements of state or local laws, unless to do so would violate the priest-penitent relationship of the sacrament of penance.

Reasonable cause means to believe that a child has been subjected to sexual abuse. The suspicion of abuse should be based on the reasonable interpretation of the child's complaints or on observation of the child's physical condition, behavior, and/or changes in either over a period of time. It is not necessary that a reporting employee observe any external physical signs of injury to the child. It is sufficient to suspect that abuse has occurred when a child complains of having been sexually molested. In such cases, the report must be made.

Through its diocesan policy the local church is in a position to have some influence on how society at large copes with sexual abuse. The policy has potential to be an instrument for raising awareness, for education, and for prevention. It is proposed therefore

- 6. That policies make special reference to prevention and education measures in place.**

More and more dioceses are requiring better screening procedures for employees, volunteers, diocesan clergy, externs, religious and seminarians. Various questionnaires and forms are developed for this purpose. The committee sees this evolution positively and therefore proposes

- 7. That policies include a reference to appropriate screening procedures for seminarians, employees, and volunteers with responsibilities for dealing with the young.**
- 8. That the policy be communicated to priests and religious, and to employees if applicable, and that all acknowledge acceptance in a formal manner.**

Education sessions for clergy are receiving increasing attention. More than a few references in the policies allude to the importance of priests being their brothers' keepers. In this respect the committee proposes

- 9. That in educational sessions priests be provided with regular opportunities for updating their knowledge on child sexual abuse from viewpoints such as new scientific knowledge, church policy and canon law, civil laws, and issues of moral theology, professional ethics, the theology of sexuality, the pastoral care of victims, and coping with the disclosure of misconduct by a colleague.**

NB As documentation separate from this report on diocesan policies, the committee has arranged for a series of articles that hopefully will be helpful to NCCB members. They will be referred to throughout this report. Three are relevant to this proposal no. 9:

- "Pedophilia: Diagnostic Concepts, Treatment, and Ethical Considerations" by Fred Berlin, M.D., Ph.D. and Edgar Krout, M.A.
- "Sexual Abuse as an Abuse of Power" by James Gill, S.J., M.D.
- "False Memory Syndrome" by Paul R. McHugh, M.D.

Because a smooth working, comprehensive policy is potentially a good means for prevention and education, the committee proposes

- 10. That consideration be given to setting up a diocesan advisory body to evaluate periodically the effectiveness of the policy in place and to propose revisions as indicated.**

This body would be consultative in nature, independent of the day-to-day working of the policy, be seen to have an arms length relationship with regard to internal diocesan structures, and be responsible to the bishop.

3. ADMINISTRATIVE GUIDELINES

3.1 In General

Before entering into detailed procedural points, many of the policies have some general comments to contextualize what was to follow. Here are some examples.

The intent of all that follows is to promote a ministerial environment in which those who minister in the church and those who receive the church's services can expect to do so in safety.

The primary purpose of the policy is the safety of children, the well-being of the community, and the integrity of the church.

All involved are to be treated with candor, fairness, and dignity.

These policies and procedures are to be implemented with justice and equity: they shall also be fair and responsive to the pastoral needs of the victim, the victim's family, the parish community and diocesan community and to all other persons.

This policy sets forth a process of internal church governance and is not determinative of any civil or criminal liability of the accused, the diocese or any religious order involved.

All procedures may not apply to a given situation and may require modification to meet particular needs; therefore the bishop reserves the right to modify or replace these procedures at his discretion and commits himself to review them periodically for adequacy.

A prime objective of all investigations conducted under this policy is the determination of the fitness of the accused person for the ministry previously exercised in the church or for any other ministry in the church. In order to obtain the fullest information possible, such investigations and the information resulting from them shall be held confidential by all concerned except for mandatory reporting required by law.

Care must be taken to avoid defamation of the character of all concerned.

It is important for all the Christian faithful to know that both civil law and canon law provide penalties for the crime of falsehood in which innocent individuals become victims of false denunciation and calumny.

When an accusation is made, the rights of all persons involved must be protected. Prompt and incisive action is essential and non-negotiable.

The response of the diocese includes the pastoral care of the victim, the well-being of the community, and the assessment and treatment of the offender. Care is taken that all persons involved will be treated in a manner that is consistent with the gospel values of dignity, compassion, understanding, justice, as well as those standards which are normative in the wider professional community.

Every assurance is given that the diocese will spare no effort to determine the truth and to deal appropriately with the individual who is accused.

Retaliation and/or discrimination against any person who complains of or who reports sexual misconduct is strictly prohibited and will not be tolerated.

No action regarding a priest will be taken on the basis of anonymous, uncorroborated accusations.

Anonymous complaints are dismissed in the absence of accompanying firm, and/or readily verifiable, facts. The priest is informed of the anonymous complaint and of the disposition of the matter.

It is to be noted these policies are administrative and not penal in nature. They take into account the enacted and acknowledged rights and duties by civil and canon law.

(After nine years evolving) ... The policies and the procedures we have adopted reflect our experience and the studies of many others. These policies must always be construed in the light of the gospel and the principle salus animarum suprema lex, that is, the well-being of the people is our primary obligation.

The response of the diocese to any allegation of sexual misconduct by clergy, lay employees, or volunteers must be based in the gospel values of dignity, compassion, understanding, and justice.

Justice calls the church to respond with compassion and fairness to the persons involved and to uphold the integrity of the church's witness and ministry.

When an allegation is made against a priest assigned to an institution belonging to a religious community or other non-diocesan entity, or who is in residence in the diocese, his religious community or home diocese handles the complaint according to its policies and procedures. However, the diocese does not delegate its responsibility, as provided in this policy, to report when allegations come to it.

When allegations are made, the diocese requires full disclosure of any of the facts the one making the allegation might have.

Actions taken by the diocese when it receives an allegation of abuse by a priest are not an expression of any judgment concerning the veracity of the allegations, but rather are intended to indicate the serious nature of such cases and to respect the rights of all concerned.

We have no policy.... we would follow the policy of the local Roman Rite diocese, wherein the transgression allegedly took place.(an eastern rite).

It must be kept in mind that individual circumstances may prescribe a course of action that is at variance with these guidelines, particularly when the requirements of civil or canon law indicate a different approach.

Individual circumstances prescribing a course of action at variance with the guidelines will be documented.

These guidelines are not intended to create any rights in any person, to obligate the diocese to act at any time or in any manner, or to establish any responsibility of the diocese. In addition, there may be cases where the tenets of the Catholic religion, the prescriptions of canon law, or the greater good of all concerned require that action at variance with the provisions of these guidelines be taken.

We present these guidelines not because of past failures on our part, not to cause alarm or fear, but rather to set forth a clear policy for the protection of our clergy, deacons, religious and laity.

As was noted above, 116 of the 157 policies examined apply not only to clergy and religious, but to diocesan lay employees as well. With this inclusive approach the policy is a broader instrument for education. All who have to subscribe to it in a formal way (through written acceptance) would see themselves having special responsibilities within the diocesan church. The committee sees this trend as worthwhile and proposes, unless there is already a separate policy in place for employees,

11. **That consideration be given to having the diocesan policy apply to clergy, religious, and employees, in the context of sexual abuse, misconduct, exploitation, and harassment.**

If this approach seems feasible for a given diocese,

12. **That in the principal diocesan policy dealing with sexual abuse there be mainly general references to the manner of dealing with clergy and religious, and there be developed a sub-policy to cover the intricacies of canon law in their regard.**

From general information available, the committee is aware that a fair number of allegations are raised regarding acts that supposedly happened in the distant past. Obviously the requirements in different dioceses are varied, but there seems to be a growing need to differentiate between current and past allegations and the manner in which they are handled. Accordingly, the committee proposes

13. **That each diocese examine its history in this regard and, based on the risk to the innocent and the vulnerable, consider having a risk track and a non-risk track approach to implementing the procedures.**

Most policies make explicit provision for a detailed, investigative phase of an inquiry. This critical phase of the process is to be carried out as professionally as possible. Therefore out of fairness to all concerned it is proposed

14. **That because of the special skills required to do a proper and expeditious investigation, individuals with the primary responsibility for this role be given appropriate training before assuming the position.**

In the policies there are frequent references to confidentiality. There is of course no question of bending or breaking the sacramental seal. However, dealing with professional confidentiality in the face of imminent danger of child abuse is quite another question. The principle generally recognized is that professional confidentiality does not prohibit disclosure of information if there is a danger in not doing so. Moreover, there are statutory reporting mechanisms in place requiring this disclosure to specified authorities. Beyond this statutory provision the general rule in the case of the danger of child abuse is disclosure on a need-to-know basis. Disclosure for any other purpose is only made with the consent of the person providing the information. A final point: those in a position of responsibility are mindful of the negative consequences of invoking the confidentiality argument unnecessarily, an action which can lead to a perception by the public of cover up.

The complexity of dealing with an incident of sexual abuse is acknowledged by everyone who has had any kind of direct experience with the matter. All the more reason therefore that the whole problem be dealt with from the multidisciplinary perspective. In so approaching the issue, there is a greater prospect that all the individuals and groups involved - victim, family, parish community, diocesan church, the accused, and society at large - will be appropriately cared for and dealt with. Therefore, it is proposed

15. **That there be identified in each diocese experts from the many disciplines involved in the serious study of issues connected with sexual abuse in order to approach the problem in its pastoral, legal, psychological, sociological, medical, and educational dimensions.**

3.2. Civil Law

The role of diocesan attorneys is referred to throughout many of the policies. When an incident of sexual abuse comes to the attention of a diocesan official, attorneys are immediately informed in order to assure that the civil law responsibilities of the bishop are met. Here are some references to attorneys in other contexts.

In order to have access to the full response of the diocese it is not necessary to hire an attorney or to initiate legal proceedings. But it is the right of anyone to do just that.

Our offer of financial assistance in getting therapy and/or spiritual direction cannot and should not be taken as an admission of guilt on anyone's part.

Where an official proceeding is pending or about to be instituted, the diocese retains all records and other material that may be evidentiary which are related to the matter.

During the period of litigation the church offers support to the victims to every degree possible within the perimeters imposed by the diocesan legal counsel.

As regards the legal costs for the defense, dioceses take different approaches as illustrated by the following policies:

The legal costs for defense are borne by the perpetrator.

Should the matter become one of civil or criminal action, the diocese will cooperate with and respect the judicial process. The diocese will provide legal counsel to the priest.

The accused is advised to obtain an attorney and a canonical advisor at the accused's expense.

The accused is advised to enlist his/her own counsel, independent of that of the diocese. Diocesan assistance for such counsel may be available depending on the nature of the case.

The cost of legal assistance is borne by the priest. The diocese reimburses the priest for his reasonable legal expenses if he is found to be innocent of the allegations and in compliance with this policy.

The diocese has a right to take action against (the guilty person) to recover its judgment and legal expenses.

The vast majority of the policies are quite clear in stipulating ways in which they implement the principle articulated at the November 1992 NCCB General Meeting concerning civil law obligations in relation to sexual abuse cases. In this regard the committee proposes

- 16. That policies be reviewed to assure that this principle of honoring civil law obligations is articulated in a practical manner.**
- 17. That policies clearly state a willingness to cooperate with government authorities (civil and criminal proceedings) to the extent possible in the circumstances.**
- 18. That there be an explicit reference in the policy regarding coverage of the accused's legal expenses.**
- 19. That, while maintaining a pastoral tone, the policy be clear that there could be occasions when the Church may in justice defend itself.**

The committee draws your attention to two articles, among those referred to above at recommendation no. 9, concerning legal aspects to be attended to in relation to the sexual abuse question. These articles are:

- "The Role of the Diocesan In-House Attorney" by Jack M. Hammel
- "The Role of Outside Counsel" by Andrew Eisenzimmer

3.3. Canon Law

In such a serious and complex subject as the crime of sexual abuse of a minor by a cleric, canon law sets forth mandatory procedures. At the principle/guideline level many of the citations from the bishops given throughout this report are either the basis for or an expression of particular canons.

The many ways canon law can be articulated in a specific policy for a diocese are almost as varied as the dioceses themselves throughout the country. For that reason the committee has decided not to attempt to produce a model or typical policy. Moreover, as regards the canon law aspects touching on sexual misconduct, the members of the committee have noted the very complete report, dated September 1994, from the Committee on Canonical Affairs. Accordingly, only one further comment will be offered in this area. The review of the policies in place show that some are very brief and rely heavily on dealing directly with the canons in sorting out the various steps in the process. Others are quite lengthy and highly developed, spelling out in great detail how the canons are applied and the process unfolds in their dioceses. Both approaches have validity, especially when they are combined with competent and experienced personnel to implement them.

For your reference Appendix "A" of this report contains a bibliography of canon law articles on the topic of sexual abuse of minors by members of the clergy.

Appendix "B" is an outline of elements in a policy which includes canon law factors and other points as well.

3.4. Insurance

A review of the policies reveals that many dioceses have taken large portions of their procedures from sample policies supplied by their insurance companies. Some have simply taken the sample and, as it were, filled in the blanks.

Here are some excerpts regarding insurance from some of the policies reviewed:

The appropriate diocesan official notifies the diocesan attorney and (the insurer) immediately.

Ours is primarily a pastoral mission. In the legal system each one's rights are affirmed and defended. The diocese has contractual obligations with its insurers and we are bound to live up to them. It is our hope and preference to abide by our stated pastoral mission as well as our contractual obligations.

Reports of incidents must be given to the underwriting managers immediately upon receipt of knowledge by a responsible diocesan official. The diocese must use the sensitive claims team to investigate and handle such cases.

Notification of the incident will be given to the diocesan insurers in accordance with the terms of any applicable insurance policies.

Any insurance service for the diocese is put on notice of a possible claim and is requested to provide whatever service or coverage is available.

The (diocesan) delegate reports to the insurer of the diocese that an incident has taken place when it is established that this is in fact the case.

For initial treatment costs medical insurance provides primary coverage, with the diocese covering the excess of the insurance allowance. For second occurrence treatment, medical insurance provisions apply, with no additional obligation by the diocese. It is a condition of diocesan insurance coverage that for a priest who engages in sexual misconduct the diocese will not have liability insurance for that priest for a period of at least five years from the time the incident was reported to the insurance carrier.

Diocesan insurance does not cover an individual acting outside the scope of ministry within the church.

If the tone of the policy is an asset for its pastoral effectiveness and for education, it probably should not look as if it came directly off the desk of the insurance carrier. Conversations with personnel from these companies indicate that they are concerned and caring people, but they do need to see that their interests are protected by certain points being covered in diocesan policies. Accomplishing this end does not impede those responsible for the pastoral and education aspects from effectively putting their stamp on the policies. The committee therefore proposes:

- 20. That, to the extent possible, the pastoral and educational tone of the policy be maintained with reference to the insurance aspects that must be included in it.**
- 21. That dioceses seek insurance contracts to provide optimum pastoral and clinical support to those in need.**

As mentioned above, some insurance carriers have given sample guidelines or a framework around which a policy could be developed. For your information Appendix "C" contains one such example from The Catholic Mutual Group.

The committee once again refers you to another part of this report for an article done at its request entitled: "Sexual Abuse and the Catholic Church: An Insurance Viewpoint," authored by the leadership of the Catholic Mutual Group.

4. VICTIMS

Though many of the principles/guidelines already quoted are pastoral in nature, the following seem to be in a category by themselves.

In the Scriptures, Benjamin was the youngest of the children of Jacob and Rachel, profoundly vulnerable and even uncertain of his own name and identity (Genesis 35: 16-20). Born into a family troubled by rivalry and jealousy, and exploited by his siblings at times, Benjamin is a symbol for all whose early years are troubled. ...Thus, Benjamin is a symbol for the victim, the perpetrator, and the larger fabric of society which abandons its apathy and comes to an understanding of the evil of abuse, working for a new sense of justice and rehabilitation for all. (Excerpt from the introduction to Project Benjamin, "an active, pastoral response to persons involved in sexual abuse.")

We are open and respect your complaint.

We will provide an advisor/advocate, if you so choose.

WE will help you obtain counseling support.

We will provide information about support groups.

We will help you obtain spiritual direction.

We will help you bring your concern to the proper church officials outside our diocese.

While we are all in need of redemption and forgiveness for our failings, there is a special harm and injury given to those who are victim-survivors. We use that term because we want to underscore the fact that people are not simply victims as though what happened to them stops there. People are also resilient and however difficult the path to wholeness may be, they are survivors. By using the joint term, we acknowledge their being wounded. At the same time we mean to urge on their healing and recovery and aim to help it when we can.

Compassion requires that primary attention be given to the person alleged to have been offended.

Diocesan policy encourages the use of a friend, family member, colleague or anyone else of the person's choosing to accompany a person who is making a complaint.

In principle, nothing about what the pastoral team members say or do should leave room for inference that their purpose is to investigate the validity of the allegation.

Church authorities offer pastoral, moral, and spiritual help to the person and family involved. Such assistance follows from the caring role of the bishop and the church and shall not be considered as an indication that the diocese is in any way culpable or responsible for the actions of the employee.

Alleged victims and their families are advised that they may have legal rights that can be vindicated only with the assistance of an attorney of their choosing.

Pastoral support is offered to the victim if the parents are consenting and if such is allowed by the appropriate public authority.

No matter their age or experience, minors are not blamed for causing or encouraging the actions of the offender, even if at times the child appears somewhat responsible.

While reconciliation remains as desirable, the diocese in no sense requires participation as a condition for further involvement in the church community.

The victim should be neither pressured nor rushed to take part in a process of reconciliation.

The diocese will not require an attempt at reconciliation between violator and victim. The involvement of any diocesan personnel in non-authorized reconciliation efforts is treated as a violation of this policy.

Families often require the same compassion and sensitivity as that of the victims and are not to be forgotten in the healing process.

Only a minority of policies has elaborate guidelines for dealing with the affected parish community. For those that do the underlying principle seems to be:

In responding to affected parish communities the diocese is guided by these three principles:

- these parishes undergo a complex process of grieving when they learn a trusted and respected leader has been accused;**
- a most important element in healing is receiving accurate information of what happened;**
- the healing of the community is a multidisciplinary challenge**

The principles quoted above illustrate the compassion that informs many of the policies. It is important for victims to know early in the process of healing what the diocese can do for them and what it cannot do and why. It is generally accepted that the victim's greatest need is to be heard, and to be told of the church leadership's sorrow that the person has been hurt. The individual should be informed that appropriate action will be taken in regard to the perpetrator, and that the church will help the victim with the process of recovery. Providing information to the victim concerning the perpetrator can be an important aspect in the healing process but it is best read on a case by case basis by the professionals providing the care.

As regards victims, the committee proposes

22. **That every policy recognize that primary attention be given to the person alleged to have been offended, to the family, and to the parish community.**
23. **That the policy indicate there is some kind of multidisciplinary body available to provide concrete, direct, and individualized assistance to victims, their families, and the affected parish community.**
24. **That the diocese seek ways to involve the people in general in the whole process of healing the often serious and long-lasting aftereffects of child sexual abuse.**
25. **That the diocese promote sessions to affirm and encourage the body of priests, whose morale can be adversely affected by the actions of relatively few of their colleagues.**

You are referred in another part of this report to two more articles done at the request of the committee and focusing on victims. One is by Coadjutor Archbishop Harry J. Flynn entitled "Care for Victims and Their Families." The other, by Reverend Stephen J. Rossetti, Ph.D., D.Min. entitled "Parishes as Victims of Child Sexual Abuse."

5. ACCUSED

In the policies reviewed, the principles/guidelines dealing with the accused are generally consistent and frequently make the same points. Here is a sampling:

In both the secular courts and in canon law a person is presumed innocent until proven otherwise.

The presumption of innocence does not preclude the diocese from taking prudent action before the investigation is completed.

The diocese is solicitous of the needs of the accused priest in order to see that he gets the personal support he needs during a very difficult time.

At no time after an allegation has been made does the bishop or any priest involved in the case hear the sacramental confession of the accused priest.

Diocesan representatives dealing with the accused make it clear they act as administrators and not as counselors or confessors.

When a priest is asked to take a leave from his assignment because of an accusation of sexual misconduct, the Director of Priests' Personnel will assist him in finding housing, arrange for his financial support, and encourage him to receive pastoral and psychological support during the time immediately following the accusation.

Any administrative leave will be planned and circumstances determined in a way specific to each situation and to each priest in accord with canon 1722. In general, an administrative leave will be time limited, will allow for re-determination at the end of such time limit; will specify living arrangement, location, financial support; will address treatment, conduct and aftercare.

Because the stigma and shame associated with sexual abuse of children might make the accused fear that he/she will be abandoned by the church, the pastoral team does whatever it can to help the accused to experience the church's support whatever the outcome of an investigation or trial.

Participation of the accused cleric in appropriate professional counseling is required as a matter of clerical obedience (c.273). Counseling referral is for treatment, not for punishment.

In all possible cases the offender should be the primary person responsible for the payment of the victim's therapy and attendant expenses and will be required to reimburse the diocese for all expenses incurred.

The diocese has the right to take action against the perpetrator to recover its judgment and legal expenses.

In cases involving rumor, especially when the accuser retreats into anonymity, the case may be dismissed as poorly founded. However, the activity of the person in question is monitored to see what develops, if anything.

The diocese is responsible for the salary of a priest undergoing treatment who has been relieved of his pastoral responsibilities in accordance with this policy.

An accused cleric does not have the right to be assigned a ministry, nor to residential or long-term therapy at diocesan expense.

Note: Two dioceses have a protocol for dealing with an allegation against the bishop. One is a full page in length inserted in the general diocesan policy. The other states:

Allegations against the bishop are beyond the scope of this policy. Direct all allegations to the Vicar General who contacts the Papal Pro-Nuncio and the appropriate government department.

In most of the policies, certainly most in the "second generation" category, the accused is the principal subject in the section dealing with the investigation and the canonical disposition of its conclusions. One of the most difficult areas for a diocesan bishop is the appropriate handling - timing especially -of the administrative leave question. Some dioceses are developing a graduated series of restrictions, to be invoked depending on the degree of certainty the bishop has regarding the allegations.

On the question of certainty The Cardinal's Commission on Clerical Sexual Misconduct with Minors (Chicago: June 1992, 21) had the following comment:

This preponderance of evidence standard can be stated in this way: Would a reasonable person, viewing the evidence in the light most favorable to the victims, believe it was more likely than not that the alleged acts occurred, that they constituted sexual misconduct, and that the priest committed the acts. Hearsay is acceptable evidence to reach this conclusion. Its reliability determines the weight given to it; its reliability is determined by the Commission (the trier of fact) from the totality of the circumstances.

Given the complexity of the procedures involved as regards the accused, the committee has no special recommendations for this section. The quotations cited from the policies in use were offered principally to give a sense of how the accused is generally referred to in the policies. Next to appropriately caring for the victims, however, the future of the accused when the allegations are substantiated provides an enormous challenge for religious leaders and for the diocesan church. This report therefore has a separate section on the question of reassignment or reintegration into ministry.

6. REASSIGNMENT

This part of the policies - reassignment or reintegration into ministry - is evolving at a very rapid rate, as evidenced in the policies reviewed. Around this topic there is a convergence of all aspects of the sexual abuse question: pastoral, preventative, legal (civil and canonical), financial, clinical, and local (smaller dioceses simply do not have the possibilities of the larger ones.) Here are some citations from the policies themselves on this question.

Some of the elements that help shape the bishop's decision are:

- **the outcome of proceedings in the civil courts;**
- **the advice and judgment of professional counsellors who have treated the priest;**
- **the wellbeing of those ministered to by the church;**
- **the best interests of the church.**

Upon the conclusion of therapy and aftercare a priest or deacon may be assigned to a parochial ministry, be assigned to a non-parochial ministry, or be assisted to resign from all clerical ministry. Some of the factors that will be considered in deciding to return a cleric to active ministry are: feelings of the victim(s), ability to assure the safety of the community or organization to be served, availability of an appropriate assignment.

If the bishop determines, after receiving the recommendation of the Advisory Committee, that a priest will not be returned to ministry, the bishop will offer him a program of retraining so that he can find employment and become self-supporting.

If the priest does not express a desire to return to restricted ministry or to live in such a supervised setting, or to resign from ministry and seek laicization, the diocese may pursue appropriate courses of action permitted under the Code of Canon Law.

If it is determined that no reasonable assurance can ever be given by diocesan officials that a given priest will not succumb again to behavior of the kind which brought the original complaint, no matter what the assignment, the priest will be counseled out of the ministry to another way of life, depending on the circumstances of each case. If a priest holds an ecclesiastical office, he will be asked to resign it; if he refuses to tender his resignation, the canonical procedures for removal from office will be followed or a formal ecclesiastical trial may be instituted according to canon 1740 and following of canon law.

... a convicted priest pedophile will not be permitted to return to active priestly ministry.

No priest who engages in sexual misconduct with a minor should be returned to a parish ministry or any other ministry with access to minors. No assigned conditions exist which make an exception to this.

An incardinated priest who has been judged guilty of child sexual abuse may be considered for a restricted assignment but only in accord with recommendations from the rehabilitation team.

The priest-monitor serves as a regular link between the returning priest and the diocese, as a friend for a fellow priest in very difficult circumstances, and insures that the aftercare program agreed on is being carried out.

Future ministry will require a full sharing with the bishop of all information developed in the course of treatment; authorization from the individual under treatment is required in all cases to allow the treatment providers to communicate freely with the bishop.

The diocese does not accept for ministry a religious or non-incardinated diocesan priest whom it knows to have sexually abused a minor.

In this section of the report on diocesan policies the committee offers some reflections based on previous NCCB discussions, and current publications, followed by several suggestions.

First of all it is widely acknowledged that the reassignment challenge involves seeking how to integrate the multiple factors that come into play. No single set of factors can or should dominate to such an extent that others are not properly honored.

The reassignment difficulty is grounded in such theological considerations as the identity of the priest in the church, the sacramentality of priestly ordination, and the priest's relationship to the diocese and to the bishop. Pastoral attention focuses on combining compassion and accountability with a view to understanding and forgiveness, along with a prudential judgment on the likelihood of recidivism. It is generally accepted that priests who have offended against children should never return to any ministry that includes minors. The possible return to some form of ministry has also to be read in the light of how the victim will be affected and on how well the church community is prepared. How open the perpetrator is to disclosure of his situation to those with a need to know is also of great importance.

More specifically, and allowing for the special characteristics of each case, the bishop is faced with issues such as

- the nature of the offense
- the depth of conversion
- the sincerity of resolve
- the availability of ministry
- adequate supervision, and
- stewardship of diocesan finances

Part of the reality of reassignment of one guilty of sexual abuse of minors is the substantial risk of liability for the diocese. It is generally agreed that the cause of action arising out of a priest's sexual misconduct is ordinarily grounded in the theory of negligent selection or retention. Hence the critical importance of exhibiting a reasonable standard of care. The treatment center normally has a key role in assisting diocesan officials at this stage. The conditions and the decision should also be in writing. All of which leads the committee to propose

- 26. That, given the complexity inherent in the reassignment question, the diocesan policy make provision for some type of advisory body to assist the bishop in this regard.**

As an incardinated cleric in the diocese, the individual has a right to ministry and/or support by the church. The dilemma for the bishop is weighing this right over against the duty to protect the diocesan church and society from a possible recidivist. It is acknowledged that priests in recovery should be under some type of supervision as long as they remain the responsibility of church authorities. The personnel available in the diocese and the financial resources needed are major factors in reaching acceptable conclusions. In deciding whether to permit a priest to return to ministry, therefore, each diocese has to adapt to its own possibilities, while living up to its obligations of fairness and justice.

For your information here are the options offered by one diocese:

1. Return to ministry with appropriate restrictions and follow-up program. The priest's immediate supervisor is fully informed of his background and current status.

2. Three to five years outside active ministry with a good prognosis for return. From the beginning the hope of both the priest and the bishop is that some form of ministry can be restored, and efforts are made to prepare for a possible return. Any return will involve restrictions and an aftercare program. The purpose of this program is to allow the priest to demonstrate continuing and progressive signs of recovery.
3. Three to five years outside active ministry with the understanding that there is little chance of return. A new assessment would be made should the priest in question petition for reinstatement to active priestly ministry.
4. No possibility of return. In this case the diocese assists the priest to petition for laicization. Should the priest be unwilling to submit such a petition, the diocese will initiate appropriate canonical procedures to preclude the priest from active ministry.

There is much to be said for a policy being as clear as practical in local circumstances regarding the possibilities of returning to ministry for a priest involved in sexual abuse. The committee therefore suggests:

27. **That the policy of the diocese be as detailed as feasible on the possibilities and types of reassignment that may or may not be open to a priest guilty of sexual abuse.**

The committee refers you to another article it has had done, by Frank Valcour, MD, entitled "Expectations of Treatment for Child Molesters." The committee is planning a major article on recidivism and long term care; this should be available late in the fall.

Finally it is the intention of the committee to prepare a major document on the practice and possibilities with regard to reassignment to ministry. This document should be ready toward the end of the year.

7. MEDIA

Most of the policies have at least a brief reference on giving information to the public. The following is a sampling of the approaches taken:

There is a primary spokesperson to the media both in answering questions about a particular case and in addressing the broader questions raised. Release of such information will preserve and protect the integrity of the policy and respect the rights of those involved.

The spokesperson is apprised as soon as the diocese learns of allegations or investigations.

All complaints are treated as confidential. Therefore the diocese neither confirms nor denies to the media 1) the identity of the person communicating the allegation; 2) the identity of the minor; and 3) that a complaint has been made against a particular person until such time as the person has been charged by the civil authorities, or until the allegation has become a matter of public knowledge.

To highlight the importance of the communications factor in dealing with sexual abuse cases, the committee proposes:

- 28. That the diocesan policy make reference to an approach for consistently relating with the media and to a designated, well informed and experienced spokesperson (with substitute) for all inquiries and news conferences.**

For an in depth treatment on this topic, you are referred to an article done for the committee by Msgr. Francis Maniscalco of the USCC's Office for Media Relations entitled "The Media and Sexual Abuse Cases: Elements of a Media Plan."

8. CONCLUSION

The committee is most grateful for the opportunity it has had to review and to reflect on the policies dealing with sexual misconduct in the church. Collectively they represent a powerful response to a difficult and disturbing phenomenon common to society at large. The "Five Principles" articulated at the November 1992 General Meeting continue to shine through and influence the evolution of the policies.

It is the hope of the Ad Hoc Committee on Sexual Abuse that this sharing of a sampling of what you the members of NCCB are saying in your local policies, along with the commentary and suggestions offered in this report, will be a worthwhile contribution to the evolution of the policies through the "second" and on to the "third" generation of the revisions underway.

APPENDIX A
AD HOC COMMITTEE ON SEXUAL ABUSE
DIOCESAN POLICIES
SUMMARY OF COMMITTEE SUGGESTIONS
SEPTEMBER 12, 1994

1. GENERAL GUIDELINES

1. That all dioceses consider having a written policy on sexual abuse of minors.
2. That the tone of the diocesan policy, particularly in its introduction, be clearly pastoral, while appropriately dealing with the legal (civil and canonical) and financial obligations of the diocese.
3. That the policy be a public document thereby indicating that the local church is open to the accountability implied in it.
4. That any qualifying statements required in a policy be appropriately presented so that the pastoral tone not be diminished.
5. That a glossary be provided of the technical terms used in the policy.

2. PREVENTION - EDUCATION

6. That policies make special reference to prevention and education measures in place.
7. That policies include a reference to appropriate screening procedures for seminarians, employees, and volunteers with responsibilities for dealing with the young.
8. That the policy be communicated to priests and religious, and to employees if applicable, and that all acknowledge acceptance in a formal manner.

9. That in educational sessions priests be provided with regular opportunities for updating their knowledge on child sexual abuse from viewpoints such as new scientific knowledge, church policy and canon law, civil laws, and of moral theology, professional ethics, the theology of sexuality, the pastoral care of victims, and coping with the disclosure of misconduct by a colleague.
10. That consideration be given to setting up a diocesan advisory body to evaluate periodically the effectiveness of the policy in place and to propose revisions as indicated.

3. ADMINISTRATIVE GUIDELINES

3.1 In General

11. That consideration be given to having the diocesan policy apply to clergy, religious, and employees, in the context of sexual abuse, misconduct, exploitation, and harassment.
12. That in the principal diocesan policy dealing with sexual abuse there be mainly general references to the manner of dealing with clergy and religious, and there be developed a sub-policy to cover the intricacies of canon law in their regard.
13. That each diocese examine its history in this regard and, based on the risk to the innocent and the vulnerable, consider having a risk track and a non-risk track approach to implementing the procedures.
14. That because of the special skills required to do a proper and expeditious investigation, individuals with the primary responsibility for this role be given appropriate training before assuming the position.
15. That there be identified in each diocese experts from the many disciplines involved in the serious study of issues connected with sexual abuse in order to approach the problem in its pastoral, legal, psychological, sociological, medical, and educational dimensions.

3.2. Civil Law

16. That policies be reviewed to assure that this principle of honoring civil law obligations is articulated in a practical manner.
17. That policies clearly state a willingness to cooperate with government authorities (civil and criminal proceedings) to the extent possible in the circumstances.
18. That there be an explicit reference in the policy regarding coverage of the accused's legal expenses.
19. That, while maintaining a pastoral tone, the policy be clear that there could be occasions when the Church may in justice defend itself.

3.3. Canon Law

3.4. Insurance

20. That, to the extent possible, the pastoral and educational tone of the policy be maintained with reference to the insurance aspects that must be included in it.
21. That dioceses seek insurance contracts to provide optimum pastoral and clinical support to those in need.

4. VICTIMS

22. That every policy recognize that primary attention be given to the person alleged to have been offended, to the family, and to the parish community.
23. That the policy indicate there is some kind of multidisciplinary body available to provide concrete, direct, and individualized assistance to victims, their families, and the affected parish community.

24. That the diocese seek ways to involve the people in general in the whole process of healing the often serious and long-lasting aftereffects of child sexual abuse.
25. That the diocese promote sessions to affirm and encourage the body of priests, whose morale can be adversely affected by the actions of relatively few of their colleagues.

5. ACCUSED

26. That, given the complexity inherent in the reassignment question, the diocesan policy make provision for some type of advisory body to assist the bishop in this regard.
27. That the policy of the diocese be as detailed as feasible on the possibilities and types of reassignment that may or may not be open to a priest guilty of sexual abuse.

7. MEDIA

28. That the diocesan policy make reference to an approach for consistently relating with the media and to a designated, well informed and experienced spokesperson (with substitute) for all inquiries and news conferences.

8. CONCLUSION

APPENDIX B

SELECT ISSUES IN LAW ON THE CLERGY

1. John P. Beal, "Administrative Leave: Canon 1722 Revisited," *Studia Canonica* 27 (1993) 293-320.
2. John P. Beal, "Doing What One Can: Canon Law and Clerical Sexual Misconduct," *The Jurist* 52 (1992) 642-683.
3. Nicholas P. Cafardi, "Stones Instead of Bread: Sexually Abusive Priests in Ministry," *Studia Canonica* 27 (1993) 145-172.
4. Peter Cimboric, "A Psychologist Looks at Sexual Misconduct," *The Jurist* 52 (1992) 598-614.
5. Bertram F. Griffin, "The Reassignment of a Cleric Who Has Been Professionally Evaluated and Treated for Sexual Misconduct with Minors: Canonical Considerations," *The Jurist* 51 (1994) 326-339.
6. L.M. Lothstein, "Can a Sexually Addicted Priest Return to Ministry After Treatment? Psychological Issues and Possible Forensic Solutions," *The Catholic Lawyer* 34 (1991) 89-115.
7. Francis Morrissey, "Procedures to Be Applied in Cases of Sexual Misconduct by a Priest," *Studia Canonica* 26 (1992) 39-73.
8. Francis Morrissey, "The Pastoral and Juridical Dimensions of Dismissal from the Clerical State and Other Penalties for Acts of Sexual Misconduct," *Proceedings of the Canon Law Society of America* (1990) 221-239.
9. Raymond C. O'Brien and Michael T. Flannery, "The Pending Gauntlet to Free Exercise: Mandating That Clergy Report Child Abuse," *Loyola of Los Angeles Law Review* 25 (1991) 1-56.
10. Jerome E. Paulson, "The Clinical and Canonical Considerations in Cases of Pedophilia: The Bishop's Role," *Studia Canonica* 22 (1988) 77-124.
11. James H. Provost, "Some Canonical Considerations Relative to Clerical Sexual Misconduct," *The Jurist* 52 (1992) 615-641.

APPENDIX C

SOME ISSUES IN A POLICY ON SEXUAL ABUSE

Have a plan in place, along with the personnel for implementing it, before an accusation is received.

1. Be sure the plan is in harmony with local civil laws.
2. When a complaint is to be made:
 - To whom should it be directed?
 - What is to be done for the victim(s)? To what extent?
 - What is to be the situation of the accused cleric while the investigation is pending?
 - What is the procedure for dealing with the media and the public?
 - In what manner and by whom will the complaint be evaluated?
 - Who will do what, when?
 - What procedure will be followed to reach a definitive resolution of the complaint?
 - What are the possibilities for reassignment, and how will that be decided?
3. Establish a working relationship with a treatment center.
4. Promulgate and publicize the policy.
5. Follow the policy.

APPENDIX D

CATHOLIC MUTUAL GROUP

SAMPLE POLICY RELATING TO SEXUAL MISCONDUCT

[The following policy is a sample and is provided only to assist a (Arch)Diocese in formulating a policy. Use of this sample is not required. Prior to the adoption of any policy on sexual misconduct, a (arch)diocese should obtain the advice of legal counsel.

If used, this sample policy must be revised as necessary to comply with applicable state and local laws and to conform to the organizational needs, abilities, and requirements of a particular (arch)diocese. No review of individual state and local laws was made in the preparation of this sample policy.

Comments appearing in brackets are those of the drafter and are not part of the policy itself. They should be removed by the (arch)diocese which adapts this sample for its own use.]

1.0 Policy. It is the policy of (Arch)(Diocese), that sexual misconduct by personnel of (Arch)(Diocese) while performing the work of the (Arch)(Diocese) is contrary to Christian principles and is outside the scope of the duties and employment of all personnel of (Arch)(Diocese). All personnel of (Arch)(Diocese) must comply with applicable state and local laws regarding incidents of actual or suspected sexual misconduct, and with the following requirements.

This policy does not address sexual misconduct in general, but only in the special circumstances described herein. It is intended to establish requirements and procedures in an effort to prevent sexual misconduct by personnel of the (Arch)(Diocese) and the resulting harm to others, while the work of the (Arch)(Diocese) is being performed, and to provide guidance to the personnel of the Diocese on how to respond to allegations of sexual misconduct if any do occur.

2.0 Definitions. For the purposes of this policy only:

2.1 "Sexual misconduct" means any sexual conduct of (Arch)(Diocese) personnel while performing the work of the (Arch)(Diocese) which is:

a. Unlawful; or

b. Contrary to the moral instructions, doctrines and canon law of the Catholic Church and causes injury to another.

2.2 "Personnel" includes all personnel of the (Arch)(Diocese), including officers, employees, lay volunteers, clerics and religious personnel.

3.0 Distribution of Policy. A copy of this Policy shall be distributed as follows:

[A sample "acknowledgement of receipt" form is attached for those dioceses which may wish to use such a form.]

4.0 State and local laws. [The following is a summary of reporting and other requirements of applicable state and local laws relating to incidents of sexual misconduct.] OR [Attached to this Policy is a copy of the reporting and other requirements of applicable state and local laws relating to incidents of sexual misconduct.]

- 5.0 **Education.** The following personnel of the Diocese, and such other personnel of the (Arch)(Diocese) as (identify position) may require from time to time, must attend designated educational programs on methods of recognizing and preventing sexual misconduct involving children or others:

Other personnel of the (Arch)Diocese are encouraged to attend such educational programs.

- 6.0 **Background and reference checks.** Beginning (date), the following prospective and current personnel of (Arch)(Diocese) shall complete an informational questionnaire, a copy of which is attached hereto:

[A sample informational questionnaire is attached as Example A. An alternative which has been suggested for priests is the adoption of an agreement between the (arch)diocese and appropriate religious Orders that the order will disclose to the (arch)diocese, in advance of the canonical presentation of any priest, any knowledge by the Order of actual or alleged physical or sexual abuse by the priest. The Diocesan clergy's background would of course be monitored by the (Arch)bishop and his clergy personnel director.]

- 6.1 Completed questionnaires shall be reviewed and, as appropriate, investigated by (identify position), and shall be maintained in the personnel file of the (arch)diocese, with access limited to (identify positions).
- 7.0 **Obligation to report.** Any personnel of (Arch)(Diocese) who has actual knowledge of or who has reasonable cause to suspect an incident of sexual misconduct by any personnel of (Arch)(Diocese) shall comply with any applicable reporting or other requirements of state and local laws (unless to do so would violate the priest/penitent relationship of the Sacrament of Reconciliation), and shall report to the (Arch)(Diocese) as follows:
- 7.1 A verbal report of the incident shall be made immediately to (position in (Arch)Diocese) and a written report shall be prepared. [A sample reporting form is attached as Example B.]
- 7.2 (Position identified in paragraph 7.1) shall immediately notify the (identify who in (Arch)Diocese should receive notice), (identify attorney) and (identify insurance administrator) of the reports.
- 8.0 **Investigation of incident reports.** Each reported incident will be immediately investigated, with care taken not to interfere with any criminal investigation, and with a high level of christian care, concern and confidentiality for the alleged victim, the family of the alleged victim, the person reporting the incident, and the alleged perpetrator.
- 8.1 Legal advise both civil and canonical, shall be immediately obtained; the investigation shall be conducted by (identify position(s) in (Arch)Diocese).
- 8.2 Investigation of a priest shall be made in accordance with Canon Law. (see canons 1717 and following)

- 8.3 The alleged perpetrator will be immediately relieved of responsibilities to (Arch)(Diocese) and placed on administrative leave pending the outcome of the internal and any outside investigation, such leave to be with or without pay or benefits as (position in (Arch)Diocese) may decide.
- 8.4 Appropriate records will be kept by (identify position) of each incident reported and of the investigation and the results thereof. Such records shall be marked confidential and be securely kept at (identify location), under lock, with access thereto limited to only the following: (insert position(s) in (Arch)Diocese).
- 8.5 Notification of the incident shall be given to insurers in accordance with the terms of applicable insurance policies.
- 8.6 When accusations are made of sexual misconduct involving personnel of the (Arch)(Diocese), contact by (identify position in (Arch)Diocese) with alleged victim and family should be promptly initiated. Contact should be made by priestly counselors chosen by the (arch)bishop for the purpose of offering whatever concern or solace may be needed, with no comment as to the truth of any accusation. Medical psychological and spiritual assistance and, in appropriate instances, economic assistance may be offered in the spirit of christian justice and charity, but legal advise must first be obtained.
- 8.7 Any media contact or inquiries regarding an incident of sexual misconduct by personnel of (Arch)(Diocese) must be directed to (identify position in (Arch)Diocese).
- 9.0 Action where guilt determined. Any non-clergy personnel of (Arch)(Diocese) who admits to, does not contest, or is found guilty of an incident of sexual misconduct shall be immediately terminated from employment and any position of responsibility with (Arch)(Diocese). Any clergy in similar circumstances will be suspended from the exercise of his ministerial duties according to the provisions of canon law. Further penal sanctions, including, but not limited to, dismissal from the clerical state, may be contemplated pending the outcome of any civil/criminal actions, if any.

11/16

AD HOC COMMITTEE ON SEXUAL ABUSE

OBJECTIVE NO. 2

REPORT ON EVALUATION AND TREATMENT CENTERS

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INTRODUCTION

One of the objectives for the Bishops' Ad Hoc Committee on Sexual Abuse relative to the use of evaluation and treatment centers. The objective reads:

To compile descriptions of sexual abuse evaluation and treatment centers, church-related and others - for priests and lay employees - including their specialties, style of contact with referring bishops, and type of client information shared; to collate a series of key questions their professional staff expect to be asked by bishops on the occasion of a referral, along with a list of questions the bishops themselves may be asked; and to provide bishops with suggested criteria for looking at evaluation and treatment centers.

This report covers ten evaluation and treatment centers that were approached to cooperate in this review. These facilities were selected following conversations with senior staff of the National Association of Church Personnel Administrators and a review of the most recent edition (1992) of their publication **Treatment Facility Resource Manual**.

These centers were requested to supply responses to questions based on the four-part outline given at the beginning of this report. The bishops on the ad hoc committee are grateful for the 100% response by these facilities and for the insights they offered for consideration by the bishops.

Supplying this material for review by NCCB members does not imply endorsement by the ad hoc committee of any or all of the facilities described. Their self-descriptions really do speak for themselves. The criteria for assessing a potential facility for use by a bishop are also in the words of the respondents themselves.

The Ad Hoc Committee on Sexual Abuse is grateful to these and to all other centers for care that are living out so explicitly the healing mission of the Church.

Later in the fall there will be an updated version of this report available for NCCB members based on a survey of the bishops in mid-September regarding all of the facilities that they have been using.

CENTERS REPORT - OBJECTIVE NO 3

PART 1

**JOHNS HOPKINS MEDICAL INSTITUTIONS
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES**

600 N. Wolfe Street/Meyer 4-113
Baltimore, MD 21287-7413
Phone: 410-955-3130
Contact person: Paul R. McHugh, M.D.

1. DESCRIPTION

1.1. In General

Our facility consists of the inpatient and outpatient services of the Department of Psychiatry of Johns Hopkins. This is an extensive facility but one in which 10 beds are set aside for the study of patients who have trouble with various forms of behavioral problems, including sexual problems and eating problems.

1.2 Specialties

These patients represent one group though in a set of specialty units here in our Department. We also have geriatric psychiatry, depressive disorders, pain disorders and the like separately studied by specialists.

1.3 Style of contact with referring bishop

In the past, our way of relating to a referring bishop or a director of a church order was to discuss with him and the referring priest exactly what was sought and how the information would be shared. For the most part, the agreed upon information that was to be shared was all those matters that related to the public function of the referred patient, particularly those functions that would bring trouble and reveal any failure to maintain a trusting relationship with parishioners.

1.4 Type of client information shared with bishop

We certainly encourage the patient to permit us to share with the bishop all aspects of the clinical situation that will reveal the nature of the problem and its potential for treatment and recovery. After all, the purpose of evaluation is for everyone to know the truth.

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THE INSTITUTE OF LIVING

400 Washington Street
Hartford, Connecticut 06106
Phone: 203-241-8000

Contact Person: Heidi Williams McCloskey, RN, MSN, CS

1. **DESCRIPTION**

1.1. In general

Founded in 1822, The Institute of Living is a comprehensive, non-profit, hospital-based mental health network for the evaluation, treatment, and follow-up care of psychiatric, emotional, and addiction disorders. The Institute offers a broad spectrum of services and programs that are available in connection with inpatient, residential and outpatient care. Located in Hartford, Connecticut, The Institute provides service for the general population of all age groups. Our philosophy is to treat people in the least restrictive environment possible.

1.2. Specialties

The Program for Professionals at the Institute of Living is a unique psychiatric service for the evaluation and treatment of priests and men and women religious as well as other professionals. Issues of stress, emotional disorders, depression, sexual disorders, chemical dependency, and patients with all other psychiatric diagnoses, are treated confidentially in an atmosphere of compassion and respect.

A variety of settings permits flexibility in providing care. An individual may enter the system as a outpatient; a day patient with or without residential program; or as an inpatient. All cases involving sexual issues receive a core consultation consisting of extensive interviews with senior psychiatrists, psychological testing, vocational evaluation, and psychosexual assessment. Neurological and psychoneurological testing, as well as full medical evaluation, is completed when appropriate.

As an outpatient, the individual enters the system through the hospital's Consultation Service where brief or comprehensive evaluations are completed by The Institute's experts in general psychiatry, human sexuality, forensic psychiatry, spirituality, and psychopharmacology. Patients may participate in individual and/or group therapy.

For the partial hospital patient, the Professional Program's Day Treatment Center provides intensive evaluation and treatment within a therapeutic milieu. A multi-disciplinary team of experienced clinicians, including psychiatrist, psychologist, priest, nurse, and social worker provides evaluation and treatment through individual and group psychotherapy. Victims of sexual abuse may participate in the Trauma Track, developed specifically for those experiencing post traumatic stress syndrome.

An inpatient component is available for those at acute risk to self or others. As quickly as clinically possible, the inpatient will visit and participate in the Day Treatment Program.

Residential options include the Barnard Program, an apartment-living treatment program which offers staff availability twenty-four hours each day. An arrangement with St. Thomas Seminary provides a convenient living opportunity for priests. A supportive, informal community develops in this setting. Additionally, on the Institute of Living campus, accommodations are available at the Professional Suite. Living space in other areas of the Hartford community is also available. the Director decides which of these residential options is clinically appropriate for the individual patient.

A patient may easily move from one level of care to another if this move is clinically indicated. Consistency is maintained through the patient's relationship with an individual therapist and casemanager.

Extensive and careful planning for aftercare with input from the patient's diocesan or religious community superior occurs prior to discharge. An established system of telephone contact provides connection between patient and casemanager after discharge.

In recent years, The Institute of Living has developed considerable expertise in working with managed care companies. Specialized staff is available to assist dioceses in negotiating in this area when necessary.

Other specialty programs at the Institute focus on: eating disorders, chemical dependency, geriatric illness, child and adolescent problems. Programs are combined when the professional patient has multiple problems.

1.3. Style of contact with referring bishop

When a person, man or woman, is referred for issues related to sexual abuse, the following procedure occurs: the referring person calls the Director of the Professional Program (203-241-8061); the Director collects information, evaluates it, and recommends options for beginning assessment or therapeutic care.

Contact with the referring bishop, or his designate, is considered critical to effective service. The bishop receives regular and frequent communication from the casemanager and/or individual therapist. Other significant clinicians may also be involved in this communication. Contact occurs within twenty-four hours of admission and weekly thereafter. Written results of the evaluation are shared prior to the Case conference. This conference, which includes the patient, is held near completion of evaluation and/or treatment at the Institute. The purpose of this meeting is to review the progress of the patient, clarify issues regarding aftercare, offer recommendations, and answer questions. Other conferences may occur whenever clinically indicated. The bishop, or his designate, may attend in person, or a conference call by phone may be arranged. Additional contact may occur by fax or mail when needed.

1.4. Type of client information shared with bishop

The Institute will communicate to the bishop, or religious superior, whatever information about the patient that could have a bearing on the priest's ministry. This process hinges on the legal requirement that the patient signs a formal release of information. On the very rare occasions when the patient refuses this legal requirement, the bishop is notified.

A bishop plays a key role in a priest's life, both as the individual's advocate and as protector of those the priest serves. The psychiatric clinician will always inform the bishop whenever a priest's condition is likely to result in harm to another person.

All questions asked by the bishop at the time of referral will be addressed; therefore, the bishop is encouraged to be as specific as possible in defining his areas of concern. In situations where, in evaluation and/or therapy, information is disclosed by the patient that does not impact his ministry, this information would be kept confidential. The patients are encouraged to share personal issues with their bishop when this is appropriate for their mental health.

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THE NEW LIFE CENTER

P.O. Box 1876
 Middleburg, VA 22117
 Phone: 703-754-2771
 Contact Person: Thomas Drummond

1. DESCRIPTION

1.1 In general

The New Life Center is a not-for-profit corporation which operates on a therapeutic community model providing rehabilitative services to clerics and religious who are highly troubled in their own lives or troublesome and ineffective in the lives of others. The Center follows a wholistic plan which includes therapeutic interventions with the body as well as with the mind and the spirit. The residents, though troubled, and often in trouble, do not require psychiatric inpatient hospitalization. The

distinction between individuals who do require hospitalization and those who do not is made according to strict criteria during the initial evaluation.

Residents of The New Life Center live in coed groups of no more than six; each group is self-sufficient and lives in a separate house on a large tract of land. There are livestock and gardens on the land. This environment creates an invitation to each individual to become grounded in a real rather than just a metaphorical sense.

The residents run their own house. Everything must be negotiated between them from what goes on the menu for the month to who cooks on a particular day or who cleans what public space. This forces a resident to use latent social skills or to develop new ones as situations arise. The staff does no problem resolution for the clients but only acts as consultants. The aim of a program at the New Life Center is to have each resident develop as much skill at resolving interpersonal issues as possible so that the skill will translate automatically into the home environment. Accordingly, residents hold and conduct their own house meetings, at least twice a week (more often if a crisis needs attention), to conduct the business of the community and to deal with any interpersonal issues which have an effect (positive or negative) on the group as a whole.

In addition, all residents are in a weekly scripture sharing group. This serves the purpose of reawakening a scripture based spirituality in people who in many cases have not prayed in decades, and in people who escape into a fantasy spiritual life based on pious readings that are not scripture based. From that group, residents can request individual spiritual direction with the Center's Spiritual Director, a Franciscan theologian. However, 'nature' must be operating actively and positively in a person before individual spiritual direction takes place. In addition, an individual must have a plan and goals for their spiritual life so that contact with the Spiritual Director is relevant and fruitful.

Other Client staff contacts are: weekly group meeting for defining and resolving therapeutic issues; weekly women's group meeting; weekly men's group meeting. Each client is seen for individual therapeutic work at their request. Client's may arrange with the therapist to work independently on therapeutic issues with the proviso that the therapist be kept up to date on the results of such work. The rationale is that the more skilled the person becomes at dealing independently and effectively with themselves, the more likely he or she will be to translate

their therapeutic gains back into the home environment. Each individual's therapeutic program must meet exacting criteria in its formulation and for deciding on its effectiveness. The more important of these is that any change must be observable to others. The inner conviction of a resident that something is better is insufficient; others must be able to see and hear the change in the resident's behavior. With that empirical requirement, the progress of the individual can be observed and evaluated.

When an individual's program goals are observable in their behavior and can be sustained from their own inner resources, the person is transferred to a transition house. There they will live in a group of no more than three, they will have one car, money to run the house and they must use all of the skills and knowledge and new behavior they have acquired in the therapeutic residence. They must form a viable group, they must find work that is relevant to their needs and that of their community or diocese. Some people, because of legal or other circumstances, will have to find a new ministry. The transition house is the time and the opportunity to try on one or several new ministries. They do not go home as the bishops' or the provincial's problem. They will solve their own life issues about ministry and then negotiate their inclinations with the diocese or the superior. A person returning home must fit congruently into the community, whether a diocese or religious congregation, from whence they came.

An aftercare workshop is scheduled a month or two after the person returns home. Further aftercare is individually designed and relevant to the needs of the individual (e.g. some people come back to the Center for a yearly retreat, some people are in more frequent contact by phone or letter after they resolve a difficulty which allows us to reinforce effective behavior rather than foster dependency).

1.2. Specialties

Evaluation.

A standard battery of psychological and neuropsychological tests are administered in order to assess the person's resources or lack thereof. People too disorganized to mobilize inner resources are referred for hospitalization (about five percent fall into this category).

Developmental Assessment

All clerics and religious are struggling with issues of sexuality in some way. Some are struggling to manage overactive libidos; some have difficulty keeping boundaries between ministry and romance; some have specific sexual disorders (e.g. pedophilia), some have been raped, both men and women. Almost all of them are younger on the dimension of psychosexual development relative to their chronological age. Their sexuality has not grown up with them; usually because of the nature of clerical and religious formation but also because of sexual abuse and exploitation. This results in a lack of an integrated self-image. All sexual issues are viewed developmentally. That is, is the problem a need for an immature part of the person to grow up? The solution then is to produce awareness of and interest in a sexual self that is commensurate with one's age and to manage sexual awareness and interest within the constraints of vocation and professional functioning (just as vowed married people must do).

Developmental Therapy

The problem is immaturity along some dimension (e.g. social; sexual). The solution is to make that part of the person grow up. This is accomplished in several ways. Generally, the approach is to coordinate, through hypnotic induction, the immature part of a personality, which usually operates in isolation, with those aspects of the personality which are highly resourceful and functional.

Values Therapy

People often experience serious difficulty in their lives when their actions are not congruent with their basic values. By means of hypnotic induction, the core values of a person are determined and brought into full awareness. These then act as a frame of reference for changing, guiding and judging one's own behavior. It works well with issues of sexuality when a person is leading a double life, one apparently celibate and the other sexual.

Body Work

In order for nature to operate fully so that grace can be efficacious, the body is important in the therapeutic approach. It is also well known that a properly oxygenated brain prevents depression. For example, athletes do not suffer from depression. Accordingly, Yoga breathing and stretching are parts of each persons's program. This lead to increased

energy which results in a desire to exercise. Massage has a variety of health benefits. But it also teaches those with poor or no self-image much about their body. It also teaches people with sexual fears or sexual ignorance about the difference between sexual and non-sexual touching. Massage, though physically intimate, is non-sexual. Many are amazed to discover this fact.

In addition to sexual issues and disorder, a wide variety of difficulties is present in the resident population; chronic depression and anxiety; serious authority problems; chronic failure tendencies in ministry and professional life; chronic anger and aggression; lack of a self-identity as a man or as a woman; emotional and social isolation, among other things.

1.3. Style of contact with referring bishop

Contacts are usually by phone. The bishop or his representative is requested to come to the Center after approximately eight weeks for a formal evaluation, conducted by the resident, to inform him of the specific nature of the program the priest and staff have designed, what the specific issues are that are being addressed, what the specific outcomes are going to be, and how progress will be monitored. At other times, visits to the resident are always welcome by other priests or diocesan personnel. The bishop may also wish to meet with the priest at times when the bishop is in the area (e.g. during the bishops' conference). The bishop might not have access to the specific content of therapy sessions (that would be too microscopic to be meaningful in many cases), but, knowing the treatment plan and the predicted outcome, he is always welcome to ask about the progress being made and can expect specific answers and examples relevant to those inquiries.

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SAINT LUKE INSTITUTE

2420 Brooks Drive
Suitland, MD 20746-5294
Phone: 301-967-3700

Contact Person: Canice Connors, OFM, Conv. Ph.D.

1. DESCRIPTION

1.1. In General

1.1 In general, Saint Luke Institute is a thirty-two bed specialized psychiatric hospital licensed by the State of Maryland and JCAHO approved. The Institute provides:

1.1.1 A five day comprehensive evaluation program;

1.1.2 A four to six month residential treatment program;

1.1.3 A two to five year continuing care program depending on the difficulty of the presenting problem;

1.1.4 A three to six month half-way house program for those seeking greater consolidation of treatment outcomes or in transition from ministry;

1.1.5 Education programs for clergy, seminarians and church personnel directors.

1.1.6 Research projects directed to the scientific community.

All staff and professionally accredited and committed to the mission of caring for clergy and Religious and are guided by the core values of the Daughters of Charity National Health System.

1.2. Specialties

The Institute specializes in the treatment of a broad spectra of addictive diseases involving the abuse of food, alcohol and sex. It also offers treatment for such psychiatric problems as mood disorders and chronic depression. Inpatient treatment includes intensive group and individual therapies; physical therapies; attendance at 12 step meetings; education

about the particular problem the patient is dealing with; a strict exercise program and dietary counseling to assist the patient to redevelop a healthy lifestyle. Considerable attention is given to the need for behavioral change in order to assist the patient with personal acceptance and continuing recovery. All residents are involved in groups which review maturity of spiritual life and vocational history.

1.3 Style of contact with referring bishop

Residents are only accepted with the referral and sponsorship of the Bishop. Our client responsibility is both toward the individual and the Bishop. Evaluatees are required to sign a release of information form which allows the evaluation report to be sent to the Ordinary (he or his delegate may also attend the feedback session). Regular reports of patient progress are sent to the Bishop and he is involved in the planning for continuing care.

1.4 Type of client information shared with bishop

Evaluation report; progress reports during the course of inpatient treatment; continuing care plan and contract; reports following each continuing care visit.

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**SERVANTS OF THE PARACLETE
St. Michael's Community**

13270 Maple Drive
St. Louis, Missouri 63127-1999
Phone: 314-965-0860
Contact Person: Joan C. Thorn

1. DESCRIPTION

1.1. In general

St. Michael's Community provides intervention, assessment, treatment, and follow-up services for Catholic priests and vowed religious men.

Our services include:

1. A week-long assessment program;
2. A residential program which includes the following services:
 - a) a dual diagnostic program for the treatment of alcoholism and other chemical dependency issues.
 - b) a biopsychosocial program for the treatment of such issues as affective disorders, anxiety disorders, sexuality issues, life and vocation crisis.
3. Aftercare services.

1.2. Specialties

St. Michael's Community specializes in the treatment of alcoholism and chemical dependency and also the treatment of psychosexual difficulties.

1.3 Style of contact with referring bishop

Our style of contact with a referring Bishop is usually personal. Quite often, the Director of Priests Personnel or the Bishop himself will call St. Michael's with a referral. The initial contact is usually made through me since I am the Director of Admission for St. Michael's Community. Thereafter, contact is usually through a Case Manager or the Director of St. Michael's Community, Reverend Michael Foley, s.P., L.C.S.W., D. Min. It is sometimes required that a Bishop speak directly with a man's psychotherapist.

1.4. Type of client information shared with bishop

In terms of the type of client information that is shared with a Bishop, normally a man in the program is required to sign a release of confidential form. Once this release form has been signed, St. Michael's shares all relevant information with the referring Bishop. This begins during the evaluation process when a Bishop or his representative is asked to attend a feedback session in which the findings of the assessment process are shared with the person being evaluated and his Bishop. This takes place at St. Michael's and is conducted by members of the evaluating team. If a man enters the program at St. Michael's, periodic progress conferences are set up by telephone and on a personal basis throughout the duration of a man's stay. Monthly progress notes and a monthly report are sent to the referring Bishop. At the end of a man's stay at St. Michael's, an Aftercare conference is set up to design an Aftercare program. A Bishop or his representative is invited to attend all of these sessions.

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**SERVANTS OF THE PARACLETE
The Albuquerque Villa**

2348 Pajarito Road, S.W.
Albuquerque, New Mexico 87105
Phone: 505-873-0647
Contact person: Sarah Brennan, Ph.D.

1. DESCRIPTION

1.1. General

The Albuquerque Villa is a 20 bed residential treatment facility located in the south valley of metropolitan Albuquerque, New Mexico. The grounds include a swimming pool and tennis court with ample space for leisurely walking in a pastoral setting. There are bicycles and exercise equipment and a recreational therapist for supervised health maintenance. There is a pottery work-space and a large common area for television, cards and other community activities. There is a chapel for public and private devotions and private reflection.

The core components of the program are psychology, spirituality, and physical health. The various components of the program are applied interactively to promote wholistic health in each residents life personally, spiritually, psychologically and vocationally.

All residents participate communally in an hour of private prayer before the Blessed Sacrament with morning prayer. Priests who wish may take their turn presiding at the daily celebration of the Eucharist. Evening praise in common ends the program day.

Residents are involved in individual therapy and spiritual direction meetings at least weekly. Group therapies are a key component to the program and include psychotherapy groups, relapse prevention groups/classes, and focused groups in the areas of sexuality/celibacy and vocational transition. Residents may also be asked to attend 12-step groups for addictions when applicable.

Residents are encouraged to attend to personal fitness and health. A professional health and recreational therapist and a message therapist are available as integral parts of the course of therapy. Planned escorted social outings are scheduled regularly to the many scenic and

historic sites of New Mexico. They provide the residents with a break from their therapy routine, and, more importantly, an opportunity to strengthen the sense of community and responsibility for one another that is encouraged in the program.

Upon completion of a course in therapy, the resident, in conjunction with the staff, prepares a detailed course of aftercare treatment. Usually this will include on site visits with one of the staff for the purpose of facilitating the reintegration into one's community and ministry. There will also be a series of return visits to the Villa over a period of time determined by the treatment staff, the resident and the referring diocese or religious superior.

The basic cost of room and board at the Albuquerque Villa is \$80.00 per day. This includes three meals a day with snacks; light housecleaning and laundry facilities. Besides basic room and board the cost includes weekly sessions with the spiritual director, classes in Sacred scripture, spirituality and prayer, and pottery classes.

Not included are group therapy, individual therapy sessions with the staff psychologist and consultation with the consulting psychiatrist. Personal expenses for recreational purposes, use of the van for trips to town, telephone and other miscellaneous expenses are the personal responsibility of each resident.

1.2. Specialties

The relatively small size the Albuquerque Villa allows for individualized therapy tailored to meet the personal needs of each resident. The Villa is unique in its ability to integrate the experience of a community of prayer and faith sharing with highly professional standards of modern psychology, medicine and physical health maintenance.

A thorough assessment by the psychologists and psychiatrist as well as a spirituality profile is the first step in evaluating the appropriateness of the person for the Villa program. This provides the staff with the data necessary to design an individualized course of treatment for him. This initial assessment includes structured interviews, social histories, administration of a battery of projective and objective psychological tests. The testing is complemented with personal interviews and screening by the psychologist and a spiritual profile interview by the spiritual director. Other specialized is available as needed such as neuropsychological and plethysmography.

The Albuquerque Villa staff in keeping with our policy to be of service to a wide spectrum of needs, sets aside a limited number of rooms for those who are unable to return to ministry and need residence in a protected and monitored environment.

- A) Other specialties included long-term, less intense therapy programs for men who cannot respond to the demands and confrontations characteristic of some therapy modalities, or who may have been unsuccessful in other therapy programs (e.g., personality disorder diagnosis and/or recent/current inappropriate sexual behaviors).
- B) Short-term transitional programs for those who are leaving active ministry. (Drs. Brennan and Goodkind have several years' experience with the Department of Vocational Rehabilitation).
- C) A concentrated, intense, three-month program for men who were involved in inappropriate sexual behavior in the past but who have maintained their celibacy in recent years (regressed versus fixed sexual acting out; no personality disorder diagnosis).
- D) Special arrangement may be made for short term (two to four weeks) with brief focused counseling sessions and individual spiritual direction with the spiritual director.
- E) Outreach consultations and training programs for religious communities and dioceses in areas of intervention; therapist training and consultation with bishops, superiors and personnel directors in assessment, intervention, treatment and aftercare. Dr. Sarah Brennan served as Director of the Court Clinic of the Second Judicial District in New Mexico and is a certified mediator. Dr. Robert Goodkind, the Villa's psychological consultant and director of group therapy, has served as a mediator to the courts in the second judicial district. They provide specialized qualifications in working with parishes, dioceses, and religious communities in efforts to mediate the painful splits between diocese and parish, and priest and parishioner, particularly in the areas of sexual improprieties.

1.3. Style of contact with referring bishop

Regular, honest and frequent communication with the resident's sponsoring bishop or superior is considered to be an essential component of the therapeutic process. Forthright communication all around - client, staff and diocese/religious community - is the cornerstone of the Villa's program the Villa staff makes every effort to be a cordial, professional advisory resource to bishops and superiors in the personal, pastoral and ministerial decisions they need to make. From the initial contact a team approach is taken to include the man coming to the villa, his bishop and any other intermediary designated, and the staff of the Villa. The long history of the Servants of the Paraclete, their professional staff colleagues in the treatment of behavioral and psycho-sexual issues has sensitized us to the need to be conscious of the issue surrounding treatment and after-care placement.

Father Raymond Gunzel, Sp, the Director, and other staff persons are available at any time for queries and consults regarding a resident or potential program candidate. For this purpose we maintain a twenty-four hour emergency answering service.

Normally, contacts with the staff are by telephone during working office hours, letters, in-person visits, conference calls, FAX messages, and regular written progress reports from the Villa. The treatment philosophy at the Villa is that the more communication and information available for any in-coming resident, the more productive can be his time at the Villa. Any and all communications, questions, and suggestions are welcome.

1.4. Type of client information shared with bishop

Of utmost concern to the staff of the Villa is the matter of confidentiality. Civil laws regarding patient/client and priest/penitent confidentiality are very strict. Since the Villa staff believe that any priest or brother entering the program includes in his family his bishop and/or community, we request that he sign a legal release of information which allows the free exchange of information between the Villa and his bishop and superior, as well as among the Villa staff. This allows for a supportive and informed team/community approach. If a resident declines to sign such a release, serious consideration is given to the appropriateness of that individual for the Villa program. In such case as he is accepted, the limits of confidentiality are explained to him, and to the referring bishop/superior. As provided by the Tarasoff legal precedent, when there is any specific individual known to be in danger, the safety of that

person takes precedent over doctor/client privilege. However, it must be understood that posing a less specific threat to society does not allow for the breaking of the doctor/client privilege. At that point, individual civil rights and confidentiality take priority.

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**PROGRAM IN HUMAN SEXUALITY
DEPARTMENT OF FAMILY PRACTICE & COMMUNITY HEALTH
MEDICAL SCHOOL
UNIVERSITY OF MINNESOTA**

1300 South Second Street
Minneapolis, Minnesota 55454
Phone: 612-625-1500
Contact Person: S. Margretta Dwyer, M.A., L.P.

1. DESCRIPTION

For over twenty years, the *Program in Human Sexuality* has been committed to developing and providing comprehensive therapeutic services for individuals with a wide range of concerns related to sexuality.

Since sexual dysfunctions and disorders are rooted in biological, psychological, social and cultural factors, effective treatment involves a multi-disciplinary team of well qualified professionals with unique skills and training in human sexuality.

Individuals who come to the *Program in Human Sexuality* receive a comprehensive and thorough evaluation of their problems and concerns. We make every effort to coordinate this assessment with referring professionals. Once an assessment is completed, an individualized treatment process is recommended.

As in the past, the *Program in Human Sexuality* will continue to develop and evaluate new treatment approaches to sexual dysfunctions and disorders. This ongoing development will be grounded in the latest developments in basic and applied research in human sexuality. With this continuing process of development, we will fulfill our mission to provide patients with the most up-to-date and effective treatment for their concerns.

The Program in Human Sexuality, Department of Family Practice and Community Health, Medical School, University of Minnesota, provides diagnostic, treatment, research, consultative, and educational services to promote the sexual health of individuals, couples and families of all backgrounds and ages.

The *Program in Human Sexuality* is internationally recognized as an outstanding sexuality teaching and research center, and is a highly regarded center for the treatment of sexual health concerns. All of our professional staff have received specialized training in human sexuality and are appropriately credentialed through both state and national organizations.

With the consultative resources available through the University of Minnesota, the *Program in Human Sexuality* is able to provide thorough medical evaluations of various sexually-related problems and issues.

Programs and services include:

- Marital and Sexual Dysfunction
- Sex Offender Treatment Program
- Sexual Abuse Recovery
- Compulsive Sexual Behavior
- Gender Dysphoria
- Sexual Orientation Conflict
- Ethical Violations
- HIV Counseling
- Forensic Evaluation

Education and consultative services are also available.

1.4. Type of client information shared with bishop

The client information that is shared with the bishop is a considerable amount. We draw up a contract with the bishop and the client or whomever the bishop appoints as what we call "the probation officer" and consent forms are signed. This contract is made in agreement with what the bishop feels he needs to know and what the client really needs to be telling the bishop.

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SOUTHDOWN

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Canada
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1. DESCRIPTION

1.1. In General

Southdown is a 42 bed residential treatment facility, located some 25 miles north of Toronto in Aurora, Ontario. It is owned and operated by Emmanuel Convalescent Foundation, a registered non-profit charitable organization, governed by a Board of Directors comprised primarily of lay persons.

Southdown was established in 1965, with support and endorsement from the Canadian Conference of Catholic Bishops, to provide care and treatment for male clergy suffering with alcoholism. Continued requests for Southdown to extend its treatment program beyond alcoholism were honored in 1974. Presently about one quarter of the residents come for reasons around alcohol or drug dependency, while the rest are experiencing a broad range of difficulties in the form of psychological or emotional conflicts. In 1976, the Foundation assented to the appeal of the Canadian Religious Conference to make its services available to women religious. Women now comprise up to one half the population of residents. Men and women are fully integrated in all aspects of the program.

Southdown's distinguishing trait is a willingness to receive both chemically dependent and emotionally distressed clergy and men and women religious. Since its founding, over 2400 persons have found the support and care which assisted their recovery and, for most, return to active ministry. Approximately half the residents have been from Canada, 45% from the United States, and 5% from other English-speaking parts of the world.

Assessment Program

The ordinary pre-requisite for entry into the residential program is to participate in an intensive, five-day assessment, designed to identify a wide variety of psychological, emotional and dependency problems. During assessment clients undergo a complete battery of psychological tests, and detailed social, medical and psychiatric profiles are developed. As well, a comprehensive spiritual profile and an addictions profile are compiled to ensure we obtain a fully integrated diagnostic picture.

All findings are then brought before the Assessment Team for analysis and recommendation. Members of the team include a psychiatrist, clinical psychologist, neuro-psychologist, spiritual director, registered nurse, addictions counsellor and a psychometrist. Treatment recommendations are referrals are not limited to Southdown. Considerable emphasis is placed on alternative treatment possibilities, together with some prognostic indications of the results of those alternatives.

Assessment concludes at the end of five days with a meeting of the Assessment Team leader, the individual, and the referring person from his/her diocese or community. This meeting provides an important opportunity for frank discussion and co-operative planning between the individual and the diocese or community. Shortly after assessment, a comprehensive written report is sent to the individual and to whomever the assessee designates.

Residential Program

Upon admission to the residential program, each person is assigned a doctoral-level clinical psychologist to serve as their primary therapist, responsible for overall treatment planning and direction for that individual. Based on the assessment findings, clear and specific treatment goals and objectives are written, usually within the first week. In addition, each individual is assigned a spiritual director and an addictions counsellor (if appropriate) with whom they meet on a regular basis. Progress is monitored during a bi-weekly interdisciplinary team review of each resident. Length of stay usually averages from four to six months.

In recent months Southdown has instituted a more intensified program of group and individual therapy. Strong emphasis is given to small, psychodynamically oriented therapy groups that meet daily. Each group is conducted by two therapists, primarily doctoral level psychologists.

Other types of group therapy, such as bioenergetics therapy and cognitive/behavioral groups meet on a weekly basis.

In addition to the psychotherapy groups, residents participate weekly in small theological reflection groups to assist in the process of personal integration and to enable residents to frame their healing process in the context of their faith and ministerial commitments. For those dealing with addictions issues, a comprehensive program which includes education, 12 - step groups, and small group interaction is mandatory. As persons prepare to leave, they participate in an intensive relapse prevention program which can be continued in support groups throughout North America.

As well, aware of the importance of achieving healthy balance in daily living, staff continue to emphasize the importance of nutrition, maintenance of physical activity and exercise, and a variety of forms of holistic relaxation.

During their last few weeks at Southdown, residents enter a Transition Group to help them prepare psychologically and emotionally for departure and return to ministry. During this time each resident prepares a formal statement of the healing which has occurred and of specific commitments to further this healing. The resident sees this statement, or Covenant, as a reference for on-going self evaluation and continue growth.

The resident is asked to review his Covenant with his Bishop (or designate) as well as with another person in his diocese with whom he will regularly meet to monitor his fidelity to continued growth.

During this time, plans for return to ministry and community life are discussed in detail during a face-to-face close out meeting with the therapist, the resident, the referring Bishop or Superior, and a member of the Continuing Care team who will provide follow-up and ongoing support over an 18 month period.

Continuing Care

The Southdown program is defined as a period of residential treatment, followed by 18 months of continuing care follow-up, known as the "southdown Connection". The Southdown Connection was instituted to provide support and encouragement for departing residents to continue the healing process initiated during their stay here. It is designed to

facilitate the transition from a structured program back to active ministry and daily life.

Approximately 3 to 6 months following discharge from residential treatment, each person returns to Southdown to participate in an intensive, three-day program. The support person who co-signed the resident's Covenant is also invited and encouraged to accompany the former resident and to participate in some components of the three-day meeting. While here, the former resident participates in a relapse prevention workshop, theological reflection, and an intensive, day-long group therapy institute. As well, there are opportunities to meet with clinical staff who were involved with the individual throughout the course of residential treatment.

The purpose of these meetings is to review the Covenant, to assess progress, and to help guide the individual toward better living out the commitments made therein. A second return visit occurs 12 to 18 months following discharge from the residential program. If there is a need for a third visit at a later date, Southdown will accommodate this. As well, Southdown staff remain available at all times to confer with the referring Bishop or Superior and to assist with any questions or concerns that may arise.

1.2. Specialties

The Southdown residential treatment program is designed as a very individually tailored, multi-modal and holistic experience. Although we have been actively treating presenting problems around issues of sexual misconduct since 1984, these cases still comprise a relatively small part of the overall residential population. However, when such issues are part of the presentation, in addition to participation in the overall program of individual and group therapeutic modalities, some specific concerns are addressed separately.

We are aware of often competing spheres of responsibility: to the individual surely, but also to the "public", and to the Church and society. We are acutely aware of how important it is to assess risk factors for recidivism prudently and conservatively. To this end, a specifically designed "protocol" for sex offenders is rigorously applied in every instance (copy attached). We strive to maintain candid dialogue between the individual and the referring bishop/superior throughout treatment and especially during the critical transition period from residential treatment.

Southdown places a great deal of emphasis on careful diagnosis as critical to any recommendations about return to ministry. Though the professional language may not always be adequate to the task, we still find that significant numbers of our sexual misconduct population are not "classical" pedophiles or ephebophiles. There remains a significant group of grossly immature, sexually repressed, psychosexually underdeveloped persons who have transgressed behavior norms for a variety of reasons and who may or may not represent significant continued risk to the population at large. Recommendations upon termination, therefore, are quite individually tailored.

In all cases, the treatment regimen attempts to respect biological, psychological and spiritual dimensions in an explicit manner. Pharmacologic intervention is always considered for appropriateness, but in fact, is used in few cases at Southdown. The interplay of a variety of therapeutic interventions is seen as most effective. The range and intensity of group therapeutic experience, particularly the daily psychodynamically oriented groups, have been especially helpful with the sexual misconduct population. These groups allow shame-based issues to be raised and confronted with peers (including a significant number of our population who are adult survivors of sexual abuse themselves).

Other effective therapeutic interventions would include: physio-therapies (bioenergetics analysis being a principal mode), additions education and counselling (including AA, SLAA, and other modalities when appropriate), and cognitive-behavioral restructuring, particularly in identifying precipitants to inappropriate behaviour and in monitoring relapse prevention.

In short, we are optimistic about the multi-modal treatment possibilities provided in our context and try to share that optimism - even, if necessarily guarded in some cases -- with our residents.

1.3 Style of contact with referring bishop

With the understanding there are constraints under obligations of professional confidentiality between patient and therapist, Southdown nevertheless strives to provide relevant, clear communication with the referring bishop (or his designate) on an ongoing and timely basis. We strongly encourage residents to be as honest and open as they possibly can with their bishop. At the same time, we hold a clear expectation that the bishop will be as fully disclosing as possible, not just with

Southdown or the primary therapist, but with the individual as well. In many cases, overtime, both resident and bishop are able to achieve a new plateau of effective communication and mutual trust.

In all cases, the following contacts and communications occur:

- At the time of initial contact or referral, relevant information pertaining to the assessment is sought from the diocese. This is done by phone, in writing, or both.
- At the conclusion of the assessment phase, consultation and feedback with the referring party occurs (preferably in person) wherein information regarding diagnosis and treatment recommendations are presented and discussed.
- A comprehensive written report of the assessment is sent to the referring party (subject to obtaining a written "release of information" authorization from the individual).
- Upon entry into the residential program, review letters are written by the primary therapist to the referring party - at the end of the first, third, and fifth month of residency. A final letter, the most detailed and descriptive document concerning a person's stay, is prepared at the end of residency. All correspondence is seen and initialled by the resident, ensuring the individual's knowledge, but not necessarily agreement with the contents.
- the Bishop (or his designate) is requested to be present for a final meeting at Southdown prior to the individual's departure. This meeting, with the primary therapist, the resident and the Continuing Care worker, reviews progress in treatment and discusses in detail recommendations for future ministry, re-entry into the diocese and plans for ongoing therapy and monitoring as may be appropriate.
- Bishops and superiors are welcomed and encouraged to raise any concerns they may have with the primary therapist throughout the course of residency and beyond.

1.4. Type of client information shared with bishop

Within the communications framework outlined above, material relevant to the presenting issues, diagnosis, progress in treatment, and recommendations concerning suitability for future ministry are shared. In all cases where sexual misconduct is an issue, the specific questions outlined in the sexual abuse "protocol" are explicitly addressed. Assurance is given that these issues have been covered during the course of treatment.

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VILLA ST. JOHN VIANNEY HOSPITAL

Lincoln Highway at Woodbine Road
P.O. Box 219
Downingtown, PA 19335
Phone: 215-269-2600
Contact Person: Martin C. Helldorfer, Ph.D.

1. DESCRIPTION

1.1. In general

Villa St. John Vianney Hospital is a private psychiatric facility which ministers to Clergy and Religious, solely. We will soon celebrate our fiftieth year in this specialized ministry. We are a licensed, JCAHO accredited, psychiatric hospital. During the past five years an average of more than seventy priests, sisters and brothers have been admitted each year. The patients have been about equally divided between men and women. The most frequently cited reason for admission is depression. The most frequently cited behaviors that are a concern to patients or their superiors are a) the inability to function in day to day life within the ministry, b) the ineffectiveness of out-patient treatment, c) conflicts in living with others, including repeated patterns of withdrawal and d) problems associated with sexuality, particularly with acting-out behaviors. A considerable number of patients have had suicidal feelings at the time of admission and some have had actual plans to suicide. We have a specialized unit for clergy and religious with sexual disorders and sexual misconduct. During the past two years there has been an increase in the number of admissions to this unit.

Some patients are admitted to the hospital in order to stabilize them during a time of crisis. If this is the case, their medications are reviewed and, when the patients are stable, they are discharged.

Other patients are admitted for a lengthier, yet time-limited, length of stay as they work on specific problems that are more easily addressed in the specialized milieu of the hospital.

Still others are admitted for an extended length of stay as they deal with particularly severe problems such as a long history of treatment resistant depressions or sexual problems complicated by legal issues.

1.2 Specialties

As mentioned above, while we are a general psychiatric hospital, we have a unit devoted explicitly to the treatment of priests and brothers with sexual problems, including sexual disorders and sexual misconduct. The unit is limited to 20 men. Clinical treatment does not follow the addictions model. Our stress is on personal accountability, a need for a support system, and the need to develop and maintain boundaries. Highly structured aftercare recommendations are part of this treatment approach.

In addition to that unit within the hospital, Villa St. John Vianney Hospital also maintains the Anodos Center which conducts four day comprehensive psychological assessments for Clergy and Religious. We prefer that priests undergo a comprehensive psychological evaluation, either here or at other Institutions, before admission to the sexual disorder unit. One of the major changes that has taken place relates to the cost of psychiatric care for clergy. The treatment program has been reworked, and the average length of stay has been reduced to six months. On the welcome side, this means lower cost of care. On the challenge side, it accents the need for on-going and often supervised out-patient care.

The Anodos Center varied services which include out-patient psychotherapy, spiritual direction, and professional consultations to Bishops and Superiors. The center has developed an educational outreach program for priests entitled "Sexual Ethics in Ministry." Its purpose is to provide a well-informed basis for making healthy decisions regarding boundaries in pastoral relationships.

1.3. Style of contact with referring bishop

By policy, the bishop or his appointed representative, is always involved in the patient's treatment. We follow all guidelines and laws of the Commonwealth of Pennsylvania regarding these matters. Consent of the patient is necessary. Verbal communication from the staff to the bishop is at least monthly. We strongly encourage that bishops, or their appointed representative, visit the patient frequently. As a matter of fact it is now required that the bishop, or his representative, meet with the patient's treatment team thirty days after admission, at least ninety days thereafter, and at the time of discharge.

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**OUR LADY OF PEACE HOSPITAL
PEACE MINISTRY CENTRE**

2020 Newburg Road
Louisville, KY 40232
Phone: 502-451-3330
Contact Person: Michael Coppel

Abstract

Philosophy

1. DESCRIPTION

1.1. In General

Our Lady of Peace Hospital is a comprehensive psychiatric referral and treatment center committed to upholding the overall mission, philosophy, and values of the Sisters of Charity of Nazareth. Our Lady of Peace Hospital is committed to providing quality psychiatric care. We respect the dignity of all persons and encourage their physical, emotional, and spiritual growth. This ministry of healing is an integral part of the church, and an extension of Christ's mission of mercy. Our Lady of Peace Hospital provides psychiatric and substance abuse treatment to all age groups, and to all professionals, religious and laity. The Peace

Ministry Centre provides an environment where male and female religion professionals in crisis can seek treatment for emotional disorders and/or addictions. Religion professionals in crisis who are seeking our help tend to be experiencing confusion in their role, their beliefs, and their relationship with God. They may be in need of professional help to acknowledge these problem areas.

Our Lady of Peace Hospital recognizes that there are religion professionals who may not have had the occasion or willingness to reveal to anyone else the true state of their personal struggles. Religion professionals in crisis may lack the kind of trusted friend who could understand their struggles of faith. Additionally, religion professionals in crisis, due to their role as authority figure, may often feel that it is impossible to disclose any of their own limitations or failures, especially in the area of spirituality.

Our Lady of Peace Hospital encourages religion professionals in crisis to experience themselves apart from their roles, to step back for a while from their usual positions as teacher, preacher, and helper, and to experience their own imperfect and wounded humanness. These religion professionals in crisis can experience the opportunity for openness and growth in a trusting environment that enables them to admit their own urgent needs for change in both their human and spiritual life.

Our Lady of Peace believes that our treatment responsibility also extends to the family, to the religious community, and/or to significant others who are important in the treatment process. Involving these significant people in the treatment/recovery process is an important component of treatment. Therefore education, therapy and support services are offered to those significant persons in order to strengthen the functioning of the individual patient and his/her support network.

The primary purpose of the Peace Ministry Centre is to provide a comprehensive treatment environment that addresses the physical, emotional, and spiritual needs of the person and the larger interfaith system (i.e., family, church, community). The addiction issues and skill building techniques. The religion professional is assigned to one of these programs and a schedule of activities is established based upon the evaluation of the patient's cognitive and emotional functioning and assessment of needs. The goal of this assignment is to provide the maximum degree of therapeutic intervention that is appropriate to the patient's current and potential level of functioning.

Once assigned to the one of the treatment programs, individuals are assigned to the Peace Ministry Centre Track. The key components of the track are individual psychotherapy, group psychotherapy, and psychoeducational group therapies in which coping skill acquisition and problem resolution are emphasized. Some of these therapies are Spirituality Group, Biofeedback, Healing the Healer's Group, Art Therapy, Reflections Group, Spiritual Counseling, Family/Community Therapy and Interfaith and/or Catholic worship services. The structured milieu provides the opportunity for the development of interpersonal skills and maintenance of healthy interpersonal relationships. The religion professionals are blended into the milieu with non religion professionals on their home unit in order not to isolate but to promote support and sharing with others in the human experience of the treatment process. Patients also have the opportunity to engage in therapy groups which focus on their individual needs such as survivors of abuse, adult children of alcoholics, and group and individual therapy dealing with accepting responsibility for perpetration of abuse

- physicians
- human service agencies
- judicial system
- other treatment facilities
- a major superior
- a bishop
- a personnel director
- a local superior
- an employer (principal of school, president of college)
- a local house
- pastoral counseling services
- etc.

Referrals may be accepted through the 24 hour Peace Helpline at (502) 451-3333. Non-local callers may also use the 1-800-451-3637 telephone line for toll free access.

1.2. Specialties

The individual's treatment needs are assessed at the time of his or her admission. According to the assessed level of care appropriate, the religious professional is admitted to one of the following Treatment services; Adult Treatment Services Inpatient, Pathways To Peace Chemical Dependency Inpatient or Intensive Outpatient Programs, Adult Partial Hospital Program, or Peace Counseling Center Outpatient Services. Patients entering the above mentioned services would focus on psychiatric issues, treating of the whole person in an environment that is supportive of one's ministerial life is a critical component of the delivery of these services. The Peace Ministry Centre is an ecumenical, spiritually-based treatment opportunity where growth, transformation, and healing can take place.

The staff of Our Lady of Peace is aware of the fact that our ministry is one that calls for sharing in our patient's life journey of healing. By honoring this journey, the Hospital encourages an atmosphere of caring, reverence, and confidentiality for the patient.

The overall purpose is to treat individuals presenting with emotional, addictive, and spiritual difficulties and needs. This treatment is available in three levels of care: inpatient, partial hospital, and outpatient.

Another purpose is to address the educational, consultation and treatment needs of the family, church and community as they are impacted by the treatment of the individual while maintaining appropriate boundaries and confidentiality.

Referrals are accepted from a wide range of sources including but not limited to the following:

- an attending psychiatrist
- self referrals
- family members or significant others
- mental health professionals issues

For further information, the reader is encouraged to contact the Vice President of Patient Services or the Director of Nursing at Our Lady of Peace Hospital, 502-451-3330.

1.3. Style of contact with referring bishop

Our usual procedure is to have received a referral directly from a bishop. The bishop has usually made it clear to the religious professional that their participation in treatment and their progress is a major factor in deciding on placement following treatment.

1.4. Type of client information shared with bishop

The bishop, usually requests to be allowed to have communication with the treating psychiatrist. We are required by law to secure written permission from the patient to release this information, but have not yet had a problem getting that agreement.

PART 2 - KEY QUESTIONS

2.1 QUESTIONS THAT MAY BE ASKED OF THE FACILITY BY BISHOPS

The following is a synthesis of the sort of questions institutions would expect to be asked when a bishop contacts them regarding a possible referral.

- Do you have a staff especially trained and experienced in evaluating and treating priests?
- Do you have an assessment process before admission?
- Is the assessment process necessary in every instance?
- Will he be evaluated at the start of treatment or during the course of treatment?
- Are the problem behaviors I see in this patient related to mental health issues?
- What might make these behaviors worse?
- Is this patient's behavior a potential threat to others' safety? How serious is the risk and under what circumstances may he endanger others?
- How would you determine whether you could help the man or whether he should be referred for hospitalization?
- Can you justify your recommendation for or against outpatient care, residential treatment or hospitalization?
- What elements will the treatment program include: psychiatry? psychology? spiritual counseling? social work? physical fitness? career guidance? etc.
- Do you have much experience and success in dealing with the sort of problem this particular priest is presenting?
- What is the procedure of assessment of outcome, prognosis, and recommendations for placement and return to ministry?
- What is the nature of risk following participation in treatment?
- How soon can his evaluation or treatment begin?
- Will he be admitted as an in-patient or will he be given out-patient status?

- Do you have a place where he can reside if he is an out-patient?
- How long will the evaluation and/or treatment take?
- Will the results of the evaluation and the recommendations made by the staff be communicated to the bishop? In what form?
- Will the priest be present when the staff discusses its recommendations with the bishop or his representative?
- When the priest is in treatment, how often and in what way will progress reports be communicated to the bishop?
- Will the priest receive vocational evaluation and spiritual direction?
- Will the priest be able to participate in daily liturgy?
- Will the priest be treated with other priests? Also with other professionals such as physicians, lawyers, teachers, women religious, men religious, business people?
- Is the accusation against the priest founded on fact or could this be a false accusation derived from some other source?
- If the accusation is true, how should the priest be viewed for his future responsibilities and for therapy?
- What is the status of the priest's faculties?
- Will the hospital assist the bishop to understand which future assignments would be inadvisable for the priest's and others' well-being, and which ministries would be preferable for him?
- If it is inadvisable for the bishop to reassign the priest, will the hospital staff assist the priest to prepare himself for non-sacerdotal employment?
- Do you have a specific and detailed aftercare program?
- Will the hospital staff assist the priest to find a suitable therapist after discharge from the hospital, if followup treatment is indicated?
- What will the costs be?
- Will our insurance cover these costs?

- What further referral sites might be appropriate for the patient?
- Do you have any suggestions about how I might make this difficult intervention?

2.2 QUESTIONS THAT MAY BE ASKED OF THE BISHOP BY THE FACILITY

The institutions consulted in this survey had suggestions on certain points bishops may be asked on the occasion of exploring a referral to one of these facilities.

- Bishops are asked to provide as much detailed information about the presenting issue and personnel history of the individual as possible, from as many sources as possible. General information is usually not very helpful. Historical as well as contemporary data are needed.
- Name, age, place of origin (diocese/religious community), years ordained.
- Status with the diocese/religious community: good standing, suspended, with a positive evaluation possible return to active ministry, or no return to ministry under any circumstances.
- His recent assignments.
- The reason for referring for evaluation or treatment. What brought him to your attention as presenting a problem? Is there a pattern that has been repeated?
- Has there been any legal action? Are there any outstanding legal matters that might inhibit effective evaluation/treatment?
- Were complaints made about him? What do the complainants want? Description of the complaints and/or problem behavior.
- Have there been previous complaints about him? Relevant history of similar problems/complaints.
- Is he a recent offender or is the offence from years ago?
- Has the priest been abused himself?
- What has been done so far, before referral (e.g. administrative leave, etc.)?-
- What is the quality of your relationship with the priest?
- Has there been a decision, unknown to him, about his future?
- If you need to confront him, would you need someone from the hospital to be present to facilitate the encounter?

- What have you heard about him from his parishioners and other priests?
- Do you see therapeutic value in intervening in the priest's life administratively as well as pastorally?
- Will you hold the priest responsible for translating his program gains in a visible way into the diocese?
- Will you hold the priest responsible for getting along effectively with the presbyterate and with authority when he returns home?
- For purposes of treatment, it would be important to know whether or not the priest would ever be able to return to active ministry.
- Where is he now? Is he alone? Are there any danger or safety issues present? Is he suicidal?
- What have you said to him about referring him to our institution?
- What was his reaction? How open is he to evaluation? How motivated is he to treatment?
- Does he acknowledge misbehavior, if this has been alleged? Is he in denial or rationalization?
- Has he received psychological or psychiatric treatment? Type, time, and circumstances of any kind of therapeutic interventions or counselling. How did he respond?
- Has he been hospitalized in the past? Where? In whose care? Medical conditions, prescription medications, or other limiting physical conditions.
- How soon can he come in for evaluation and/or treatment?
- How willing are you to sponsor him throughout the length of the continuing care contract?
- What is your willingness to work with the primary therapist in terms of keeping information updated and to participate in future planning concerning the individual?
- Where will he live if he comes to this (non-residential) facility?

- Where will he work while in this city? (Our expectation is that the men will not be rather idle but on the contrary engage in some kind of 40 hour per week work. It does not necessarily have to be church work but we do expect our men to hold jobs and possibly even pay towards their treatment.)
- Who will be the bishop's delegate, if any, to serve as a contact person with the hospital and the priest?
- Is there insurance that may cover hospital care?
- To whom should the bills be sent?
- Has there been publicity in the media?

3. CRITERIA FOR BISHOPS LOOKING FOR A FACILITY

The institutions described above in this survey were invited to indicate criteria bishops should look for when seeking a facility for personnel of their dioceses. What follows is a summary-for the most part in their own words-of what they would suggest to the bishops. There is much complementarity in these replies, along with nuanced differences on certain points.

- (An institution) that is both experienced in the matter of evaluation and differentiation of patient's problems but as well that has an appreciation of the diocesan responsibilities and the spiritual purposes of the church. There has to be a sense in the facility that the aims of the church are appropriate aims to seek in the priestly mission and that the facility is interested in supporting, rather than altering or subverting that mission.

- Interviews should be conducted by psychologists and psychiatrists with special training and experience evaluating and treating sexual problems of the clergy, including sexual abuse.
- The psychologist who administers tests should have training and experience in assessing sexual issues and treating members of the clergy.
- An internist should examine the patient medically, along with a neurologist.
- A specialist in spirituality and pastoral care should evaluate the state of the priest's spiritual life and ministry, along with his life-style and relationships.
- A specialist in neuropsychology should be available with access to a clinical facility where special testing can be performed, if this is needed.
- A laboratory should be available where testing can be done for alcoholism, AIDS, drugs, hormonal disorders, genetic problems, etc.
- A professional staff experienced in working with priests with sexual problems should be in frequent and close communication with the bishop who refers the priest for evaluation and treatment.
- Rarely, if ever, should a priest sexual offender be treated by an individual therapist without first being evaluated in a clinical setting where an experienced team conducts the evaluation and provides initial treatment.

- The results of evaluation and recommendations for treatment are generally best communicated to the bishop in a conference including staff members, the priest-patient, and the bishop or his delegate.
- The written reports to the bishop regarding the priest's progress in treatment should be communicated regularly, in writing, clearly, and with professional estimates of how long the treatment is likely to be necessary.
- The facility where evaluation and treatment are provided for priests should be one that is approved by the Joint Commission on Accreditation of Hospitals.
- The psychiatrist and psychologist who do the evaluating should be willing to testify in court, if that becomes necessary.
- A hospital should remain in contact with the priest's referring physician, if there is one, and generally refer the patient back to that physician at the time of discharge, unless some other plan seems indicated.
- The treatment center should have enough patients who have sexual problems to be able to provide group therapy for these priests along with one-on-one treatment.
- While in treatment the priest should receive spiritual and pastoral counseling and participate regularly in liturgical worship unless, for some reason, this is inadvisable for a time.
- If priests are being treated at a hospital on an out-patient basis, it is generally beneficial and desirable for them to reside with other priests, but not necessarily exclusively. The hospital should approve their place of residence and living conditions.

- Effectiveness. How have the men fared who have been to various facilities? Do they fit back well and effectively into the diocese? Are they happy or do they relapse? Has the relationship between the priest and the bishop improved? Are the people they serve content with them? Are they managing their sexuality well? Are they still in therapy after a long residential stay (they shouldn't be)? Are they still connected to the treatment facility after several years (they shouldn't be)?
- We believe that judging by the results obtained is the only useful criterion. Statements made by facilities about themselves are often irrelevant to the real problems the diocese faces with a priest. For example, "Compassionate Care" may be a kind thing to say, but, effective intervention is the kindest thing that can be done for the priest and for the diocese. Slogans do not necessarily result in effectiveness. Being good

consumers and asking others about a facility is a good way to gauge effectiveness regardless of how a facility advertises itself.

- Experience of the center in dealing with the issue under review.
- Familiarity of the center in dealing with clergy.
- Available research on outcomes of treatment.

- The bishop needs to know what type of evaluation process is offered. Is projective testing offered? Is neuropsychological testing available?
- What type of specific treatments are available for a specific problem?
- Does the facility offer training in social, assertiveness, empathy, and cognitive skills? Does it offer sex education?
- What types of psychotherapy are available?
- It would be important to understand the spirituality that is offered by the facility. ("... religious consequences have often proven to reduce recidivism more than legal consequences."
- The cost of the program and approximate length of stay.

- In seeking healing or restoration for the suffering cleric or religious, special care needs to be given to helping the client assess and accept his personal inner needs. It is not uncommon for many priests and brothers in treatment to discover that they lacked even the basics of a life of prayer and faith. Joined to the scientific, psychological and medical aspects of prayer there needs to be skilled and professional guidance in creating an inner life of prayer and reflection grounded in sound meditative and contemplative disciplines and practices.
- Treatment centers with longevity and continuity of services provide verification of the soundness of their program. Men effectively returned to fruitful and personally satisfying ministry, or men successfully transitioned to a satisfying lay-state are the

best indications of the effectiveness of any treatment program. Those in the profession of therapeutic services are now well aware that continuity of services is paramount to quality of services. A facility **must** provide follow-up to residential care with specific recommendations for out-patient care.

- Therapeutic Philosophy: There are a multitude of treatment approaches available to those in need. There are programs which offer uniform services for all clients (e. g., 12-step programs). There are individualized programs which tailor the therapeutic experience to each resident. And there are programs which have an eclectic basis. Does the program follow established standards of care, for example, the "Proposed Standards of Care for the Treatment of Adult Sex Offenders" (if that is the presenting issue) established by the Journal of Offender Rehabilitation, (Vol. 15, Nos. 1/2 1990, Coleman and Dwyer)? Is there adequate flexibility in the program to allow for a variety of etiological factors contributing to the manifestation of the presenting issue? Are there behavioral, cognitive, and emotional factors considered in the treatment approach? A comprehensive treatment approach must include developmental, cognitive, affective, behavioral, familial, and spiritual determinants.
- It is our belief that a compatible, comprehensive team approach is irreplaceable in working with priests and brothers who have emotional, behavioral, and/or interpersonal problems. When the man feels he has the support, understanding, respect and concern of those who are trying to help him, he is in a much better position to take advantage of that professional and personal assistance. There is no substitute for confidence and trust in those who are caring for you. If there are individuals in your diocese or community who have been through a treatment program and are willing to share themselves and their stories with someone with whom you are intervening, there is no more persuasive a position for their support, understanding, and concern. They can be allies in your fight for health, honest and integrity among the priests in your diocese.

- While recognizing there are a wide variety of factors that can and do influence the selection of a treatment facility, the following represent what we hold to be essential criteria. In fact, these criteria are applied when, on occasion, (this facility) makes cross-referral to other residential treatment facilities.
- As all healing involves the whole person, the facility should provide comprehensive and effective integration of psychological, spiritual and physical aspects (i.e holistic model).

- Therapeutic staff in all areas to be professionally credentialed (e.g. doctoral level, licensed psychologists, certified addictions counsellors etc.).
- Intensive, multi-modal therapy program with clearly defined treatment goals and objectives, coupled with realistic time parameters.
- A planned program for follow-up with both the individual and the referring diocese/community. Specific relapse prevention strategies are integral to this.
- Demonstrated experience in treating sexual misconduct/abuse issues and a well-defined strategy for such treatment.

- A treatment center sensitive to the particular needs of priests.
- A treatment center that accents the faith dimension of a priest's life.
- A treatment center that is licensed, accredited and staffed by professionals who use a multidisciplinary approach to treatment.
- A treatment center that maintains communication with the bishop while maintaining professional boundaries regarding privileged communication.

In seeking a facility for evaluation and treatment, we would advise the bishop to consider the experience, staffing, and reputation of the center. The most efficient program provides a comprehensive system of care that ranges from an inpatient component to a full outpatient regimen continued through aftercare. The recommended team of caregivers should be multi-disciplinary: psychiatrist, psychologist, psychiatric nurse, psychiatric social worker. A priest or other religious person should be provided vocational evaluation and spiritual direction. Program services should be molded to individualized needs, especially the length of the patient's treatment and hospital stay. Many religious find it beneficial to be treated in a milieu that includes lay men and women who represent other professions and other religious denominations. Finally, geographic availability and personal preference should be considered.

PART 4**4. OTHER COMMENTS****(Johns Hopkins Medical Institutions)**

Finally, I think that the critical matter is to learn that problems that are found amongst priests are not unique to them but are found amongst many other patients that the unit is evaluating, treating, and rehabilitating as well. This has the advantage of enlarging a person's understanding of the problem. I hope this is helpful to you in relationship to you and your group.

(Saint Luke Institute)

It is helpful to the staff and the priest-in-treatment if a thorough understanding about the prospect of returning to ministry is available prior to the beginning of residential treatment. If the return is condition upon treatment outcome that should be clearly stated; if legal issues preclude return then the priest can benefit from that knowledge throughout the course of therapy.

(Servants of Paraclete - St. Michael's Community)

As you may know, St. Michael's and the other programs offered by the Servants of the Paraclete do not treat lay people. Therefore, we accept referrals only concerning priests and religious.

(Servants of the Paraclete - The Albuquerque Villa)

The Servants of the Paraclete have been in the forefront in giving service and aid to priests and brothers in need since 1947. Because of our pioneering efforts in this area, an area in which there was a little information and no precedent, we have come under heavy attack within recent months. Many also know - as has been recently testified to under oath by independent, well-respected professionals in this field - the Servants are also the only religious community whose sole purpose and charism is to serve other priests and religious in need. As a result of being in a field that had been ignored by the larger professional community, we have made the mistakes and benefited from the experience of having tried, failed and tried again to give assistance to fellow priests and brothers.

As a result of our efforts, and our failures, we have learned the valuable lesson of supporting our efforts by enlisting the help of professionals of the highest quality. Together with our professional lay staff we continue to offer the finest treatment modality available and at the lowest cost to the sponsoring diocese or religious communities. At the Albuquerque Villa we have enlisted men and women, lay and clergy, of the highest caliber to design and implement a program uniquely suited to meet the needs of today's clergy. We have learned hard lessons and continue ready to offer our brothers in need a treatment program that combines the spiritual with the psychological and medical resources.

PEDOPHILIA: DIAGNOSTIC CONCEPTS TREATMENT, AND ETHICAL CONSIDERATIONS

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Over the past decade we have become increasingly aware of the extent and magnitude of the sexual victimization of children in our society and considerable efforts have been made to offer help and assistance to these victims. However, to a large extent, their perpetrators have been regarded more as offenders deserving punishment than as persons needing help.

This paper serves to broaden the base of our knowledge in regard to an adult's sexual attraction to a child and helps us differentiate between the perpetrator and his offense. It is a conceptual work, exploring the nature of pedophilia, its etiology, manifestation, diagnosis, and treatment which encompasses both clinical and ethical considerations.

To an issue fraught with myth, misconception, fear, hostility, and ignorance, Dr. Berlin and Mr. Krout's paper brings clarity, order, understanding, and hope. It is only through understanding and with understanding that we will find the way to help perpetrators inhibit unwanted pedophilic inclinations. The sexual victimization of children is the abuse of power. Knowledge is power, and through knowledge we are empowered to address this problem and make our society a safer one for our children. This paper is an important contribution to the sparse literature on a serious subject.

A Nicholas Groth, Ph.D., Co-Director, Sex Offender Program, State of Connecticut Dept. of Correction, Somers State Prison.

THE NATURE OF HUMAN SEXUALITY

People do not decide voluntarily what will arouse them sexually. Rather in maturing they discover the nature of their own sexual orientation and interests. Persons differ from one another in terms of (a) the types of partners whom they find to be erotically appealing, and (b) the types of behaviors that they find to be erotically appealing. They also differ in intensity of sexual drive, the degree of difficulty that they experience in trying to resist sexual temptations, and in their attitudes about whether or not such temptations should be resisted.

When persons experience erotic desires to engage in types of sexual behaviors that could cause themselves or other harm, such as sadistic, coercive or masochistic sexual involvements, psychiatric help may be needed. This may also be necessary when a

person experiences strong erotic attractions towards unacceptable sexual partners, such as children.

Some psychiatric diagnoses can be made, then, simply by asking co-operative persons about the range of behaviors they find to be erotically appealing and about the difficulty they experience in trying to resist succumbing to such sexual temptations. This line of questioning can identify the person who meets the DSM III diagnostic criteria for sexual exhibitionism, sexual sadism, sexual masochism, transvestism, and compulsive voyeurism (American Psychiatric Association, 1978). Each of these represents an unconventional form of sexual appetite. These men, unlike the average man, often experience great difficulty resisting erotic temptations to repeatedly expose themselves, to repeatedly have themselves beaten, or to repeatedly peep in windows, depending upon the nature of their particular sexual compulsion. Masturbation cannot fully satisfy these cravings because what they crave is not just sexual release, but a specific type of sexual activity. Thus, although the average man is physically capable of exposing himself publicly, he does not have to repeatedly fight off the urge to do so, as does the exhibitionist, in order to stay out of trouble.

Another way in which sexual problems possibly requiring psychiatric assistance can be identified is by inquiring about the range and types of partners that a person finds to be erotically appealing, and about how difficult it is to resist the temptation to become involved sexually with such partners. Some men, for example, report that they are attracted sexually to both children and adults, but that when they have a satisfying adult relationship they are able to resist the temptation of becoming sexually intimate with a child. Some such men, however, during periods of time in their lives when they do not have a satisfying adult relationship do become involved sexually with children. Groth (1979) refers to such men who find both adults and children to be erotically appealing as regressed pedophiles. There are other men who experience absolutely no erotic attraction whatsoever towards adults but who have a great deal of difficulty resisting the sexual temptations that they experience towards children. Groth refers to these men as fixated pedophiles.

Pedophilia then is simply a term used to indicate that an adult finds children to be sexually appealing. This condition seems to have been identified almost exclusively in men. If a man is attracted sexually only to boys, a diagnosis of homosexual pedophilia can be made, whereas if he is attracted only to girls, a diagnosis of heterosexual pedophilia may be in order. If gender is not a factor, then the appropriate diagnosis is bisexual pedophilia. As with other appetites, the pedophilic appetite craves satiation, with recurrence of hunger an expected event.

Some men who are attracted sexually to children desire not to be and would like to change. Under such circumstances, their sexual attractions to children are said to be ego-dystonic. If a man's sexual attraction towards children does not conflict with his conscience and personal moral convictions, then his pedophilic desires are said to be

ego-syntonic. In very rare instances, some men experience erotically sadistic desires towards children. Under such circumstances, a diagnosis of sexual sadism should also be made.

There are some men who find children to be somewhat appealing erotically but who, nevertheless, find it easy to resist becoming sexually involved. Such persons may not require professional assistance. Those who do experience difficulty resisting such temptations on their own, however, may require help.

The following is a brief verbatim quote from a man whose sexual orientation can be characterized as ego-dystonic, fixated, homosexual pedophilic. The comments of this patient give some sense of how tortured and conflicted he feels by the sexual lusts and cravings that he experiences towards young boys.

"What starts a person like myself doing what I do? Why me? Why can't I be normal like everybody else? You know, did God put this as a punishment or something towards me? I am ashamed. Why can't I just go out and have a good time with girls? I feel empty when a female is present. An older 'gay' person would turn me off. I have thought about suicide. I think after this long period of time, I have actually seen where I have an illness. It is getting uncontrollable to the point where I can't put up with it anymore. It is a sickness. I know it's a sickness. But as far as society is concerned, you are a criminal and should be punished. Even if I go to jail for twelve or fifteen years, or whatever, I am still going to be the same when I get out."

This last statement was not meant to be defiant.

ETIOLOGY OF PEDOPHILIC SEXUAL DESIRES

It is a deeply rooted aspect of human nature that we experience desires to seek out a partner with whom we can share tenderness, affection, companionship, and physical intimacy. Even in animals, one can observe the so-called mating instinct. People do not experience feelings of erotic love because it is intellectually rational to do so, or because they have been taught that it is sensible to do so. Rather, there is a certain "chemistry" involved. Most of us can describe attributes, both physical and psychological, that comprise our archetypal fantasies of an idealized partner or mate. In the overwhelming majority of cases, the object of our erotic affections is a peer. Most adults do not (1) become involved sexually with children, (2) repeatedly fantasize about children when masturbating, (3) find pictures of naked children more erotic than pictures of naked adults, and (4) have to repeatedly fight off the temptation of becoming involved with children in a sexual or romantic way.

In addition to yearning for a loving adult sexual relationship, almost all of us are aware of the fact that infants and children often elicit an emotional response from us.

Rather than involving feelings of lust or erotic love, however, the feelings which often well up internally in response to children are ordinarily ones of affection and gentleness, as well as a desire to nurture, cherish, and protect. It is sometimes difficult to resist the urge to pick up and cuddle a young infant or child. We do not ordinarily fall in love with children, however, in a romantic or sexual way.

Most young people devote a great deal of time, thought, and energy towards seeking out a partner with whom to share affection, companionship, and physical intimacy. The man who, for unknown reasons, discovers that he craves that type of relationship with a child rather than with an adult, however, copes with life from a very different perspective.

Some have argued that sexual assaults are invariably aggressive (Groth, 1979). In the vast majority of pedophilic acts, this is simply not so. Most pedophiles, use no physical force whatsoever, but instead derive pleasure from engaging in sexual activities with children, sometimes in a caring way (Baker et al, 1968; Berlin, 1983b). By definition, the issue to be explained in pedophilia is one of sexual and affectional orientation. Pedophilia is not a disturbance of temperament or aggression.

SEXUAL ORIENTATION:

PENECTOMIZED MALE REARED AS A GIRL

How is it then that sexual orientation and affectional interests are acquired? It appears that both life experience and constitution play a role. The role that environment can play was dramatically demonstrated by a tragic case reported by Money (1980) in which one of two genetically identical male twins was so severely damaged at the time of circumcision several months after birth that a total penectomy was required. That child was then reared as a girl. The child's chromosomal pattern, of course, remained unchanged, and she has now reached her teenaged years. She has developed breasts by virtue of having been administered estrogens; surgically, an artificial vagina has been created. According to Diamond (1982), however, she nevertheless experiences considerable difficulty in adjusting as a female, and she is in some ways ambivalent about her status. Still, at age 19, this twin raised as a female apparently feels herself to be a woman in terms of gender identity and also experiences some level of sexual attraction towards age-appropriate males. Thus, although she is a woman with an XY rather than a XX chromosomal karyotype, as a consequence presumably of how she has been raised, she feel herself to be a woman and she finds men to be sexually appealed.

MANY PEDOPHILES FORMER "VICTIMS"

There are many additional examples showing that environment and life experiences can play at least some role in the development of gender identity and in the development of sexual orientation and interest. Groth (1979) and others have shown that many men who experience pedophilic erotic urges as adults were sexually involved with adults when they were children. Thus, in treating the pedophile one is in point of fact often treating a former "victim." One is merely treating him later on in his life after the circumstances of his childhood, or the intricacies of his biological constitution, have produced their psychological sequelae. Why sexual involvements with an adult during childhood seem to put some at risk of experiencing pedophilic sexual urges later on in life, but not others, is not known.

Money(1980) has proposed that excessive prohibition of early sexual expression may also put one at risk of developing pedophilic sexual desires. He has reported that many men with sexual disorders have come from homes where even the slightest expression of sexuality, including masturbation, was severely chastised. Gaffney et al (1984a) has documented evidence that pedophilia may occur more frequently within certain families.

Biology, too, can play a role in the development of sexual interests. Sexual behavior in humans is often a response to subjectively experienced erotic desires and fantasies. Although it appears that specific sexual tastes or preferences may sometimes be modified by virtue of early life experiences, the phenomenon of sexual desire itself is apparently unlearned and rooted in biology. Males do not have to be taught how to obtain an erection. Just as it is true of language and dialect, once acquired sexual desires are not readily modified.

It is just as reasonable to ask whether one might be put at risk of developing unconventional sexual interests, such as pedophilia, by virtue of the presence of certain biological abnormalities, as it is reasonable to ask whether one could be put at such risk by being exposed early on in life to certain environmental events. One way of addressing this issue would be to try to determine whether or not there is an increased prevalence of biological abnormalities of the sort thought to be related to human sexuality among a group of men who experience unconventional sexual interests.

BIOLOGICAL ABNORMALITIES

Berlin (1983b) evaluated 41 men, all of whom met the DSM III diagnostic criteria for some form of paraphilia ("sexual deviation disorder") looking for the possible presence of biological abnormalities. The majority of these men were either pedophiles or exhibitionists. Although no significant abnormalities were detected in 12 of the 41, a total

of 63 abnormalities was found among the other 29 men. These included 7 chromosomal anomalies (most frequently Klinefelter's syndrome), as well as 18 abnormal levels of testosterone, 8 of follicle stimulating hormone, and 14 of luteinizing hormone. There were also 7 abnormal CT scans of the brain, 4 pathological EEG's, and 5 abnormal neurological examinations. Following statistical analysis, Berlin (1983b) concluded, as have others, that there may, indeed, be an association between the presence of certain kinds of biological abnormalities and the presence of unconventional kinds of sexual interests such as pedophilia. Recently, Gaffney and Berlin (1984) documented an abnormal pattern of luteinizing hormone (LH) release over time in response to the intravenous administration of bolus of luteinizing hormone releasing factor (LHRF) in a group of pedophilic patients. At the Johns Hopkins Hospital Sexual Disorders Clinic, it is unusual to see a man who experiences recurrent pedophilic cravings in the absence of (a) a significant biological abnormality, (b) a past history of sexual involvements with an adult during childhood or (c) both.

ASSESSMENT: DISTINGUISHING BETWEEN (1) DIMINISHED MENTAL CAPACITIES, (2) PERSONALITY TRAITS, AND (3) SEXUAL ORIENTATION

Persons are sometimes referred for psychiatric evaluation because they have become sexually involved with a child. However, a diagnosis such as pedophilia cannot be made simply by considering behavior alone. Rather, for purposes of diagnosis and for proper treatment, one must try to appreciate the state of mind which contributed to the individuals' behavior.

Like any behavior, sexual behavior with a child can be enacted for a variety of reasons. For example, a person with schizophrenia may behave in a particular way in response to hallucinations "telling him to do so," whereas the alcoholic's behavior may be a reflection of diminished judgment secondary to intoxication. A mentally retarded individual may become involved sexually with a child (who incidentally may be of the same approximate mental age as he) because of the lack of availability of adults partners, and a lack of capacity to fully appreciate and understand the wrongful nature of his actions. In none of these instances would a primary diagnosis of pedophilia necessary apply.

In DSM II, conditions such as pedophilia used to be considered subcategories of a specific personality type (i.e., the so-called antisocial personality disorder). DSM II (APA, 1978) acknowledges that this is by no means necessarily so. Diagnosing a person as a pedophile says something about the nature of his sexual desires and orientation. It says nothing whatsoever, however, about his temperament, or about traits of character (such as kindness versus cruelty, caring versus uncaring, sensitive versus insensitive, and so on). Thus, a diagnosis of pedophilia does not necessarily mean that a person

is lacking in conscience, diminished in intellectual capabilities, or somehow "characterologically flawed." In evaluating a person who has become sexually involved with a child, one needs to try to determine whether the behavior in question was a reflection of (a) psychosis, (b) poor judgment and psychological immaturity, (c) lack of conscience, (d) diminished intellect, (e) intoxication, (f) a pedophilic sexual orientation, or (g) a combination of these plus other factors. One needs to evaluate independently, the nature of an individual's sexual drives, and interest, as opposed to what that person is like in terms of character, intellect, temperament, and other mental capacities.

PEDOPHILIC BEHAVIOR AND ITS RELATIONSHIP TO HUMAN APPETITES AND COMPULSIONS

Although, in order to hold persons accountable for their own actions, society tends to presume that individuals can invariably control their own behavior through "willpower" alone, this is simply not always so (Carnes, 1983). It is easy for a nonsmoker to argue that any smoker could stop if he or she really wanted to do so. Surely, this must be so in the case of the pregnant smoker, if not for her sake, then certainly for the sake of not abusing her unborn child. Many of those who have tried to give up smoking and failed, however, can appreciate the difficulty involved in trying to overcome that habit.

Patients on kidney dialysis made thirsty by the procedure often have great difficulty maintaining necessary fluid restrictions, even though not doing so can be life threatening to them (Wirth and Folstein, 1982). The more thirsty they are made by the procedure, the more difficulty they experience in limiting fluid intake. The researchers who documented this finding concluded that limits to fluid intake set by physicians may not suffice because they differ from those set by the patients own physiology (Wirth and Folstein, 1982).

It is easy for a person who is not tempted sexually by children to argue that any pedophile could stop having sex with children if he would simply make up his mind to do so. Admittedly, sometimes it is difficult to determine whether a person is trying his/her best and failing, or just not trying. This does not mean, though, that many are not trying. When it comes to appetites or drives such as hunger, thirst, pain, the need for sleep or for sex, biological regulatory systems exist that may cause an individual to experience desires to satisfy those hungers in ways that cannot invariably be successfully resisted through willpower alone. Sometimes persons may feel so discomforted by their cravings that they feel compelled to act in order to diminish their discomfort.

A common source of confusion about whether or not persons can control compulsive or appetite-related behaviors, such as pedophilia, relates to the observation that often such behaviors are enacted in a premeditated fashion. A pedophile rarely approaches a child, for example, when a policeman is present. It is important to appreciate, however,

that this is not unlike the case of the cigarette smoker who may be able to temporarily refrain from smoking while in his doctor's office because his physician's presence causes a feeling to well up inside which helps him to control his behavior. This does not mean that that smoker will necessarily be able to break the smoking habit, though, when his efforts to do so depend not upon the stabilizing presence of another individual but upon his willpower alone.

A major issue in trying to understand human behavior relates to whether one should consider a person to be (a) the passive product of life experience and constitution, versus (b) a conscious agent capable of transcending prior determinants. One does not want to excuse as "psychopathology" irresponsible behavior. On the other hand, one should not be too quick to label as misbehavior the compulsive sexual acts of persons needing help in order to be able to better control their behavior. Often a double standard is applied in dealing with compulsive paraphiliac types of human sexuality. If a person states that he is trying his best to diet, to stop smoking, or to stop compulsive handwashing, he is often believed and helped. If, however, a person say he needs help in order to be able to resist the urge to have sex with children, to expose himself publically, or to engage in coercive sexual acts, his claim that he cannot control himself through willpower alone is often dismissed. In the author's judgment, many men with pedophilic sexual orientations do need help in order to be able to control their behavior appropriately.

TREATMENT OF PEDOPHILIA: CONCEPTUAL CONSIDERATIONS

Four major modalities have been proposed for treating pedophilia. They are (1) psychotherapy, (2) behavior therapy, (3) surgery, and (4) medication.

Psychotherapy

Classical psychodynamic theory assumes that all men would ordinarily develop conventional erotic attractions towards age-appropriate partners of the opposite sex, but that this does not occur in some instances because unhealthy early life experiences interfered with the normal process of psychological maturation. Therapy utilizes the process of introspection to try to figure out what went wrong with the expectation that newly acquired insights will then facilitate the problem being rectified.

It is doubtful that individuals can come to fully understand the basis of their own sexual interests through the process of introspection alone. The average man probably cannot figure out simply by thinking about it why he prefers women rather than men. Similarly, it is not certain that the pedophilic individual can figure out the basis of his own sexuality. Furthermore, even if he could, knowing why one is hungry -- be it for food or for children, doesn't make one any less hungry, nor does it make it any easier for one

to resist temptation. Finally, there is little convincing evidence showing that the traditional psychotherapies alone are an effective means for treating pedophilia.

Behavior Therapy

Behavior therapists tend to be less concerned with the historical antecedents of pedophilia than with the question of what can be done about it. The feature common to most behavioral approaches is an attempt to extinguish erotic feelings associated with children, while simultaneously teaching an individual to become sexually aroused by formerly non-arousing age appropriate partners. Although in laboratory situations, behaviorists have shown that some pedophilic men no longer demonstrate physiological evidence of sexual arousal when looking at pictures of naked children, and that they can begin to show arousal to age-appropriate stimuli, it has not been well established that such changes invariably carry over into the non-laboratory situation (Marks, 1981). Most of us can appreciate how difficult it would be to try and stop feeling the sexual attractions we have experienced as natural throughout our lives. There is no reason to believe that it is any easier for the fixated homosexual pedophile to learn to lose his interest in boys and to become sexually aroused by women, than it would be for the average male to lose his interest in women and to instead begin lusting for young boys.

Punishment

Another type of "behavior therapy" that has been tried is punishment, usually in the form of incarceration. Although society sometimes chooses to punish for reasons other than behavior modification, behavior modification is often one of the intended goals. There is however nothing about being in prison that can change the nature of a pedophile's sexual orientation or that can increase his ability to resist acting upon improper sexual temptations.

Surgery

Two types of surgery have been proposed as a treatment for pedophilia. They are (1) stereotactic neurosurgery, and (2) removal of the testes. Neurosurgery for this purpose is still investigational and will not be discussed here. Its rationale has been explored in a review article by Freund (1980).

Removal of the testes (castration) has been suggested as a treatment for pedophilia because the testes are the major source of testosterone production in the body. There has been much confusion about castration about castration, a procedure which does not remove the penis, but which instead removes the testes in order to lower testosterone.

Testosterone is an important hormone related to human sexuality and gender differences. If the testes of a male fail to produce adequate amounts during early embryonic life, he will be born with the external anatomical appearance of a female. Thus, testosterone causes external anatomical masculinization of the fetus, and also produces certain changes in the endocrinological functioning of the male brain (Witson et al, 1981). The marked increase in testosterone production which occurs at the time of puberty in males is associated with the development of increased pubic and facial hair, deepening of the voice, an increase of muscle mass, and a marked increase in sexual libido. The idea of lowering testosterone in the case of the pedophile is to try to decrease the intensity of his sexual cravings, which are for children.

Some critics have argued that castrating the "sex offender," which involves removal of the testes, and not the penis, is like cutting off the hand of the thief. This is in no way so. Cutting off the penis would be analogous to cutting off the hand of the thief. A male animal whose penis has been surgically removed will still try to mount a female in heat, suggesting that the penectomized male is still sexually motivated, though unable sexually to perform. A castrated male, on the other hand, whose penis is intact can perform sexually but will ordinarily not attempt to mount a female in heat, suggesting that he is no longer motivated to do so.

In animals, lowering testosterone by means of removing the testes usually eventually leads to a total cessation of virtually all sexually motivated behavior, although sometimes this may take as long as two years to occur (Freund, 1980). In humans, the relationship between very low testosterone levels and low sexual libido is also fairly well established. This evidence comes from a variety of sources including studies on hypogonadal men, data from persons with adrenogenital disorders, studies on drugs that lower testosterone as side effects, and from several well controlled studies looking at the effects of administering testosterone in an attempt to increase sexual libido (Ellis, 1982, Kwan et al, 1983; Sturup, 1972; Carney et al, 1978).

THERAPEUTIC SEX DRIVE REDUCTION

In an article entitled, "Therapeutic Sex Drive Reduction," Freund (1980) reviewed data regarding removal of the testes in humans as a means of trying to help some men gain better control over their sexual behavior. In one study in Denmark, Sturup (1972) reported upon a thirty-year investigation of 900 castrated "sex offenders," many of whom were pedophiles, involving over 4,000 follow-up examinations. He documented less than a 3 percent recidivism rate. Ficher Van Rossum in Holland, Kinmark and Oster in Sweden, and Cornu in Switzerland reported comparable findings (Freund, 1980). The study in Holland involved 237 men with a 1.3 percent recidivism.

In the Swiss study, there was a 5.8 percent recidivism rate among 120 men following castration, with a 52 percent recidivism rate in the noncastrated control group. Follow-ups ranged from five to thirty years. Bremmer (1959) reported a 58 percent recidivism rate in the five years prior to treatment, in a group of men who showed only a 7.3 percent recidivism rate during the five years post-surgery. Thus, the surgical method of lowering testosterone did seem to enable many men to better control their sexual behaviors. Furthermore, many of these men did not lose their capacity to perform sexually following castration.

CYPROTERONE ACETATE AND MEDROXYPROGESTERONE ACETATE

Today it is no longer necessary to perform castration in order to reduce testosterone levels. Rather, this can now be done pharmacologically in a graduated way without the physical or psychological trauma of surgery. In Europe and the Scandinavian countries, cyproterone acetate has been used for this purpose, and there are several "blind" as well as "non-blind" studies supporting its effectiveness (Laschet and Laschet, 1976; Money et al, 1976). In the United States, since Money first began doing so in 1967 in conjunction with the treatment of pedophilia, the drug most often employed as a pharmacological method for lowering testosterone has been medroxyprogesterone acetate. Depo-Provera (Money Et al, 1976, Berlin & Meinecke, 1981; Berlin & Coyle, 1981, Berlin, 1981, Berlin & Schaerf, 1984).

Medroxyprogesterone acetate (MPA) can be injected intramuscularly once per week. There it binds to the muscle, from where it is then gradually released over the course of several days into the blood stream. At this time, the initial starting dosage used in The Johns Hopkins Clinic has been 500mg IM once per week of the 100mg per cc concentration. No more than 250cc is given into a single injection site.

Major side effects of MPA have been weight gain, and in some cases hypertension. Mild lethargy, cold sweats, nightmares, hot flashes, and muscle aches have also been reported. The drug, which is not feminizing, may cause an increased incidence of breast cancer in female beagle dogs, and of uterine cancer in monkeys. It has been used in over eighty countries of the world as a female contraceptive, supported in its use for this purpose by the World Health Organization. No studies showing an increased risk of cancer in males (either humans or animals) have been reported. Two recent articles, one in Science (Sun, 1982) and the other in the Journal of the American Medical Association (Rosenfield et al, 1983), failed to find convincing evidence that MPA is carcinogenic in humans.

There is no doubt that MPA consistently decreases serum testosterone levels significantly. This can be confirmed by means of a simple blood test. The idea of using MPA in the case of the pedophile is to try to decrease the intensity of his sexual cravings,

thereby, hopefully, making it easier for him to successfully resist unwanted temptations. The drug cannot change the nature of his sexual orientation.

What is not yet fully established regarding the use of MPA is optimal dosage, which of the paraphilias will respond most adequately, long-term side effects, and precise long-term recidivism percentages. There is little reason to believe, however, that recidivism should be any higher than those low rates documented when surgical removal of the testes was used as a method of lowering testosterone. Of more than 70 men treated at the Johns Hopkins Clinic with MPA over the past three years for some form of paraphilia (mostly pedophilia and exhibitionism), less than 10 percent have relapsed. In addition, compliance rates have been better than 90 percent.

There has been some concern about whether MPA should be given to pedophilic men who are on legal probation. In the author's opinion, if it is not an effective drug, then it should not be used at all. If it is effective, as it often seems to be, then it is difficult to see why a person should be denied the opportunity to take it just because he is on probation or perhaps even incarcerated. Some incarcerated men report that MPA frees them from intrusive, obsessional sexual preoccupations.

MPA is not a cure. It is not a guarantee. It is not a punishment. Some pedophiles report being unable to successfully resist sexual temptations through willpower alone, even with the assistance of professional counseling. Such individuals should be afforded the opportunity to see whether or not MPA confers upon them an increased capacity for self-control.

RATIONALE FOR USE OF MPA PLUS COUNSELING

Some critics have argued that psychotropic drugs such as MPA may in some ways be "mind controlling." The legitimate medical indications for use of psychotropic drugs are (a) to decrease suffering (as in the case of antidepressant medications), (b) to restore function (as in the case of antipsychotic medications), or (c) to increase rather than decrease a person's capacity to successfully exercise self-control as in the case of MPA (Berlin, 1983a).

Most pedophiles receiving MPA also attend group counseling sessions. These are similar to the type often used with alcoholics. There they are expected to acknowledge being tempted to do something improper. They then discuss among themselves strategies intended to help enable them to resist such temptations successfully. This includes discussions of whom to call, what early warning signs to look for, and what situations to avoid. The groups provide both peer pressure and peer support.

When a person desires sex or falls in love, it is often easy to become convinced that the relationship is good and healthy and not harmful or wrong. Such self-deception may at times be easy for the pedophilic individual in light of the fact that sex with children, though wrong, may not in every instance be damaging (Standfort, 1984). Some children may enjoy certain sexual and non-sexual aspects of their relationships with an adult, thus facilitating self-deception on the part of the adult. Treatment, therefore, may have to involve helping a person stop rationalizing, as well as helping him to develop strategies for more successfully resisting sexual and affectional temptations.

ETHICAL CONSIDERATIONS AND CONCLUDING COMMENTS

A few hundred years ago in New England, misguided parishioners burned at the stake women whose behaviors they feared or found offensive. Persons whom we might now treat in psychiatric hospitals were shackled, often for the better part of a lifetime. In the 1700s, the most common cause for execution in the British Royal Navy was the crime of "buggery," homosexual behavior between consenting adults (Gilbert, 1976). In each of these instances, many good people failed to appreciate the wrongful nature of these reactions. Today, the person with a pedophilic sexual orientation is often ridiculed, maligned and disparaged, with little concern about him as a person. It is simply taken for granted that the pedophile is deserving of scorn, with little more thought given to such a proposition than was given several hundred years ago to the notion that lepers should be exiled. It is difficult contemporarily to be fully aware of one's own society's assumptions.

Today, most of us would probably accept as a given the belief that any man who becomes sexually intimate with a child must simply be a callous predator, unwilling to reflect upon the possibility that such an individual might have a genuine concern for the well being of children. Labels such as "molester" and "abuser" are readily applied with little forethought. After all, how could anyone who really cares about a child's well being show so little concern and manifest such an abuse of trust as to become sexually involved? There can be little doubt that children are too unprepared and too vulnerable to fully appreciate the consequences of sexual involvement with an adult. However, imagine what life must be like for the man who finds that he never experiences feelings of erotic arousal or romantic love towards adults, as much as he might wish that he could, but who recurrently lusts for or falls in love with young boys or girls in an erotic, sensual way.

To provide treatment to persons with pedophilic sexual orientations in no way reflects a lack of concern for young children. One can treat children and treat pedophiles as well. These are not mutually exclusive choices. In counselling a child, it may help if that child understands that the pedophilic individual may genuinely have cared about him,

even though that caring were expressed in an improper way. Preventive treatment cannot be completely accomplished without dealing with the pedophile himself. To the extent that treatment helps the pedophile gain better self-control, both his interests and society's interests are well served.

Although it is not the pedophiles fault that he has the sexual orientation that he has, it is his responsibility to deal with his sexuality in a manner that does not put innocent children at risk. However, in order for him to be able to do this and to be held accountable by society, adequate treatment facilities must be made available, facilities where a person can seek help without fear of stigmatization, ridicule, retaliation, or unwarranted disdain. Only under such circumstances can one expect an individual to talk candidly about the innermost aspects of his own sexuality. This requires trust.

The values that we try to instill in our children are important. Almost two thousand years ago as an outraged crowd attempted to stone to death a woman whose sexual behavior they considered offensive, one man stepped forward to stop the retribution, speaking against such revenge while espousing values such as compassion, understanding, forgiveness, and reformation. He asked that persons be judged not simply by their behavior but with some appreciation for their humanity. Perhaps that message still goes unheeded today when it comes to the issue of how we deal with some of those who have sexual and affectional orientations of a sort that frighten us, and that differ from our own.

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THE ROLE OF THE DIOCESAN OUTSIDE COUNSEL

Andrew J. Eisenzimmer, St. Paul, MN

In reviewing how diocesan outside legal counsel can best play a role in achieving a wholistic approach to the sexual abuse question, we must first understand that, normally, outside legal counsel for a diocese is an attorney who may handle pre-litigation aspects of diocesan sexual abuse matters; who may handle litigation directly or oversee and coordinate the work of other litigation counsel; or who may be retained specifically to handle litigation of such matters. Such understanding can best be found by reviewing some examples.

In some instances the diocesan outside counsel's role is to advise the diocese regarding matters resulting from review of diocesan policies, procedures or activities in this area. Thus, for example, in responding to sexual misconduct in the Church, a diocese may seek to implement various policies. As to the diocese promulgating such policies, one role diocesan outside counsel may play is in drafting and/or reviewing such policies.

In another instance, the diocesan outside counsel's role is to advise the diocese regarding litigation matters. Thus, for example, a diocese may be sued for the misconduct of one of its priests, and the diocesan outside counsel will advise the diocese as to legal issues which arise in that litigation. In some such instances the diocesan outside counsel may also be serving as litigation defense counsel in the particular lawsuit. In other instances another attorney may be retained by the diocese and/or its insurer and the role of the diocesan outside counsel is to coordinate and manage the litigation for the diocese.

Finally, in some instances, the diocesan outside counsel may be a specialist who is retained by a diocese as its separate counsel with respect to certain matters. Thus, for example, a diocese sued in a misconduct case instead of relying upon its usual diocesan counsel, may choose to retain diocesan outside counsel who are quite familiar and experienced in misconduct litigation defense work.

BACKGROUND

The role that diocesan outside counsel fulfills in sexual abuse cases has evolved from the early 1980's. At that time, dioceses began to experience litigation over sexual misconduct cases with increasing frequency. Initially, the cases were rare, isolated instances, often settled or resolved with little or no publicity and the financial impact of such settlements, usually in low five figure dollar amounts, was negligible. Diocesan outside counsel, although usually experienced in defending personal injury cases, were rarely

experienced in handling the defense of sexual abuse cases. This was not unusual, as such cases were rare and attorneys likely had not been involved in such litigation.

In the mid to late 1980's, sexual abuse litigation began to achieve greater importance, both from the standpoint of liability issues and from the standpoint of the financial impact because such cases were soon seen to result in significant settlements and jury verdicts. Throughout this period, diocesan outside counsel frequently were compelled to educate themselves in the unique aspects of such litigation in order to assist the diocese in responding to them. During this time period, the role of the diocesan outside counsel often expanded to include public relations, policy making, evaluating and other aspects.

The 1990's have seen a continued evolution in the role of diocesan outside counsel in sexual misconduct matters. While litigation defense and litigation management continues to be one role filled by diocesan outside counsel, other roles have often been overtaken by others as dioceses have become more adept, experienced and sophisticated in their response to sexual abuse cases, and more importantly, in their response to sexual abuse victims. During this time period, diocesan outside counsel have worked to seek ways to legally protect the diocese from legal liability and have sought to organize the assets of dioceses to shield them from litigation exposure. This time period also has seen diocesan outside counsel engage in litigation with diocesan insurers over coverage and insurance policy exclusion issues.

INSURANCE

Understanding the role of diocesan outside counsel would be incomplete without an understanding of the part insurance coverage plays in sexual misconduct cases. In such cases, the diocese and its bishop have two responses. The first is primarily pastoral; concern for the victims and seeking ways to help such victims, concern for the person who committed the abuse and seeking ways to evaluate and rehabilitate such persons and concern for members of the faith community who are distressed by the occurrence of such abuse in their community.

The second response of the diocese and its bishop is largely legal; assessing the liability for such misconduct, determining the financial exposure created by such instances and creating procedures to prevent reoccurrence. This second response has been driven in great measure by insurance factors. This, in turn, has had some impact on the diocesan pastoral response.

If a diocese was fully insured for a sexual misconduct case, diocesan outside counsel could either defend the case or coordinate that defense with less concern for these other matters. Liability determination and financial exposure would be the concern of the insurers and the diocese and diocesan outside counsel could concentrate on risk management to prevent reoccurrence.

If, however, insurance was minimal, non-existent or contested, the diocese and diocesan outside counsel needed to focus narrowly on liability and financial exposure. This resulted in liability and financial exposure achieving a more prominent place on the list of concerns held by the diocese, and consequently, in the legal response undertaken or coordinated by the diocesan outside counsel.

LITIGATION UNDERTAKING

Whether by a report from a victim or someone acting on a victim's behalf, or by service of a summons and complaint by an attorney, the role of diocesan outside counsel usually begins as reactive where possible legal liability might be found. An initial assessment is usually done to determine what legal issues are present.

The diocesan outside counsel must determine what response is being made to the victim and the faith community, or what investigation is being conducted in order to determine whether such undertaking may have an effect on litigation matters. For example, if the bishop or the bishop's delegate meets with the victim are statements or promises being made which may be used against the diocese in litigation? Are efforts to soothe the faith community, seek evaluation and treatment for the alleged abuser or other responses going to also impact on the litigation? Diocesan outside counsel usually works closely with the diocesan response team to monitor or evaluate such response.

As to the litigation itself, diocesan outside counsel begins by determining what parties are defendants, usually the diocese and a parish or other institution. What follows is an attempt to determine whether insurance coverage exists which might insure these defendants. If such insurance exists, the diocesan outside counsel will tender or present the defense of the case to the insurer. Typically, the insurance policy obligates the insurer to defend the diocese by selecting, retaining and financing litigation defense counsel. Additionally, the policy will require the insurer to indemnify or warrant payment of financial obligations imposed by law.

In some instances the diocesan outside counsel may be the attorney retained by the insurer to defend the litigation. If so, the role the diocesan outside counsel plays is not only to advise the diocese of all aspects related to the litigation, but also to actually undertake the defense by conducting litigation discovery, usually by means of depositions, interrogatories and the like. In addition, diocesan outside counsel in such instances would be the attorney to make or resist motions, to attend hearings on various issues, to represent the diocese and the insurer in any alternative dispute resolution proceedings, and if necessary, to actually try the case.

In other instances the diocesan outside counsel is not the attorney retained by the insurer to defend the litigation. In these instances the attorney retained by the insurer will undertake the litigation activities and typically diocesan outside counsel will monitor,

oversee and coordinate such activities and typically report the progress of the litigation to the diocese and advise the diocese as to such aspects related to the litigation.

Regardless of whether the diocesan outside counsel is the attorney retained to defend the litigation or not, early on the diocesan outside counsel must review documents, files and other materials which may be relevant to the litigation so as to assess and determine whether any problem issues are present related to litigation discovery. Thus, diocesan outside counsel may review chancery priest or personnel files, priest placement files, complaint files, archives (whether secret or not) and any other written materials which may be sought in litigation. Many of the early litigation battles were fought over the discoverability of church documents. Diocesan outside counsel have frequently been occupied in matters relating to state statutory privileges, constitutional protection, privacy issues and other matters which have had an impact on whether the opposing party might get access to Church records.

As these cases and litigation in this area have evolved, diocesan outside counsel have been able to refine and define definitional and other standards in this area to assist the diocese in responding to discovery requests. This has also resulted in diocesan outside counsel becoming closely involved in the formation and drafting of diocesan policies relating to the creation and retention of records.

This matter of discoverability of Church records has assumed great importance in cases where such records might identify other possible claimants and therefore, increase the potential for litigation exposure of the diocese. In many instances diocesan outside counsel have found themselves moving through a legal minefield, caught between the litigation party's obligation to disclose facts and documents relevant to the case and the recognition that such disclosure may well create further and greater litigation and liability exposure for the diocese.

At the same time, diocesan outside counsel must review and evaluate the various legal theories being pled against the diocese in such litigation. In such cases, claims of negligence or claims of vicarious liability are frequently made. The diocesan outside counsel must review the known facts to determine whether proof of negligence might be found. Diocesan outside counsel must also review the facts and law to determine whether the diocese can be found to be vicariously liable for the misconduct of its representatives, even though it may not have known of any propensities to engage in such conduct on the part of that representative.

As these legal liability theories evolve over time, diocesan outside counsel have had to keep abreast of changing laws and doctrine around this concept of ascending liability. While the law has always addressed liability questions relating to master-servant, employer-employee or principal-agent relationships, application of the resulting liability theories to the organization of the Catholic Church has presented unique questions for diocesan outside

counsel to struggle with and understand in an attempt to position the Church to avoid this ascending liability.

LITIGATION SUPPORT

The diocesan outside counsel in such cases have been fortunate in that there have been resources which they could tap to assist them in representing the diocesan client. The Office of General Counsel (OGC) of the USCC, under Mr. Mark Chopko, has made special efforts to advise and assist diocesan counsel in litigating these cases. In addition, organization of the diocesan attorneys from around the country in the National Diocesan Attorneys Association (NDAA) has enhanced the ability of diocesan outside counsel to confer with colleagues involved in similar litigation to share ideas, legal theories, discovery approaches and litigation strategy.

This network of diocesan attorneys has allowed the diocesan outside counsel to evaluate litigation approaches to determine the best course of action for the diocesan client. In addition, the sharing of information about expert witnesses, opposing attorneys, court decisions and jury verdicts has been invaluable to the diocesan outside counsel.

LITIGATION EVALUATION

The most difficult and troublesome aspect of the role of diocesan outside counsel has been in evaluating cases against the diocese. Especially in the early cases, there simply was not a history of litigation and jury verdicts to rely upon to assess and evaluate cases from the standpoint of settlement and potential jury verdict ranges. While information about traditional negligence and tort litigation abounds, little if any information was directly reflective of what diocesan outside counsel might expect in cases against the Catholic Church. Cases of negligence in sexual abuse or misconduct cases simply were not analogous to slip and fall or other negligence cases typically litigated.

As time went on, such information was developed on a case-by-case basis and that information was frequently shared through the OGC and NDAA networks of diocesan attorneys. Before such information was available however, diocesan outside counsel needed to be creative in assessing such litigation.

One tool utilized by diocesan outside counsel which was valuable early on, before litigation information was available, but which has remained valuable to the present, is the use of focus groups or mock juries. In such instances, diocesan outside counsel would arrange to present a condensed version of the facts and law to a select group of individuals and have them "deliberate" to a conclusion. Reviewing the results of such deliberations, together with interviews with the focus group/mock jury participants, allowed the diocesan outside counsel to assess trial strategy, to evaluate strengths and weaknesses in the case and to attempt to quantify the dollar value of such cases.

Another tool utilized by diocesan outside counsel has been the use of jury selection consultants at trial to assist litigation counsel in jury selection. Increasingly today attorneys need to use such experts to select a jury that will not only be fair and impartial, but be receptive to the Church's posture in these cases.

The future will see greater use of consultants in the area of witness preparation. While Church officials are often dynamic and effective public speakers, no one is ever quite comfortable testifying from the witness stand. In the appropriate case, diocesan outside counsel may recommend use of witness preparation consultants to enhance the delivery of testimony of the witnesses.

SETTLEMENT

Like litigation generally, most sexual abuse litigation undertaken by diocesan outside counsel is settled. In many instances, the negotiation expertise of diocesan outside counsel has been an important component in getting such cases settled. Sexual abuse litigation presents challenges where a victim's anger or desire to use litigation to change the Church may present impediments to litigation settlement. The diocesan outside counsel has, in many instances, sought to use alternative dispute resolution (ADR) in order to overcome such barriers. Often the use of a mediator has been effective in getting the parties beyond such emotional barriers to settlement. The diocesan outside counsel has needed to be ready to not only use ADR effectively, but to position the case so that the opposing party and counsel are agreeable to such alternatives as well.

Settlement often results in the need to be creative in formulating settlement agreement provisions acceptable to both sides. Diocesan outside counsel have prepared and drafted settlement agreements covering confidentiality issues, agreements regarding assignment, apologies, counseling assistance, educational assistance and pastoral matters. In many instances, diocesan outside counsel have been able to guide the settlement and draft settlement agreements which have permitted both sides to conclude the litigation.

TRIAL

In a very few instances settlement simply has not been possible and diocesan outside counsel has been required to try the case, often to a jury. The trial itself presents the unusual challenges one might expect in such instances. In addition, unique challenges are often present in examination and cross examination of expert witnesses regarding the psychological impact of sexual misconduct by clergy. Other testimony may relate to church organization and structure, or relate to church finances. Diocesan outside counsel must be able to present this testimony to the judge or jury who are often not familiar with such matters.

POST TRIAL

Following trial, the diocesan outside counsel must be responsive to post trial motions and appeals. While these matters may be typical of most litigation, one different aspect may be the constitutional application in a particular case. Decisions which impact on the Church, whether they involve the assignment and supervision of clergy or whether they involve the imposition of punitive damages, may raise constitutional issues. One role to be assumed by diocesan outside counsel, therefore, is to evaluate and assert, if necessary, such constitutional challenges.

INSURANCE REVISITED

As has been stated, insurance coverage plays an important part in sexual misconduct cases. The role of diocesan outside counsel has often included representation of the diocese in litigation with its own insurance carriers.

With increasing frequency insurers are denying coverage for sexual misconduct cases. Often they rely upon policy exclusions or injury definitions to support their denial of coverage. In some instances, disputes may arise between insurers over how a claim is to be allocated between or among a number of insurers.

In this area, diocesan outside counsel has had to play a prominent role in advocating for the diocese to force the insurers to respect and accept their obligations under insurance policies, or to bring resolutions to coverage disputes between or among various insurers.

In other cases, proof of insurance coverage may be incomplete or lacking. If so, diocesan outside counsel may need to undertake investigation to locate and establish insurance policies or secondary evidence of such coverage in so-called "lost policies" cases. This may also result in the need to litigate coverage issues between the diocese and its insurer. This has required that diocesan outside counsel gain the required expertise to pursue these matters.

FUTURE ROLES

As stated, there has been a continual evolution in the role of diocesan outside counsel in sexual misconduct matters. In earlier cases diocesan counsel might have been called upon to handle not only litigation matters, but also non-litigation matters such as responding to news media, responding to victims, dealing with psychological evaluation and treatment of victims and the accused and many other aspects of sexual abuse cases.

Today, diocesan outside counsel have returned to handling largely litigation related issues and responding to diocesan clients by advising them as to policies and procedures. Some of the earlier tasks performed by diocesan outside counsel have now been undertaken

by public relations staff, by diocesan sexual misconduct response teams and by evaluation and treatment professionals.

The future should see a further refinement of the role of the diocesan outside counsel as one being more purely legal in nature. At the same time, the diocesan outside counsel will need to continue to develop expertise in handling sexual misconduct cases. The future approach will call upon the diocesan outside counsel to be more effective in the management and coordination effort among the various personnel involved in misconduct cases.

The diocesan outside counsel will also be expected to play a larger role in prevention and risk management areas. This has already been seen in diocesan outside counsel advising the diocesan client regarding misconduct policies, formulating background investigations and questionnaires and other preventative measures. It is expected that diocesan outside counsel will also be called upon to assess and evaluate legal issues as they relate to the reassignment of personnel involved in misconduct cases.

Certainly diocesan outside counsel have a role to play in addressing the legal element in educational efforts undertaken by the diocesan client in the sexual misconduct area. Efforts must continually be made to educate diocesan personnel about these matters. Just as diocesan outside counsel played a part in educational efforts in other areas, there is a part for them to play in the area of sexual issues in ministry.

Diocesan outside counsel must also continue their efforts to review diocesan organization, financial affairs and related liability and insurance elements to maximize the legal protection of Church assets. These efforts will require the assistance of diocesan outside counsel experienced not only in litigation but also diocesan counsel experienced in corporate law, trusts, endowments, and various other disciplines.

Finally, diocesan outside counsel must continue to respect the limitations of the role they can play in these cases. At times diocesan counsel are tempted to substitute their judgment for that of diocesan leadership. Decisions by diocesan leadership cannot be driven solely by legal considerations, however. Legal considerations are only one element, albeit an important one, in that decision making process. Other elements, especially pastoral considerations, must be considered as well. In that regard, the role of diocesan outside counsel is supportive and advisory, and diocesan counsel cannot forget that ultimately it is the client who, after considering all these elements, must make the decisions in these cases.

CARE FOR VICTIMS AND THEIR FAMILIES

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BY: Archbishop Harry J. Flynn, D.D.
Archdiocese of Saint Paul and Minneapolis

9/29/94

Any kind of abuse has a terrible and horrendous effect in the life of a victim. When that abuse is physical, sexual or psychological, the effects are far-reaching not only on the victim but also on the family of the victim. When the victimizer or perpetrator is a person in whom trust has been placed, the effects are compounded. This certainly is true if the perpetrator or victimizer is a doctor, a teacher or a therapist, and poignantly so when the perpetrator is a priest.

A priest should be one who gathers, not scatters. A priest should be one whose whole life is caught more in giving than in receiving. A priest is one who lives his life after the mission of Jesus Christ, a life that is a mission of healing, certainly not of hurting. A priest is one about whom there should be positive, healthy, and nurturing memories, not nightmares because of harmful actions in the past.

Whenever a person is victimized in any way, be it physical, psychological or sexual, emotions borne out of that victimization come forth - emotions of anger, hurt, confusion - and too often within the depths of the victimized sometimes a tendency even to hurt out of the hurt. When the victimizer is a priest, and certainly whenever the victim is an adolescent or child, then the Church must stand ready to reach out in the most dramatic way to victims and their families.

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The reflections that I will share here are reflections borne of my own particular experience as Coadjutor Bishop and Bishop in the Diocese of Lafayette, Louisiana.

In June, 1983, the news broke concerning the sexual misconduct of a certain priest in the Diocese of Lafayette. The family of one of the victims was the first to have filed a suit. Since that time, over eighty cases have been settled in court or out of court, and a tremendous amount of money has been paid to the victims and their families because of violations and victimization by a very small number of priests. Some cases have been dismissed because of prescription, but vast amounts of money have been spent as compensation to victims, attorney fees, ongoing medical and psychological expenses and even school tuition which was part of many settlements made by the diocese. These funds were supplied by diocesan contribution, insurance company payments and monies that were procured by our own diocesan insurance program.

When one realizes the financial implications of sexual abuse, it would be very easy, indeed, to forget that the Church is still the Church and that the bishop is still the shepherd. It would be easy not to reach out in a pastoral way to those who have been violated even though we might even appear, at times, to be in adversarial roles because of the litigious circumstances in which we find ourselves.

It seems to me that the underlying presence a bishop should have in a relationship with anyone who has been victimized is a listening presence. A listening presence is borne out of prayer. It means that we are able to be still in the presence of another and not feel that we must say something out of defense or explanation. It means asking ourselves what this person is saying, and what is being left unsaid. We are looking at the person, and letting that individual express his or her pain in any way that seems appropriate at the moment.

There is always the tendency to interfere, and to try to respond immediately to every detail that is raised. However, a listening presence means that we really don't respond until in some way the person's pain has entered into our own lives. In other words, only when we have experienced some of the pain of the other person should we attempt to respond.

Isn't this true in all situations in which a person is distressed, filled with anxiety or in pain? If a minister of the gospel tries to respond to that pain without having felt any of it, there is a certain violation of that person. This is true in the relationship of the victim of sexual abuse to a bishop when sexual abuse has been perpetrated by someone within the Church, such as a priest. The bishop must learn first of all to listen. He must learn to be conscious of that moment when he first experiences the pain of the victim and then learn when it is time to speak.

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After the first suits were filed in the Diocese of Lafayette, Bishop Frey, who was Ordinary of the diocese at the time, visited the homes of some of the victims and listened to their expression of hurt. Indeed, it was very painful for him, as it was for anyone who accompanied him. When I arrived in Lafayette in 1986, I continued to do this to some degree. There was a tremendous amount of anger expressed. Sometimes that anger was so deep and far reaching and coming from so many sources that one could not help but wonder if at least some of the anger was not misplaced. However, the bishop has to be extremely careful about making this judgment.

In other words, the answer to the question of when there has been enough expression of anger is a mystery, and I don't believe that the bishop is the one who should try to respond to that mystery. Rather, he needs to realize that every victim is an unique individual and every family has its own corporate personality history, and style of dealing with problems. He needs to realize that there is every reason in the world for any victim of sexual abuse to be angry and for family members as well. His role is simply to be there and let that anger, hurt and confusion be expressed. Again, his role is a listening presence, and that listening presence needs to take place either in the home of the victims or in the bishop's office, but the bishop needs to quiet his own heart and be able to receive the confusion and hurt before attempting to respond to it.

When many victims come forward at one time, it is necessary for the bishop, after personally being involved with those victimized to provide in some way for that healing to continue. This can be done by providing professional therapists for those victimized or by permitting the victims to choose their own therapists. Another option might seem less professional, but yet is adequately pastoral to reach out to those who have been victimized.

The Diocese of Lafayette hired a Religious Sister skilled in counseling to visit the families of victims in their homes, to listen, and to let the bishop know what more could be done. Many good things happened from this. This particular Sister was well known to many of the families, through her teaching in a school attended by parents of victims. She was readily able to gain the trust of the parents and to respond to them truthfully and with openness without appearing to be defensive on the part of the diocese. In other words, she represented the bishop and the diocese, but she knew well her role which was to represent the needs of the victims to the bishop. She wasn't the only presence for the victims, she was another presence.

I believe that it is important to remember that the more ways we find to reach out to those who have been victimized, the more effective will be the final healing.

It is good for an archdiocese or a diocese to host educational workshops periodically on child abuse - physical and

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sexual. It is good to offer these not only in the see city, but in several locations. The Diocese of Lafayette set up such workshops in 1986. They were administered by the diocesan Office of Family Life and featured psychologists and counselors who addressed every aspect of the subject of abuse. These professionals not only made helpful presentations but were available to meet with individuals and groups.

It was interesting to note the number of victims who were from families in which there had already been physical abuse, verbal abuse or alcohol abuse. One can't help but wonder whether that kind of background made the youngster fertile territory for any kind of perpetrator. I often wondered whether the anger of some which seemed so extensive and unusually prolonged, and without apparent abatement was borne out of the reality that other abuse had occurred and the expression of continued anger was a misplaced way of dealing with it.

It is my firm conviction that every archdiocese and diocese should have an annual liturgy for victims of violence. The liturgy that we held in the Diocese of Lafayette attracted those whose family members might have been murdered or hurt in any way, victims of sexual or physical abuse, victims of assault or rape. This particular liturgy scheduled in early December, was one of the most effective healing agents within the Diocese of Lafayette. Every year victims of various kinds of violence, including sexual abuse, would attend that liturgy - new faces and familiar ones. Every year they would experience the pain once

again and then come to a new level of healing and wholeness. There was always a substantive number of persons, though never an enormous crowd.

In the beginning, we held this liturgy in the Cathedral. Then we moved it to the smaller Immaculata Chapel on the grounds of the diocese's Catholic Center. People attending those liturgies heard the Word of God on forgiveness and the power of God's Word on His wonderful and everlasting love. The Eucharist played a significant part in the whole process of healing. And after the liturgies people had an opportunity to meet in a very small and private reception. It was a powerful and effective way to reach out to those victimized in any manner.

I believe there is no limit to the good that can be done by the bishop's personal involvement with victims or with the families of victims. I can remember attending a funeral of a young man who had been victimized by a priest. He had committed suicide. His mother was an employee of the diocese, and his four brothers, all pall bearers at the funeral, had also been victimized. I went to the funeral so that I could in some way extend myself to that family and let them know that I stood with them in their pain. It was painful for me.

When I left Lafayette to come to St. Paul, the mother of that family wrote me a beautiful letter and told me how meaningful it was on that occasion to look up and see me sitting in the sanctuary at the funeral of her victimized son who had

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committed suicide because he could not apparently live with the pain.

There is a part within each of us that does not like to walk into situations that are uncomfortable. We are diffident to do so. However, when we have the grace and courage to walk into those painful situations, a tremendous amount of healing can be done, and that healing is born out of our pain.

After settlements are made with individuals who have been victimized, there is a tendency for us to think that everything has been taken care of. That is not always true. I recall a young man coming to visit me who had been a victim of sexual abuse by a priest. The young man had received a settlement from the courts, but never really had an opportunity to sit down and express his feelings. His parents also wanted to express theirs. They came to see me and told me how terribly angry they had been because of this victimization. I listened to them and they spoke at length. At the end of the conversation, I simply said that I was sorry for all that they had gone through, and hopefully that such perpetration would be minimized because of their own coming forth. This young man had been victimized from the time of his First Confession and on each occasion until his last confession. In other words, the Sacrament of Reconciliation, rather than an opportunity for healing and nurturing, was a time for hurting. After that initial visit, I offered to go to their home and have dinner. I did. It was healing for them and certainly so for me. I can recall standing at the door of the church on one occasion

bidding the parishioners good-bye and someone tapping me on my shoulder. It was this young man and he smiled and said to me: "I just want you to know that I am all right, Bishop."

There is a tremendous grace in a healing moment in saying, "I'm sorry." On one occasion I had a meeting with a woman who had been sexually victimized years ago by a priest who has long since died. She had been dealing with some of the psychological effects of that victimization. One day I met her in my office and listened to her story. At the end of the story, I simply said to her, "I'm sorry." "I'm so sorry that you have experienced this." "I'm so sorry that you had to carry this with you all these years." She responded with a beautiful smile and said, "I have never heard those words before." Those were healing words for her. The words were powerful because they were spoken from my heart and I had listened to her pain before I spoke them. I think this is the secret of responding to any kind of victimization. We should experience some of the pain ourselves before responding. Only when our hearts are heavy and only when the pain burdens us should we respond. If we respond before we experience that pain, there is a certain violence done to the victim, a violence that is unnecessary and certainly unwarranted.

(I might add that there are no easy guidelines on how much time and attention to a person or a situation within our ministry is enough; how to respond to the many other problems that often are present in the families of victims; at what point after many

and varied attempts to heal we might begin to enable people in a problem situation instead of helping them get on with their lives. Personal judgment and the ministerial and social service resources of the diocese and the civic community attuned to these issues can help give perspective.)

Finally, the bishop must remember that he is ministering in a human situation that is often filled with many complexities. He must also remember that he himself is limited and responds with different levels of intensity and attention on different occasions. It is possible that at times he may not appear to be pastoral, even uncaring. It seems to me that we want to do the best that we can and reach out in the most loving way. At the same time, we are human and limited and will not always rise to this challenge perfectly.

Besides accepting others and listening to others, we need to listen to our own hearts and accept ourselves as good human beings who try to bring new life and resurrection out of situations that are broken and painful. Our God will be the final healer and we need to leave something to Him.

Priests, Power and Sexual Abuse

James J. Gill, S.J., M.D.

Knowledge has been long recognized as a source of power. Moreover, it has been conventionally identified as one of the best available resources for altering human behavior that involves an abuse of power. The pursuit of scientific knowledge about power is an enterprise initiated only during the past half century, but research is already producing information linking power closely with sex and violence. Harvard psychologist David C. McClelland, for example, in Power: The Inner Experience, reported his finding that men with a high level of need for power are more likely than others to read Playboy and other "girlie" magazines and watch TV programs that convey images of violence. Other research, along with clinical experience, has repeatedly shown that power is an element intimately and consistently related to sexual abuse. It is that relationship which this article will explore, particularly as it exists in cases where priests are the perpetrators and their victims are children.

Clarification of Terms

Sexual abuse of children involves an adult's intense and recurrent sexual urges and sexually arousing fantasies which are expressed in sexual activity with prepubescent (generally age 13 or younger) children or with an adolescent (from age 14 through 17), with the adult at least five years older than the victim. The perpetrator of such activity is usually called a pedophile when a victim is a child and an ephebophile when a pubescent child or adolescent is abused.

The term power is used in conversation by millions of people every day, but most of the time its meaning is assumed to be clear enough that definition is unnecessary. They would probably be willing to accept without question the way sociologist Max Weber defined it: power is "the possibility of imposing one's will upon the behavior of other persons." The distinguished economist John Kenneth Galbraith, in The Anatomy of Power, agrees with Weber when he describes the exercise of power simply as "someone or some group is imposing its will and purpose or purposes on others, including on those who are reluctant or adverse." It is Galbraith's understanding of the various types of power and their sources that I intend to use as a theoretical skeleton on which to flesh out my perception of the ways power plays a role in sexual abuse.

Three Instruments of Power

In his dissection of power's "anatomy", Galbraith identifies three instruments for wielding or enforcing power. He designates them as "condign power", "compensatory power", and "conditioned power".

Condign power obtains the submission of others to one's purpose(s) by inflicting or threatening some sort of adverse consequence(s), should the other refuse to comply. An example would be a priest threatening to humiliate a child in public if

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the child does not participate in the sexual behavior the man has in mind. Or, he might threaten to prevent the boy or girl from playing on a school team, which the child ardently desires to do. Galbraith writes: "Condign power threatens the individual with something physically or emotionally painful enough so that he forgoes pursuit of his own will or preference in order to avoid it." In brief, this instrument of power wins submission by promising or administering punishment.

Compensatory power is demonstrated by offering an individual financial payment or some other sort of reward so that she or he forgoes pursuit of her or his own preference in order to obtain what is promised instead. For example, a priest desiring sexual compliance from a child may offer to take the boy or girl on a trip or provide a longed-for item of clothing as payment for an affirmative response. Giving something of value to the child is essential, and even praise or signs of admiration may serve as the form of reward. If the child being abused is young enough, or naive enough, the priest may succeed in obtaining compliance by promising that God will reward the "person who is good to a priest" with the gift of eternal happiness. On the contrary, in the same circumstances the priest may use condign power to threaten the child with interminable suffering in hell as payment for non-cooperation in the proposed sexual deed.

Conditioned power is exercised by changing someone's belief(s). Through persuasion, education, or exposure to prevailing social beliefs about what is natural, proper or right, the person becomes disposed to submit to the will of another or of others. In this case, the submission reflects the person's own preference, and he or she does not even recognize that submission is occurring. For example, a priest may persuasively teach the child that sexual actions are acts of love and that God will be pleased if the child shows love for the priest this way. Or, the priest may capitalize on the fact that in the child's milieu (society) there is a commonly held conviction that anything that a priest wants should be done for him or given to him as a sign of gratitude for all he is doing for his parishioners. Again, as seen in these examples, this third instrument of power involves the child's conviction (resulting from becoming conditioned to behavior) that responding to a priest in a cooperative way -- even sexually -- is right and good, just as being obedient to parents is right and good.

Conditioning is considered explicit when the child's belief (preference) is deliberately cultivated by the priest. On the other hand, a preference can be dictated by the culture (represented by the family) surrounding the child; in this case the conditioning is termed implicit. An instance of the latter would be the conditioned belief that priests -- since they are good and holy men -- deserve to be shown respectful subservience at all times, and their integrity is never to be questioned, even if they are saying that the sexual behavior they are proposing is "just for the good" and "sex education" of the child.

Obviously, simplistic explicit conditioning of children in the home, in Catholic schools, and at church on Sunday, can heighten their vulnerability to sexual abuse if authority figures (priests, coaches, police, clergy, etc.) are designated as always deserving complete respect and unquestioning compliance with their wishes. It is the cultivation of such misleading beliefs, either explicitly or implicitly, that allows the priest to have control and power over the child and his or her behavior.

Galbraith lucidly summarizes the way implicit conditioning is accomplished:

All societies have a yet more comprehensive form of social conditioning. It is sufficiently subtle and pervasive that it is deemed a natural and integral part of life itself; there is no visible or specific effort that wins the requisite belief and submission. Thus parental authority need not in most cases be asserted; it is seemingly normal and what all children by nature accept. And similarly the authority of the schoolteacher and priest...Such implicit conditioning bears comprehensively and invisibly upon the individual from birth.

Once belief is won, whether by explicit or implicit conditioning, the resulting subordination to the will of others is thought to be the product of the individual's own moral or social sense -- his or her feeling as to what is right or good.

Three Sources of Power

After examining those three forms (instruments) of power, the question naturally arises: What permits or enables individuals to exercise them? Galbraith suggests that there are three sources, or causes: these are personality, property and organization.

The personality of the individual with power may include physical strength or size, together with qualities such as charm, kindness, interest, intelligence, humor, solemnity, seeming honesty, and the ability to express thought in a cogent, eloquent, repetitive or otherwise compelling manner. All of these can be helpful in winning belief (i.e., conditioning) on the part of the child and thus setting the stage for successful sexual seduction. In other words, personality is generally found closely associated with conditioned power. However, the appearance and physical capabilities of the individual may also enable him or her to exercise threatening

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(condign) power. Through their well-developed personality, priests--especially in relation to small children--can often exercise both the conditioned and condign forms of power.

Property, or money, gives to a person the possibility of purchasing submission through the use of compensatory power. But, at times, when the individual is considered wealthy, others may become submissive in a conditioned way, since they perceive in him or her an aspect of authority and a certainty of purpose which they believe merit deference and compliance with his or her wishes. If a priest has enough money -- and many of them do -- to buy gifts or pay for excursions that children enjoy, experience shows that it is all too easy for him to purchase sexual compliance, especially when the child is poor or deprived of affection or pleasure within his or her home and the context of dysfunctional family life.

Organization is generally established because an exercise of power is needed. Military structures and labor unions, along with the Church, give obvious evidence of this truth. And once an organization is functioning, it is capable of conditioning people to respond through persuasion. Enemies surrender on the battlefield and owners capitulate to strikes that are staged by their employees, when conditioning power is brought to bear in a convincing way. An organization may also have access to condign power, giving it the ability to administer diverse forms of punishment. The Church, for example, has power to excommunicate (and, in the past, to burn a heretic at the stake) and can use the threat of such punishments as leverage to exact compliance with its purposes. Additionally, the Church--like other organizations such as Boeing Aircraft or The International Monetary Fund--has been able, at times, to gain cooperation with its aims by using compensatory power based on its property and perceived wealth.

In one of the most interesting paragraphs in his book, Galbraith cites the Catholic Church as providing one of the most obvious examples of the three sources of power and the three related instruments for exercising it. He writes:

In earliest Christian days, power originated with the compelling personality of the Savior. Almost immediately an organization, the Apostles, came into being, and in time the Church as an organization became the most influential and durable in all the world. Not the least of its sources of power was its property and the income thus disposed. From the combination of personality (those of the Heavenly Presence and a long line of religious leaders), the property, and, above all, the unique organization came the conditioned belief, the benefices or

compensation, and the threat of condign punishment either in this world or the next that, in the aggregate, constituted the religious power. Such is the complex of factors in and, in great measure concealed by, that term (power).

All of this power of the Church is often recognized as being vested in priests. Children, especially, are unlikely to view these leaders as distinct in any way from the organization which they officially represent. Consequently, as a result of their identification with this sacred but powerful corporate body, priests have access to power that is at times compensatory, and at other times condign or conditioned. In other words, they can get what they want in many life situations simply because they are "men of the cloth", which to their constituents implies special entitlement. Children, seeing what exceptional deference is displayed by adults toward these men, would naturally find it difficult to say "no" to the priest who strongly requests or demands their sexual compliance. It is usually the persuasive power of the priest along with his highly respected role that draws the child to submit himself or herself, even when the behavior is objectively abusive.

Powerless Elicits Abuse

In Understanding Race, Ethnicity and Power, Elaine Pinderhughes describes how individuals who feel powerless frequently act "in ways that will neutralize their pain with strategies that enable them to turn that powerlessness into a sense of power." Manipulation is one such strategy. Priests who seduce children into complying with their sexual desires--and the same would be true in relation to adult women--are often giving evidence of their own feeling of powerlessness in the face of what they perceive as overwhelming power exercised by the pope, bishops, and sometimes by pastors and even parishioners. In such cases, the abused victim is simply being exploited in an unconscious effort by the clergyman to attain a "sense of power", which Pinderhughes reminds us is critical to the maintenance of "one's mental health."

On the other hand, at times the priest himself may be manipulated into sexual misbehavior by adolescents or adults who behave in sexually provocative ways in order to defend themselves against a pervasive sense of their own powerlessness. To be able to resist these temptations, priests would have to be "comfortable with themselves and with their own power needs", says Pinderhughes. Moreover, "High self-esteem, which we have learned is in part dependent on a clear and positive sense of cultural identity, is needed along with a strong sense of self-differentiation...Only such attributes and capacities will enable (priests) to control the feelings mobilized by the power tactics these clients will use, and to behave appropriately with them," she concludes.

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Workshop Provides Remedy

Finally, the foregoing discussion of the abuse of power in instances of sexual abuse, particularly on the part of priests, naturally leads to the question: What can be done to reduce the incidence of sexual abuse by clergy and other ministers? A good answer is provided by the Center for the Prevention of Sexual and Domestic Violence, which is situated in Seattle, Washington. In a published trainer's manual for their "Workshop on Clergy Misconduct: Sexual Abuse in the Ministerial Relationship", the authors view prevention of sexual abuse as a matter of preserving ministerial boundaries, and they present their prevention plan in terms of promoting "individual health", which includes both personal health and professional health. Their fundamental assumption is that "ministers who actively maintain their own physical, spiritual, emotional and psychological health are less likely to violate boundaries through sexual misbehavior."

When the Center's writers use the term institutional health, they are speaking of the characteristics of religious institutions which sustain healthy and effective ministries. They observe: "Healthy institutions have an organizational 'climate' in which sexual contact or sexualized behavior toward congregants/staff is unacceptable." Concretely, the Church communicates to clergy and employees, through their policies and procedures, that "such behavior will not be tolerated and will be punished. Built into their structures and routine practices are mechanisms that reduce the opportunities for sexual abuse in ministerial relationships and allow detection of this behavior when it does occur."

The Workshop writers are realistic. They acknowledge that prevention cannot heal the wounds resulting from abuse. Neither can it stop the sexual predators, since they are not likely to change their behavior voluntarily. But it can decrease the chance that ministers will "wander" across boundaries, thereby reducing the sum of sexual abuse within the ministry. The writers recognize that the key to solving the problem is education that (1) teaches ministers to maintain boundaries and to repudiate any justification for "wandering", (2) protects against victimization, and (3) creates an institutional climate where sexual abuse is not tolerated.

The Workshop provides a "Self-Assessment Checklist" designed to help participants become aware of crucial factors that influence their behavior with regard to boundaries. It explains:

(The) risk of doing harm to those whom we serve or supervise can be considerably reduced through self-knowledge and self-care. If we understand our personal history and its effects on us, our behavior and perceptions are less likely to be shaped by that history. If we are aware of our personal needs and are taking care of those needs in appropriate ways, we are less likely to impose those needs inappropriately upon our ministerial relationships. And if we are aware of the power

implicit in our role and how that power affects those whom we serve and supervise, we are less likely to misuse that power.

Questions such as the following are included in the Workshop and are designed to help participants recognize their needs, particularly in relation to power:

- Do I acknowledge the power inherent in my professional role?
- Am I aware of the effects of that power on those with whom I interact--for example, the attraction that power holds for some people?
- Do I remain alert to my potential for violating boundaries due to that power?
- Am I aware of the consequences to me of my violating the boundaries of my ministerial relationships?

As helpful as the Workshop is to its clergy participants, it perhaps more importantly also serves as a reminder that the misuse of one's sexuality in ministry and the connection between abuse of power and sexual misbehavior are topics for repeated and profound discussion in seminaries where future priests are being educated and trained. Formation personnel and spiritual directors in that setting are positioned strategically to raise the issues of sexuality and power in conversation with every candidate for the priesthood. Bishops and religious superiors should make sure that these guiding men and women are adequately educated about sexuality and trained in the skills that will make profound and personalized discussion of these topics possible in every seminary and house of religious formation.

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THE ROLE OF THE DIOCESAN IN-HOUSE ATTORNEY

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Introduction

It is understood that the Ad Hoc Committee has commissioned eight or nine articles about the many aspects of the sexual abuse question. It is further understood that the Committee is trying to help the Bishops come as closely as possible to a "wholistic" approach to the problem; primordially pastoral but with the appropriate and necessary legal and financial bases covered.

My task, as I understand it, is to offer my reflections on how the in-house diocesan attorney plays his/her most effective role to achieve this wholistic approach. However, before outlining my thoughts it is, of course, appropriate to clarify what is meant by the terms "Diocesan Attorney" and "In-House Counsel".

The "Diocesan Attorney", in the classical sense, is normally the lawyer(s) who routinely represents a Diocese on a variety of matters [i.e. as either an In-House General Counsel serving as a full-time Diocesan employee, or as an outside General Counsel]. If a lawsuit involving sexual abuse is filed, an In-House Diocesan Attorney, like myself, would not be hired by the insurance company to represent the Diocese. Rather, insurance defense counsel would be retained. Depending on the circumstances, and the desires of the particular Diocese involved, a Diocesan Attorney who serves as outside General Counsel may or may not be retained by the insurance company. Thus, there are four possible "counsel" scenarios:

1. An In-House Diocesan Attorney who handles only the pre-litigation aspects of Diocesan sexual abuse policies and procedures [but does oversee and coordinate the work of litigation counsel on behalf of the insured Diocese].
2. An outside Diocesan Attorney who handles only the pre-litigation aspects

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of Diocesan sexual abuse policies and procedures [but does oversee and coordinate the work of litigation counsel on behalf of the insured Diocese].

3. An outside Diocesan Attorney who handles both the pre-litigation work as well as the direct handling of all litigation aspects pertaining to sexual abuse.
4. An outside counsel assigned by the insurance company who does not serve as the outside General Counsel or "Diocesan Attorney" except with regard to specialized matters [e.g. sexual abuse claims and/or other insurance defense work].

As can be seen, the role of the Diocesan Attorney in scenarios 1 and 2 are quite similar. Thus, while I will confine my paper almost exclusively to "In-House" counsel, the potential overlaps of function; particularly with respect to scenario #2, should be noted. (Andrew Eisenziemmer, who will prepare a paper on the "Role of Outside Counsel", will focus on scenarios #3 and #4.)

The Traditional Role of the Diocesan In-House Counsel versus a Recommended (and, in some cases, already evolving) New Role

The question is increasingly raised, "Why are Diocesan Attorneys involved at all if the Church is secure in its claim that it investigates and responds pastorally to allegations of sexual misconduct by members of the clergy, religious, lay employees and volunteers?" However, anyone who has been directly involved in, or taken the time to carefully study, the complex issues which attend charges of sexual misconduct understands that the Diocesan Attorney should have a role to play in such matters. The real questions relate to the degree of emphasis on, and the visibility of, the Attorney. In this vein the "Catholic Church" in general (e.g. the various Dioceses and Religious Congregations) has perhaps been rightfully criticized for overemphasizing legal concerns and the use of lawyers when addressing the subject. The topic of sexual misconduct by members of the clergy; particularly concerns about "pedophilia" (which often is erroneously cited by the media and others as involving a sexual attraction to any minor regardless of his or her age) has become almost a frenzy. Whether fair or not, the expectations (both within the Catholic community and outside of it) of a thorough, open, and "just" response from the Catholic Church are higher than for any other organization, religious or otherwise. This creates a natural and understandable tension within the Church Hierarchy between wanting to do the "pastorally right" thing and desiring to do the "legally safe" thing; between wanting to assist true victims with obtaining the reasonable restitution which they may be entitled to

from the perpetrator under Church law (or in otherwise receiving charitable assistance from the Church) versus wanting to act responsibly as stewards of the Church's common weal. That is, a desire to be pastoral without laying down the gloves and allowing the Church to be knocked senseless financially and reputation wise.

Sexual misconduct, particularly pedophilia, genuinely turns everyone's stomach. There is a clear understanding that these matters must be dealt with and not "covered up" as is so often falsely alleged even in regard to the current handling of cases (i.e. as opposed to situations from decades past when no one, including the mental health and law enforcement communities, understood the problem). However, who is to be assigned to deal with the problem has oftentimes been handled by possible candidates like a hot potato. The task is a very delicate, stressful and time consuming one. It seems that no matter what the outcome neither the complaining party nor the alleged perpetrator is ever satisfied that the situation was handled properly (which, in some cases, may be a good sign in light of the old adage that a good settlement is where neither party is satisfied nor feels that they "won").

There was a tendency by many Church authorities, particularly in the early years of the "sexual abuse revolution" (circa 1985-1990), to see the issue as having so many "legal" overtones that all aspects of the matter, from responding to the press, to interviewing all contemporary articles on the pathology of sexual misconduct, to formulating sexual misconduct policies, to interviewing witnesses and victims, etc., were considered best left in the hands of the lawyers. Diocesan Lawyers faithfully responded to the call. However, despite their best efforts, they have been able to do little more than keep their fingers in the dike. Thus, in order to prevent the waters of the now broken dam from flooding the fertile grounds of Christ's Church, the problem must be viewed (both in word and in deed) as the entire Church's responsibility, not simply the lawyers'.

It is this author's opinion that a swinging of the pendulum in the direction of an enhanced focus on the pastoral aspects (**particularly at the investigatory phase**) would help to restore the severely tarnished image and credibility of the Church (especially its clergy). Ironically, I believe it would also, in the long run, result in fewer suits being brought (and smaller settlements and jury awards).

Perhaps the highly publicized approach of the Chicago Archdiocese serves as the best current example of this philosophy. In that Archdiocese there was a substantial involvement of the Catholic faithful in the drafting and implementation of the sexual abuse policy and procedures, including the establishment of an **independent commission** to investigate claims of abuse. While the representatives of that Archdiocese are likely in the best position to evaluate the affect that the policies and procedures there have had on such things as clergy

morale, it seems that Catholics nationwide, as well as the general public (including the media) view that system as open and credible. The fact that Cardinal Bernardin was treated relatively fairly in terms of the usual prejudgments of the public in cases of alleged sexual misconduct, can be attributed in part to the Cardinal's compassionate and incredibly candid response. But, perhaps more important were the initial findings made by the Archdiocese's independent commission. The Cardinal demonstrated that he was not above his own policies and procedures. Furthermore, under the system in place there, one or several priests are not placed in the highly uncomfortable position of acting as sole jury and judge over the actions of a fellow priest, lifetime spiritual brother, and often-times close friend. (At a minimum then, that Archdiocese allows itself to remain above reproach in terms of the customary assertions that an "old boys protection network" is in place).

More about the Future

In order for a truly wholistic pastoral approach to emerge, Diocesan Bishops must actively and directly use their influence to change, even more, the sexual abuse policies and procedures and the way in which the insurance companies and representatives write and apply insurance policies. Pursuing this latter point, which often influences the former, should become easier in the future since most Dioceses in the country are now covered by such self-insurance networks as The Ordinary Mutual (TOM) in the western United States and the Catholic Mutual, which is nationwide. TOM, for example, currently requires, as a condition of coverage, that there be a "team" approach in responding to sexual abuse allegations. The team generally consists of individuals such as the Bishop or his delegate; the Diocesan Attorney (whether "In-House" or "Out-House"); a canonist; a mental health professional; the Priest Personnel Administrator; the Superintendent of Schools, etc. The team approach is a laudable attempt to be more wholistic. However, in many respects, the emphasis is still on maintaining the Attorney Client/Attorney Work Product privileges relative to the team's investigation. This enhances the perception among the Catholic community of a shroud of mystery, subjectivity and cover up. Thus, even though well intentioned, this approach has a tendency, in many cases, to cause the pastoral aspects and goals to be unappreciated and unfulfilled. That is to say, the "circling of the wagons" around the attorney and the Bishop creates a widespread perception, albeit often unwarranted, that the Church's real motivation is to "cover-up" scandal and protect its legal tail from its "failures".

It may be wise then, to explore further whether the Diocesan policies and procedures on abuse, as well as the policies of the insurance companies

(particularly the self-insured ones) should be coordinated so as to permit the investigations of abuse to be conducted by an independent, highly qualified commission which has a clear understanding of the nature and scope of its mandate. The inclusion of this mandate component is essential if Dioceses are to avoid the risks of lapsing into a form of "McCarthyism" or "guilt by virtue of allegation". For example, when to place a person on leave and what to say publicly during the early phases of the Commission's investigations, are crucial decisions affecting the reputation and future livelihood of individuals. Therefore, there should be a degree of flexibility allowed which would take into account the nature of the charge. By way of illustration, different thresholds concerning the time for placing someone on the leave of absence might apply where an apparent consenting adult situation is involved, or in cases involving allegations of so-called "repressed memory" that do not appear to include independent, corroborative facts.*

If the establishment of the independent commission is considered, it should be done with a full understanding that, in all likelihood, the information gathered by, and the discussions among, the Commission members (as well as their ultimate findings) will not be protected by any legal privileges in the event of the lawsuit (It should be kept in mind, however, that virtually all key facts, impressions, etc. surrounding an incident have a tendency to come out in litigation anyway during the course of interrogatories, depositions and court testimony). On the other hand, the traditional candid and confidential relationship between the Diocesan Lawyer and the Bishop (e.g. in evaluating and acting upon the findings of the Commission) would still be legally preserved. Under this model, the In-House/Out-House Diocesan Attorney should continue to serve as a close secondary (not primary) advisor on such things as establishing preventative procedures; providing continuing education programs for clergy, religious, lay employees and volunteers, parents, children, and parishioners; reviewing proposed press releases, etc.

* In the Spring of 1994, the Board of Trustees of the American Psychiatric Association (APA) issued a statement "in response to the growing concern regarding memories of sexual abuse." In part, the statement says: "It is not known what proportion of adults who report memories of sexual abuse were actually abused. Many individuals who recover memories of abuse have been able to find corroborating information about their memories. However, no such information can be found, or is possible to obtain, in some situations. While aspects of the alleged abuse situation, as well as the context in which the memories emerge, can contribute to the assessment, there is no completely accurate way of determining the validity of reports in the absence of corroborating information" (Statement of the APA Board of Trustees, adopted December 12, 1993).

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If and when all efforts to pastorally investigate and resolve complaints of abuse have failed, Diocesan Attorneys should encourage the use of Alternative Dispute Resolution (ADR). Preferably this should take place in a Church Tribunal or some other acceptable ecclesiastical forum so that claims which almost always exclusively involve Catholics can be resolved by Catholics. Alternatively some form of mutually acceptable binding arbitration could be utilized. These ideas, of course, will not be welcomed by many greedy plaintiffs' lawyers (who with increasing frequency find clients, file suits, hold press conferences and, only after all this is done, they inform the Diocese or Religious Congregation about the allegations). However, if a Bishop/Commission is perceived as having been candid and fair throughout, a prospective plaintiff may prefer to pursue this route despite the protestations of counsel.

The American Medical Association (AMA) also recently formulated the following conclusions and recommendations:

"The AMA has a long history of concern about the extent and effects of child abuse. Child abuse, particularly child sexual abuse, is under recognized and all too often its existence is denied. Its effects can be profound and long-lasting. The Council on Scientific Affairs recommends that the following statements be adopted and that the remainder of this report be filed:

1. That the AMA recognize that few cases in which adults make accusations of childhood sexual abuse based on recovered memories can be proved or disproved and it is not yet known how to distinguish true memories from imagined events in these cases.
2. That the AMA encourage physicians to address the therapeutic needs of patients who report memories of childhood sexual abuse and that these needs exist quite apart from the truth or falsity of any claims.
3. That Policy 515.978 be amended by insertion and deletion to read as follows: The AMA considers recovered memories of childhood sexual abuse to be of uncertain authenticity, which should be subject to external verification. The use of recovered memories is fraught with problems of potential misapplication. (emphasis added)
4. That the AMA encourage physicians treating possible adult victims of childhood abuse to subscribe to the Principles of Medical Ethics when treating their patients and that psychiatrists pay particular attention to the Principles of Medical Ethics with annotations Especially Applicable to Psychiatry.
5. That Policy 80.996, which deals with the refreshing of recollections by hypnosis, be reaffirmed." (Note - this policy, adopted in 1984, places heavy restrictions on the use of hypnosis if it is to be used as a technique to "refresh recollection")

In Sum

Diocesan Lawyers have uniquely been at the forefront "fighting the good fight" in connection with the issues surrounding sexual abuse from approximately 1985 to the present. I believe I speak for many Diocesan Attorneys (certainly many whom I've spoken to in the western United States) when I say that our "starring role" in this great play should now rightfully be relegated to membership in the supporting cast. The legal crutches, often used in the past by the other actors, must be cast aside if the viability and credibility of the Church is to be restored.

The Diocesan Attorneys have, over the past decade or so, summarized and evaluated the criminal and civil laws pertaining to the various types of sexual transgressions within the Church context. We have organized or participated in seminars dealing with the legal components of the problem. Along with the Bishops and/or their delegates we have spearheaded the investigations of abuse complaints. We have drafted or assisted in drafting Diocesan policies dealing with Abuse and Harassment of all kinds. We have vigorously studied, and often served as the central repository for, nationwide press clippings dealing with the subject as well as any information addressing the psychological dimensions of the problem. We have given advice on the relative risks involved in proposed reassignments to ministry and retentions in employment, and in establishing the cautionary steps to be followed if reassignment or retention is chosen.

Now it is time for the torch to be passed. It is time for more widespread and independent involvement in the establishment of sexual abuse policies and procedures; particularly as relates to the investigations of alleged abuse. In this way, the problem will more likely be viewed as it should be -- the problem of the entire Church community.

THE MEDIA AND SEXUAL ABUSE CASES ELEMENTS OF A MEDIA PLAN

by Monsignor Francis Maniscalco

Among the principles for dealing with accusations of sexual abuse by priests that were enunciated in June 1992 by then-National Conference of Catholic Bishops president, Archbishop Daniel E. Pilarczyk, at Notre Dame was the following: "Within the confines of respect for the privacy of the individuals involved, deal as openly as possible with members of the community."

That statement supports what may be called a tempered openness to the media in dealing with cases of sexual abuse by priests. Clearly such accusations are going to make local news, and the problem of clerical sexual abuse continues to be covered in the national media. Yet as such situations become more diverse and complex, applying the above principle becomes less a matter of clear and easy decisions.

Since a brief article cannot cover all contingencies, the best thing to do is to suggest the elements of a media plan which should be part of any policy on pedophilia.

The principal diocesan personnel delegated to deal with the issue of sexual abuse by clergy should form a working group for response to the media. This group should develop a written plan. If the diocese has already developed an overall crisis management plan, its media component might be relevant to developing this plan.

A SINGLE SPOKESPERSON

Perhaps the single most important element in the media plan is designating a single spokesperson on the issue; and the single most important qualification for the spokesperson is that he or she be experienced in speaking credibly to the press.

Why a single spokesperson? It is good policy to have someone formally speaking for the diocese to whom the media can be referred and whom they can quote. If several diocesan officials talk to the media, that can be confusing in both content and expression. All key diocesan and parish staff should be informed who the spokesperson is and refer comments to that person. Having a single spokesperson won't stop the media from getting quotes from whomever they can; but there will not be confusion about what the diocese has said officially.

As to the need to have a person experienced in speaking in a credible way to the media, this is an important skill which not everyone has developed. Lawyers or doctors who communicate effectively with their peers have been known to be less effective with other audiences, even with their clients and patients. The same can happen in the media context. Someone quite skilled in the issues can fail to communicate them effectively to the media.

In a matter as serious and as sensitive as sexual abuse, it is essential that the spokesperson be a credible figure who knows how to put the matter in media terms. Where there is a diocesan communications officer, that person would be an obvious choice for spokesperson.

The spokesperson has to be fully informed. Information should not be withheld from the spokesperson; and there need to be clear and concise decisions, in turn, on what information the spokesperson is not to share with the media.

Being fully informed includes a knowledge of the overall diocesan response to the problem in the recent past as well as to specific cases. The spokesperson should also know the statements of the Bishops' Conference on the problem and have some acquaintance with the problem of child abuse in general. If the spokesperson appears to be insufficiently informed, there will be no credibility, and the media will definitely look elsewhere.

If, on the other hand, the spokesperson is manifestly well informed, is clearly "in the loop," so to speak, that is a giant step toward being a credible figure. Another factor in credibility is maintaining a straightforwardness that indicates the spokesperson will communicate as much information as possible and not unnecessarily withhold information. Such a person can say the equivalent of "no comment" without sounding like a door slamming shut.

One of the most important aspects of dealing with the media is handling the follow-up calls after a story has broken. By now the reporters have probably heard from several sources and are starting to sort out the elements to go into their reports. The final product may depend on whether, during these follow-ups, the reporter considers the word of the spokesperson to be trustworthy.

The more information the media have from sources like the one described here, the less likely they are to go with rumor, innuendo or one-sided accounts. Alternatively, if those types of stories appear, the presence of an effective spokesperson will strengthen any complaints against them, since the diocese can demonstrate it made every effort to cooperate with the media.

A much more controversial suggestion is that, where possible, a priest be the spokesman on sexual abuse by clergy. The case against doing this is that the issue

of special pleading by the spokesman will surely arise. On this basis, sometimes spokespeople are chosen seemingly as a contrast to the organization represented. However if this is perceived as a ploy, it usually backfires.

The case for choosing a priest is that such a choice may indicate a lack of defensiveness and be seen as offering as the diocese's representative someone who, on account of the state of life, may very well be the most knowledgeable and experienced spokesmen for a matter that so directly affects the priesthood and pastoral ministry to the people.

In the end, though, more important than state of life is competence in dealing with the media.

If not already media trained (e.g. on-camera skills), the spokesperson needs to build on natural talent with media training so that the diocese has the best possible representation. It is also wise to conduct media training for any diocesan representative who may be approached on the issue of sexual abuse. There may be occasions when someone other than the spokesperson finds making a reply to the media inevitable. This usually happens in what is called an ambush situation which even skilled communicators find difficult. All diocesan representatives should be prepared for such incidents.

DETERMINING THE BISHOP'S MEDIA ROLE

If a priest is an appropriate spokesman, one might ask: What about the Bishop? Part of a comprehensive media plan should be to designate when it is, in fact, appropriate for the Bishop himself to meet the press.

As head of the diocese, the Bishop is the only one who can give the ultimate assurance that individual cases or the problem in general are being dealt with. Once upon a time, it was sufficient to do this in writing and to issue press releases. With a society that is becoming mostly visually oriented, it becomes increasingly important to provide a visual of the Bishop speaking to his people in this matter as well as in others.

One occasion very appropriate for the Bishop himself to appear at a news conference is to announce the diocesan pedophilia policy or major revisions of it. On such an occasion the Bishop has the opportunity to reassure his people directly that there will no tolerance of sexual abuse and that, if it has occurred, pastoral care will be offered to those injured by it.

The Bishop's presence on other occasions should not be ruled out beforehand. An incidence of sexual abuse with particularly compelling elements or one that has attracted national attention may justify the Bishop himself being the spokesman. However, as in other matters, his importance should not be diminished by bringing him forward too often, when other spokespeople would do as well.

Whenever the Bishop himself speaks, there needs to be a thorough briefing because, in his case, some media are likely to emphasize an inadvertent error of fact or infelicitous expression.

SORTING OUT THE ISSUES

Development of a media plan also implies sorting out the issues involved, in particular, the legal and pastoral ones, which can be at odds.

Behind most media inquiries is the simple question: "Is the Church doing its job in dealing with a particular case or the problem of pedophilia in general?" This question may also be of interest of the general public. A Bishop obviously wants to offer reassurances that the matter has been dealt with. However, because of the liability issues, he may receive advice to say nothing at all or to issue a statement so harmless that it is literally next to nothing. Others are likely to emphasize as much openness with the media as possible to get the diocese's message across to the general public.

Both points of view have their legitimacy; and both have to be satisfied at least partially. Advice so risk-adverse that the Bishop cannot even express in general his condemnation of sexual abuse and his concern for the victims of it deprives him of the opportunity to reassure the people of his diocese. On the other hand, public statements that characterize the diocese's belief or lack of belief in charges yet to be proven is unfair as well as unhelpful.

The working group designing the media plan must sort out these issues. One point of view on them, agreeable to all, should be defined with regard to the issues, on the basis of which a clear and consistent message to be conveyed in the media can be developed, even if the result is saying in public not as much or not as little as some would prefer.

PLAN NEEDS TO BE LONG-TERM AND COMPREHENSIVE

The media plan cannot a short-term one, i.e. a plan to deal with a breaking story. It needs to be long-term and comprehensive. Where a criminal trial or civil suit is involved the story will surely reappear at various stages in the progress of the case. Planning needs to include what contacts will or will not be made with the media at these stages.

In civil suits the media have shown a good deal of interest in how a diocese defends itself. While the defense has to be conducted according to the best legal advice available, how that defense is presented to the media can have important repercussions for the diocese. Such considerations should be part of determining what, in fact, is the

best defense, given all the values involved. The willingness of some plaintiffs' lawyers to be available to the media or make their clients available evidences that even when a matter is to be resolved before a judge and jury, public opinion is considered entirely relevant.

Even such traditional legal defenses as invoking the statute of limitations may be attacked as the Church's attempt to evade responsibility by using "technicalities." Perhaps the best response to this accusation is for Church to demonstrate its willingness to assume its moral responsibility even where, by normal standards, it bears no legal responsibility.

One example of an unfortunate public perception is that of the Church as another "deep pockets" organization. It is not irrelevant to combat that with information that demonstrates either that a diocese may not be as affluent as often supposed or that its money is not for personal profit but for the spiritual, educational and charitable works of the Church.

A media plan needs to take into consideration the aftermath of a suit or a trial. When a suit is settled out of court and the settlement is sealed, this is sometimes portrayed as a "cover-up." Given the media's omnivorous appetite for information, it's difficult to persuade them that this is not the case. However, it may be worthwhile reminding them that in our litigious society, in which fighting a lawsuit can be far more costly than settling, settlements are becoming less and less indicative of the merits of a case.

In a criminal case, whether the priest is found guilty or not guilty, there needs to be a prepared response about the priest's continued affiliation with the diocese. This includes cases in which a prison sentence has been imposed. A diocese should also be prepared for questions about the sentence and be alert to how the sentence of a priest appears in relation to the sentences of others convicted on similar charges.

Where it is known that priests have been sent away for treatment, the media may want to know where and what kind of treatment. The former may be legitimately off limits. The diocese may, however, want to indicate, in general and non-technically, what "treatment" consists of.

Another concern is the possible re-emergence of a case. In the recent past, for example, victims have renounced settlements made several months or years before and demanded further action on the part of the diocese. If this becomes a public matter, responding to it requires a thorough updating in the case. It may happen that, with a case several years old, diocesan officials may decide that they would indeed handle it differently if the case were current.

It may then be necessary to indicate further steps the diocese may take, even revision of its policy. These cases often involve one of the toughest tasks of all: putting the issue into its historical context so the media are challenged to see why a once reasonable solution needs to be revisited.

CONCERN FOR VICTIMS

Church representatives have often indicated that a primary concern is the pastoral care of victims. The media plan needs to show how this concern is made concrete, although the delicacy of the issue makes doing so one of the most difficult tasks of all.

If a lawsuit is involved, the legal system invariably casts the diocese (often the bishop personally) and the victims as adversaries. The media often pick up on this and exacerbate it.

Without putting down the victims' rights to seek relief through the courts, the right of the diocese to defend itself and its need to safeguard its ability to continue to carry on its service to its people needs to be thoroughly explained.

Even when there is not a lawsuit and victims have been satisfied with the pastoral care they have received, little of this information is likely to be available to the media. Understandably some victims may hesitate to have their stories publicized.

Probably the most likely ways concern for victims can be shown is by establishing a diocesan policy, by the effective implementation of that policy when cases arise, and by an always pastoral attitude displayed towards victims when speaking with them and of them, even in the midst of legal proceedings. Also, services the diocese makes available to victims, through Catholic Charities, for example, should be acknowledged as instances of diocesan concern for victims.

DEVELOP A PRO-ACTIVE STANCE

Another element of the media plan is to develop what is often called a pro-active stance: to be ready with the story rather than to have it break elsewhere. While one may hope that a case of sexual abuse may not make news, circumstances make that less and less likely, especially in the present atmosphere. The removal of a pastor at an odd time (during Holy Week, for example) can signal a story. Leaving both media and parishioners in the dark to speculate on the reasons can worsen the situation.

It should be spelled out in advance under what circumstances the diocese itself will make the announcement of a case of abuse.

A media plan should also involve having some written documentation at hand for media inquiries. Available from the USCC Media Relations Office are the National Conference of Catholic Bishops statements and the "Brief Overview of the Conference Involvement in Assisting Dioceses with Child Molestation Cases." Prepared in the diocese ought to be the local diocesan policy on sexual abuse; perhaps a locally developed "Brief Overview" of the diocese's response; and models of statements for various situations.

Since many media inquiries are likely to be of the nature, "What is the Church doing about sexual abuse," it is certainly handy to have available a brief statement describing diocesan efforts. This will aid both the efficiency and consistency of response. Where possible the development of audio-visual material would make this kind of information more available to the electronic media.

IMPORTANCE OF THE OVERALL MEDIA RELATIONSHIP

Effective overall relations with the media are an essential part of any media plan. If there have been good relations between the media and the diocese in the past, this is likely to have some impact on the handling of this specific matter. Obviously the reverse can be true. Also good media relations is not a matter only of dealing with the reporters. They are not the last word in the development of stories. They have editors above them who probably have or soon will have a viewpoint on the diocese. Besides news stories, there are also editorial comment and independent commentators. Much of the latter is more common in the press than in electronic journalism, but they can be factors even there.

It is relevant to the diocese's overall relationship with the media to develop contact with the editors, editorial boards and executives of media organizations. Especially with regard to a story that has become one involving charges of Bishops' "covering up" the problem of pedophilia, the availability of Bishops to talk to these other actors in the media and demonstrate their grasp of the problem and their commitment to resolving it is an effective response to the charge.

Nor should the media go unchallenged. If they are not living up to their own standards of professional conduct at any level, this should be pointed out, with the supporting evidence. Personal meetings are best for this, but letters to the editor either for or not for publication can be used. The opportunity to respond through op-ed pieces or listener and viewer replies to broadcast editorial comment should also be taken advantage of.

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A judgement also needs to be made about cooperation with media outlets which have shown themselves sensationalistic or biased. While keeping them informed along with the rest of the media, you may decide not to provide them with additional interviews and media contacts.

ROLE OF DIOCESAN MEDIA AND CONTACTS WITH OTHER DIOCESES

A media plan also needs to consider how to involve the diocesan media. Such involvement can be a sensitive issue. However, to exclude the diocesan media may be to miss what may be the only opportunity in the local media for a full and accurate presentation of the matter. Also to be considered is the effect of excluding Catholic media from a story of obvious importance to the Catholic community. Diocesan media people may argue that their exclusion from such stories affects their overall credibility, which is clearly a real possibility.

The newspaper also provides an opportunity for the Bishop to share his thoughts directly with his people on this matter.

When diocesan media personnel, such as the newspaper editor, are part of the working group, the potential for conflict between being a news gatherer and the confidentiality of the working group needs to be assessed.

The need for interaction among the spokespeople from different dioceses should be considered. The media is alert to the various ways dioceses respond to cases, especially those geographically close to one another. It is helpful to know how and why cases are handled the way they are in the surrounding dioceses and to be ready with an explanation of the differences.

GENERAL OBSERVATIONS

A few additional observations can be made.

On the whole, Church spokespeople have been relatively absent from reports on this issue, while individual victims, victims groups, and their lawyers have been in the media. Some media bias can be perceived in this situation, but it also has to be acknowledged that for quite a while the matter was handled by the Church privately. That needs to change. Spokespeople for the Church need to be available to assure the public of what the Church is doing.

Also, it was noted above that growing complexity makes media decisions more difficult. Previously most cases involved charges of relatively recent behavior which were verified or rebutted fairly quickly. Now the charges often go back many years, are not as

easily verifiable, and may or may not indicate a continuing sexual disorder which disqualifies a priest from further ministry. Another problem connected with allegations from long past is the phenomenon of the recovery of repressed memories. These memories apparently have been proven accurate in some cases but spectacularly inaccurate in others.

Neither the Church nor the media is on entirely sure ground in dealing with ambiguous cases. That itself makes for a tense relationship since the media will often choose to publicize these cases while the Church -- or any other organization or accused person -- will counter that an allegation is not proof and that there may be a need for further corroboration before going public. This is a discrepancy of approach not easy to reconcile.

In addition, this increasing complexity makes a media plan more necessary than ever. The media are contributory to making pedophilia a national issue for which many Catholics are demanding some kind of national response. One does not have to live in the South to have heard of the Gaulte case nor in New England to know about James Porter. Reports of financial troubles in one diocese over pedophilia cases raise questions about all dioceses. With such national attention, it is at least as likely that the Bishops' overall response will be judged by the worst handled cases in the media as by the best.

With due respect to the right of each diocese to conduct its own affairs, analysis of media coverage offers ample reason for regional and national coordination on a response to the pedophilia problem.

Finally, it is worth pointing out that we live in a nation in which the media and the populace are suspicious of large organizations and their leadership. While it is to be hoped that this would not be true of Catholics and the Church, in a matter involving the safety of children, many may decide to err on the side of skepticism.

The effort to convince the media that the Church is working hard to eliminate the problem of clerical sexual abuse is not for the media's sake, but for the sake of the millions of Catholics who will be influenced by the messages that come from the media and for the sake of their confidence in the Church and the priesthood.

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SUMMARY

To sum up, as part of its pedophilia policy, a diocese should set up a group, made up of the principal diocesan personnel involved in dealing with the issue of clerical sexual abuse, to coordinate a media response. They should draw up a long-term media plan that involves:

- 1) designating a single spokesperson;
- 2) determining when to involve the Bishop with the media;
- 3) defining a point of view with regard to the issues involved from which is developed a clear and consistent message to be conveyed in the media;
- 4) making concrete the diocese's pastoral concern for victims;
- 5) developing written and/or audio-visual materials about the diocesan response for use by the media;
- 6) providing for media training for the principals involved;
- 7) considering the inclusion of the diocesan media;
- 8) contacting other dioceses to find out about how they respond.

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"RECOVERED" MEMORIES OF ABUSE - AN HISTORICAL REFLECTION

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I realize that whenever one writes about aspects of the history of psychiatry in an effort to illuminate some contemporary issue it is possible to be misunderstood. A review of experiences of the past, after all, is not science - it rests on things other than data. It is retrospective and selective. Most historical conclusions must be tentative. The past and the present are not the same. If, for example, I review, as I shall, past mistakes of medical thought such as the witch-craze of past eras when considering the issue of "repressed memories" of sex abuse, some might think that I believed that every contemporary claim of trauma or sex abuse in childhood was such a mistake. But witches do not exist and we all agree the sex abuse of children does.

One must emphasize that the study of psychiatry's history does not identify the causes or the nature of contemporary psychiatric issues. Those issues have to be addressed on their own merits with the instruments of today. Historical review, however, shows the collective experience of the psychiatric discipline and thus directs how we must practice today. It does not tell us what conclusions we must draw. It tells us how we must proceed so as to minimize error by demonstrating how past proceedings provoked it.

I plan here to review a set of historical events, each of which tells something about the pitfalls of practice. Knowledge of these pitfalls has always in the past and must now direct and justify how we evaluate a patient, how we consider alternatives,

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how we employ information, how we collaborate with each other. We can then discern whether standard practices are being followed in managing repressed memories of sex abuse.

For all that the focus is on potential pitfalls, it is legitimate to propose a hypothetical schema from the historical record that might challenge the current epidemic of "recovered" memories. Such an hypothesis is helpful in that it provides an alternative, "null" hypothesis against which to compare other views of the nature of these memories and direct investigation to confirm or reject them.

Again, nothing that I am saying should be construed as denying that child abuse and incestuous acts occur. Nor am I denying that such abuse may have been underestimated. I have worked at Johns Hopkins for over a decade with a variety of sex abusers and with their victims. Victims exist and they deserve our concern and our help in rehabilitation.

My plan is to briefly describe three important past events and develop their implications for practice.

First: The witch-craze of the 16th and 17th centuries as an example of the invention of psychological entities out of a climate of social legend.

Second: The outbreak of hysterio-epilepsy at the Salpetriere under the direction of J-M. Charcot as an example of professional induction of symptoms, the nature of hysteria, and its group support.

Third: The phenomena of flashbacks as studied in their first

appearance in World War I (WWI) as an example of psychological events that can be misinterpreted and their correct implications overlooked. I will employ these historical examples to make a basic point: doctors make mistakes and must modify their practices in their light, so as to avoid making similar ones in the future.

II

Witch-craze

During training every psychiatrist - at least in my generation - got lectures on the witch-craze. I remember how the Professor at the Maudsley Hospital in London, Sir Aubrey Lewis, spent two hours on the issue and how at first I thought he had chosen to do so because of the times - 1950s - and the political movement in the United States of the "Red Scare" which in newspapers was described as a witch hunt. When I mentioned this to him, wondering why he wanted to beat so hard on the open door of us liberal psychiatrists, Sir Aubrey became indignant. "Dr. McHugh, this has nothing whatsoever to do with Americans, the suspicions of the Soviet Union, Joseph McCarthy. I want psychiatrists to consider the witch-craze for purely professional reasons. It demonstrates the capacity of psychiatrists to invent false explanations for problematic behaviors and to create false images of the minds of others."

I took this rebuke to heart and its message that psychiatrists have the power to invent or imagine entities of mind, and therefore they are obligated to find ways to validate what they propose. The witch-craze, in fact, made clear that validation means something

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much more than proposing ways - even consistent ways - to make a diagnosis.

The witch hunters received explicit "operational" ways of identifying witches. They taught each other and wrote their procedures and views in a large and influential book. This book entitled Malleus Maleficarum or the Hammer of Witches spelled out in exquisite detail the kinds of behaviors that characterize the witch and also identified the kinds of marks on the body that were of congress with devils, incubi and succubi. The Malleus had as its epigraph: Haeresis est maxima opera maleficarum non credere ("to disbelieve in witchcraft is the greatest of heresies").

What was learned from this that might illuminate practices with "recovered" memories and the whole concept of "robust repression"? First: The fact that there is a manual telling how to recognize the manifestations of repressed memories does not confirm them. It is an exercise in creating a consistent approach to the diagnosis amongst therapists - a uniformity of diagnostic practice. It does not validate the presumed abusive experience. It is disrespectful to scripture to call The Courage to Heal the bible of the victim-self help movement. I believe The Courage to Heal could be viewed as a contemporary Malleus Maleficarum and, given the way it is quoted and employed, could carry a similar epigraph.

The issue for "recovered" memories is validation - and validation in every case when it appears. What that means is that the therapist must confirm the actual abuse before he or she launches into therapy. Some therapists will react strongly and

very negatively to the requirement that they must confirm an opinion when they wish to get on with therapy. However the effort at finding external confirmation of a diagnostic opinion is a standard practice with all psychiatric disorders and must be emphasized when what is claimed is a serious, criminal offense by parents against children and a devastation to family unity.

It is not required that the therapist himself or herself carry out the diagnostic validation. This can be turned over to an open minded consultant who can press through hospital and school records, reach external informants, and assess all the parties involved in the charges. But to treat for repressed memories without any effort at external validation is malpractice pure and simple; malpractice on the basis of standards of care that have developed out of the history of psychiatric service - as with witches - and malpractice because a misdirection of therapy will injure the patient and the family. Such misdirection is the theme of the next section

III

Charcot and Hystero-epilepsy

The history of the practices of J-M. Charcot at the Salpetriere in 1880s taught many lessons about practice. Jean-Martin Charcot was the most distinguished neurologist and psychiatrist in France in the late 19th Century. Charcot - and the scientifically oriented psychiatrists of the time were interested in the neural control of the muscles and the body. He, for example, led the way in the development of a systematic

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neurological examination; he discovered many diseases, as for example, Amyotrophic Lateral Sclerosis - Lou Gehrig's disease - and he had very distinguished pupils - including the great neurologists, Pierre Marie and Joseph Babinski, and the great psychiatrists, Sigmund Freud and Pierre Janet (who coined the terms, repression and dissociation after studying with Charcot).

At a crucial time in the mature years of his career, Charcot was presented with an intriguing situation. The Salpetriere Hospital, where he was the chief physician, was reorganized and the epileptic and hysterical patients - both with episodic conditions - were placed together in the same section. Gradually more and more of the hysterical patients began to show odd attacks - very similar to the epileptic, but sufficiently different to make Charcot believe that he had discovered a new entity - a new disorder at the interface between mind and brain, hystero-epilepsy. He began to study the manifestations of this condition with the same precision, exactitude and detail that he employed on all other neurologic patients. He watched every movement of the patient, recorded the similarities and distinctions in comparison with epileptics, tested ways to provoke and sustain the attacks and displayed his results to others.

Strangely, the patients became more and more disturbed, had more spells, and progressively more intriguing kinds of fits. What had at first been rather simple and quiet events emerged into dramatic provocative behaviors suitable to enthrall an audience of doctors and interested spectators from the intelligentsia of Paris.

Eventually quite wild group behavior involving many patients together surfaced at the hospital. For example, a group of women took to assuming a fixed posture and held themselves frozen in it whenever a bell was rung.

Charcot thought that hystero-epilepsy was a new disorder and that he had made another important discovery in neuropsychiatry. One of his students, Babinski, disagreed. Charcot had not discovered something, he had induced something out of his authority, his methods of study and investigation, his interest, and the hospital situation where real epileptics and pseudo-epileptics were grouped together. Babinski believed that suggestion started the behavior and social circumstances sustained it. He claimed that the patients would not improve unless Charcot changed his approach to them.

Gradually it became apparent that Babinski was right about the nature of this outbreak of hysterical behavior and its treatment gradually developed. In order to stop a patient from repeatedly displaying an imitation of epileptic seizures two practices were required - isolation and counter suggestion. Isolation meant separating epileptic from hysterical patients. Counter suggestion meant offering another idea to the patient than her view that she suffered from a disease very intriguing to Charcot. The doctors and other staff turned their and thus the patient's attention from the hysterical behavior and onto the life circumstances that had brought the patient into care originally, offering support and understanding to those issues. This was the beginnings of

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psychotherapy.

How does this set of events relate to repressed memories? Charcot showed that just as there was epilepsy, it was also possible to create a pseudo-epilepsy. If one had a pseudo-epilepsy and focused on its counterfeit manifestations, they would worsen. If the patient remained amongst groups with both epilepsy and pseudo-epilepsy, she would not improve. The patient does improve when diagnostically distinguished from the actual epileptics and a relatively simple management then devised.

The resemblances to multiple personality and repressed memory are clear. The interest in how many personalities are to be found generates tens to hundreds of them. Also patients who were sexually abused and those with pseudo-memories of sex abuse are often placed together by therapists in "incest survival" groups. The patients with the pseudo-memories tend to develop progressively more complicated and even quite implausible memories of their abusive childhood. Particular ideas are induced from the mass media and spread throughout the group - such ideas as multiple personalities and satanic cult explanations for parental excesses are the most frequent.

The patients often do not get better. Months to years of therapy continue to keep many of these repressed memory patients angry at their fate and misinformed about their lives. The lesson from Paris to apply here is that it is crucial in practice to differentiate the incest injured from those with false memories. The treatments are as different for each of them as is the

treatment of epileptics and pseudo-seizure victims and are misdirected if differentiation is neglected.

IV

The Flashback Phenomenon

The so called flashback has emerged in this decade as a hallmark of the repressed memory of sex abuse and post-traumatic stress state. It is often employed to confirm a diagnosis of abuse in patients who without this phenomenon have no memory of it. Several questions emerge, but primarily the question is whether a flashback is actually a memory phenomenon, a vivid flash bulb reproduction of a life event? In other words, is it to be interpreted as evidence of what it displays? Much of this is for the scientists of memory to decide. But the historical record should provoke caution in reaching that conclusion.

First "flashbacks" are rather common phenomena - they are described accurately in the repressed memory literature. They do occur in frightened and traumatized people and are particularly prevalent in close temporal relationship to the fear or trauma. They appear in the drowsy hypnogogic state, but also as dreams, and occasionally when fully awake as vivid visualizations associated with feelings of terror.

All trauma patients have them - victims of crime, combat, accidents, civil unrest, war persecutions. Flashbacks are not cultural phenomena but rather universal human responses. For example, Cambodian refugees, including children who suffered horrible persecution have them. They can be mild and transient

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after minor scares and trauma - perhaps only disturbing one night's sleep. Or they can be severe and long lasting after prolonged and terrifying traumas such as suffered by soldiers in continuing battle.

They were described in World War I in a classical book, entitled War Neuroses, by John MacCurdy. He studied the phenomenon carefully and made clear that these experiences reproduce some features of the setting where distressful events occurred - the subject remembers the trench, for example - but the event depicted in the "vision" as he called flashbacks was not a simple replication of an event, but the development from the experience of a "worst fear" scenario - the soldier visualizes that a hand grenade had fallen at his feet or that the enemy soldiers are appearing and overwhelming his comrades. Intense fear and other appropriate emotions accompany these experiences.

Thus, it was not that memory was jogged to replicate an experience in "the mind's eye", but rather that fear ran riot. The visions served a survival purpose by driving victims from combat and avoiding in the future circumstances that might generate experiences of the kinds imagined. They are mental phenomena with purpose behind them.

What have we learned with regard to flashbacks from this historical review - flashbacks are not so much reproductions of events as they are "worst fears" envisioned in settings where the patient could imagine even more traumatic consequences.

What should we say about appearance of such vivid

recollections in patients in therapy? By the flashback history, we are not entitled to presume that they are simply reproductions of the past. They are more likely expressions of worst fears generated out of the focus of therapy - and may represent not post-traumatic states from an abuse but a post-traumatic state generated by the reawakening of childhood fears and fantasies. Their temporal relationship to therapy in the sense that they follow its beginnings rather than precede it suggests this possibility. Flashbacks can not confirm abuse because they are not simply relivings of events. They are useful in confirming worst fears people share such as the frightening possibilities enwrapped in childhood's vulnerability.

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Conclusion

Finally, what hypotheses might emerge from this historical review? Some alternatives are critical for the "recovered" memory field and should direct investigations to remove some of the heat of controversy from the subject. As long as it is assumed that the only alternatives when memories of sex abuse emerge in treatment are that the accusers are either telling the truth and any objection is an expression of denial or that the accusers are malicious liars with some peculiar ax to grind, then no productive investigations will emerge. With charges and countercharges practice will remain stuck within them. I believe that it is critical to state that child abuse does occur and perhaps is occasionally forgotten. However, there is evidence that false

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memories of various kinds of abusive experiences also occur. This evidence includes alien abduction claims, retractions of previous claims of sex abuse, and now the emergence of wild satanic cult memories with no bit of objective evidence to confirm them. Our responsibility as psychiatrists is to find a way to differentiate the true from the pseudo-memories. To facilitate such a process some hypotheses about how a pseudo-memory could be generated can be helpful.

Pseudo-memories can be interpreted as phenomena of the hysterical kind - that is complaints by which the "sick role", or in its contemporary form the "victim role", is generated by social and self suggestion out of the misinterpretation of psychological states. A sequence that would explain hysterical pseudo-memories and place them in context with other hysterical phenomena is the social vortex into which patients are drawn permitting an epidemic of complaints of the pseudo-memory variety to emerge. What culture suggest, doctors develop. What doctors describe patients supply. What patients provide culture confirms.

This proposal can be better laid out in a graphic way as a cycle of interrelating psychosocial features that feed upon themselves and produce the energy for a social catastrophe. Entry into this cycle can be at any point - but usually comes with a patient suffering from some kinds of psychiatric symptoms for which she seeks both explanation and relief. These symptoms can be due to illnesses such as major depression, or to panic states, demoralization, etc. She is drawn into this cycle by being joined

with medical opinion that she harbors "a memory" and finds in the "sick role" a victim's view of the external sources of her psychological distress. The victim's role sweeps her into groups of like minded or actual victims and helps confirm her opinion. The schema as depicted speaks for itself and its social juggernaut quality is apparent. It places together - as this history suggests - the invention aspect (the mind can split, Satan exists, etc.) tied to cultural legend, the suggestive and inducing power of experts, the group contagion, and the misinterpretations of experience.

This alternative explanation for pseudo-memories encourages efforts to differentiate them from viridical memories of abuse. This is the essential first step in treatment. This differential diagnosis may not prove simple. But it demands a good faith effort to find objective evidence of the abuse and a careful scrutiny of the plausibility of the patient as a witness. Pediatric and school records must be investigated, family members who should have been witnessing an abusive home environment consulted, and eventually an approach to the accused that would give an opportunity for either confession or explanations of alternatives should be made.

Diagnosis will direct treatment and further management. For the sexually abused the treatments are rehabilitative and not different from other traumatized individuals who must be encouraged to move forward in their lives and begin to emphasize the assets rather than the liabilities in it.

The treatments for individuals with pseudo-memories include

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isolation, counter suggestion, eventually explanation and reappraisal of the actual psychiatric problems that may in fact be major illnesses, situational problems etc. with their own specific treatments. Rehabilitative psychotherapy for both the individual and the family will always be necessary if a previous charge of sex abuse was levelled and quite complicated in itself if family injury has occurred.

Efforts at prevention of pseudo-memories and the termination of the contemporary epidemic are equally clear from the schema. This juggernaut can be interrupted at several points other than just the treatment of individual patients. The need is to report in the mass media the reality of false memories as well as real memories, to attack the legends in the culture particularly for example the existence of huge numbers of pathological abusive families and satanic cults, to insist on appropriate diagnostic practices by therapists with penalties eventually placed on their neglect.

These later exercises in prevention will not be easy. They may be twisted to sound like (1) not believing in sex abuse, (2) denying dynamic aspects of mental life. Neither of those ideas are true and nothing said here should imply them. It really is just following the standard rules of psychiatric practice derived from the history of this discipline and finding within them the means of progress. After all it still is true as Santayana said: "Those who cannot remember the past are condemned to fulfil it".

PARISHES AS VICTIMS OF CHILD SEXUAL ABUSE

Stephen J. Rossetti, Ph.D., D.Min, St. Luke Institute, MD

A few weeks ago I was in a parish whose pastor was publicly charged with sexually abusing a 13-year-old boy. The boy, now a young man, revealed details of an alleged four-year relationship that started with overnights to the priest's camp, lavish gifts, and wrestling. Three years later it progressed to genital fondling and mutual masturbation.

The priest stated publicly that he is innocent. He claimed the alleged victim is emotionally unstable and out to ruin his priesthood. The Statute of Limitations has run out on possible criminal charges but a civil suit is pending. The young man desires a monetary compensation for the trauma that he believes he has suffered.

The media have been reporting every detail of the confrontation between the alleged perpetrator and the accuser. The priest's parish has gone into shock. The pastor was, and still is, deeply loved by the people. His ten years in the parish were filled with many acts of kindness and pastoral sensitivity. Parishioners cannot reconcile the good that he has done with the charge that he was sexually involved with a young boy. They are divided between feelings of affection for the pastor and feelings of disgust and disappointment.

This internal conflict is emotionally paralyzing and many parishioners are feeling increasingly helpless. They are looking for assistance but their pastor is on administrative leave and the recently-appointed temporary administrator is reluctant to take any action. Diocesan lawyers have counseled the Bishop against going to the parish and releasing any information; they have recommended he remain silent for the duration of the legal proceedings. Rumors are flying in the parish and throughout the diocese. For example, someone heard that there are many other victims who have come forward but have not gone public.

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Parishioners are becoming very angry. Some are angry at the pastor; they believe he is guilty and they feel betrayed. Others are angry at the alleged victim for bringing up charges; the victim and his family are being ostracized from the parish. Many are angry at the media for the sensational way the story has been covered. Everyone is angry at the Bishop; they believe he has deserted them in their hour of need. And nobody in the parish knows what is happening....

This scenario is being repeated in scores of parishes throughout the United States. As allegations of priest-child sexual abuse begin to surface in other countries, as they already have, similar disastrous events will take place around the globe.

Increasing Awareness of Child Sexual Abuse Trauma

Before the 1970's, sexual contact between a minor and an adult was rarely called sexual "abuse." At the time, there was little known about the possible psychological trauma caused by such encounters. Many believed the children would soon forget. Several studies said that the proper response to incidents of child sexual abuse was simply not to overreact.

For example, the celebrated Kinsey report on human sexuality stated that most of the sexual advances by adults toward female minors were "not likely to do the child any appreciable harm if the child's parents do not become disturbed" by the abuse.¹ The Kinsey report noted that while 80% of the children who had sexual contacts with adults had been frightened or upset, "in most instances the reported fright was nearer the level that children will show when they see insects, spiders...."²

There were even isolated statements in the literature suggesting that sex between an adult and a minor could have an educative function. The Kinsey report addressed the issue of pre-adolescent boys being sexually involved with a female adult. They believed that "the cases are so few" as to be negligible. They went

on to suggest that such events may have a positive meaning: "Older persons are the teachers of younger people in all matters, including the sexual."³ Since the publication of the Kinsey report, our understanding of the effects of sexual contact between adults and children has changed dramatically.

With the increasingly psychological sensitivity of our society, an increasing openness in dealing with sexual matters, and the burgeoning child rights movement, there has been an explosion in the literature on child sexual abuse. The short-term and long-term traumatic effects associated with incidents of adult-child sexual contact are being documented and effective clinical interventions are being developed. Organizations that promote "consenting" sexual relations between adults and children, like the Rene Guyon Society and the North American Man/Boy Love Association, are increasingly perceived as fringe groups promoting a twisted agenda.

Like the wider society, the Catholic Church in the United States has come to recognize the trauma caused to the victims of child sexual abuse and their families. The American bishops have recognized their responsibility to aid victims of clerical-child sexual abuse. In its November 1992 general meeting, the National Conference of Catholic Bishops (NCCB) passed a resolution in which they promised to "Reach out to the victims and their families and communicate our sincere commitment to their spiritual and emotional well-being."

Moreover, as our knowledge of the effects of child sexual abuse grows, it is becoming evident that the damage done by clerical sexual misconduct is affecting a wider population. There has been a recent awareness that the trauma caused by child sexual abuse extends far beyond the immediate victim and the family. When allegations of clerical-child sexual abuse arise, it is becoming apparent that priest's worshiping community is profoundly affected.

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Increasing Awareness of Trauma to Parishes⁴

The Canadian Conference of Catholic Bishops' (CCCCB) document, *From Pain to Hope*, reported that "groups or institutions felt stigmatized when it was revealed that some of their members had been implicated in incidents of allegations of abuse."⁵ The reputations of these parishes or institutions were damaged, and their operations were placed under a cloud of suspicion. The parishioners themselves felt tarnished.

I know of concerned chancery officials who have telephoned new parish administrators in the wake of allegations of clerical sexual misconduct and were told that the parish is "fine." Similarly, the Winter Commission, which investigated sexual abuse of children by clergy in Newfoundland, found that some Catholic officials denied that harm had come to the parishes whose pastor had been charged.

But the Commission's report refuted such claims: "In certain instances, the view was expressed that the scandal had not had any direct impact on parishioners. This stance, maintained by some clergy and parish officials, is contrary to the evidence provided by individual lay women and men."⁶ When the parishioners feel safe enough to vent their feelings, the trauma emerges.

In Chicago, Cardinal Bernardin's Commission on Child Sexual Abuse found that incidents of clergy sexual misconduct had a negative impact on parishioners. Its report said that "incidents of sexual misconduct with minors, when they become known, also have a severely negative impact on the parish communities where priests have served."⁷

The Canadian bishops' document pointed out that it is important to intervene in affected parishes. One of the recommendations of *From Pain to Hope* is to "manifest particular pastoral care for the suffering of the parish community when one of its priests is accused or convicted of child sexual abuse."⁸

Nancy Hopkins, who has worked with Protestant parishes with similar prob-

lems, emphasized the importance of early intervention. She noted, "Intervention with the congregation is, therefore, as crucial as with the primary victims, the pastor, and his family."⁹ In the same article, Hopkins made an even stronger assertion: "I am convinced that to do nothing with the congregation is to invite the forces of darkness to take over."¹⁰

The Traumatic Effects on Parishes

A parish whose pastor has been charged with child sexual abuse is almost always divided. There will be divisions in the parish leadership. There will be divisions and conflicts within the parish itself.

Some parishioners who have personally been affected by sexual abuse in their own family may react very strongly; the allegations will reopen old wounds.

For others, the pastor has been a source of blessing for them: he may have visited them when they were sick or baptized their children. These people are more likely to receive the allegations with incredulity.

People's responses will be affected by a number of factors including their relationship to the priest and their feelings about the priesthood in general. Parishioners who have become part of the priest's inner circle will react differently than the occasional church-goer who cannot remember the pastor's name. Similarly, parishioners who have come to revere the priesthood and the Catholic church will respond very differently than others who have become embittered in their religion.

Parishioners' reactions will also be affected by their stage of faith development. For theorist James Fowler, those who are in the earlier stages of faith development, a "conventional" faith, have difficulty distinguishing symbols of the divine, such as the priesthood, with the divine itself. For these people, religious symbols "are not separable from the what they symbolize."¹¹ Therefore, they will expect a priest to be a uniquely holy person and they will not be able to entertain

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the notion that he may have sexually abused a child.

People in the earlier stages of faith development are especially likely to have emotional and spiritual needs for the pastor to be innocent. They may be the most vociferous in claiming that the priest has been unjustly accused. To accept that the allegations might be true precipitates an internal crisis in them that challenges their underlying spiritual and psychological beliefs. This is a particularly vulnerable group and requires special, patient attention. Some of these may become so disillusioned that they end up leaving the Catholic church altogether.

A few other parishioners will be in Fowler's later stages. They have already come to recognize that divine symbols point to God but are not divine in themselves. Therefore, they accept that a priest can be a source of grace and a channel to the divine, yet have very human faults, including the disease of pedophilia. For this group, the allegations will still be upsetting, but less likely to precipitate a crisis of faith.

The emotions of parishioners in affected parishes will run the gamut from anger, disappointment, disgust, betrayal, disbelief and shock to sadness, grief and compassion.

Long-Term Effects

Some of the possible long-term effects have been documented in a study that I conducted with the support of *Twenty-Third Publications* in Mystic, CT. Roman Catholics in the United States and Canada were randomly selected from *Twenty-Third Publications's* mailing list. The respondents included 1,013 laity of whom 87% were active lay ministers in their churches, e.g., lectors, religious education directors and Eucharistic ministers.¹² Thus, the overwhelming majority of the sample included our most active and committed lay people.

The 1,013 active lay Catholics in the sample were separated into three groups: Group 1 consisted of those who had no awareness of a priest in their

diocese being charged with child sexual abuse; Group 2 included those who knew of a priest in their diocese who had been so accused; and Group 3 was made up of those whose own pastor had been charged. The differences between these three groups regarding their trust and confidence in the priesthood and the Church were striking.¹³

TABLE 1¹⁴

SURVEY STATEMENT	PERCENT AGREEMENT		
	Group 1	Group 2	Group 3
"I believe the church will safeguard the children entrusted to its care."	50%	38%	28%
"I would send my child to a Catholic summer camp."	78%	73%	65%
"When a new priest arrives in our parish, I wonder if he is someone we can trust." (% <u>disagreement</u>)	59%	48%	44%
"When someone wants to be a priest today, I wonder if he has sexual problems." (% <u>disagreement</u>)	81%	73%	58%
"I trust the Catholic church to take care of problems with its own clergy."	53%	33%	25%
"I look to the Church to provide guidance on issues of human sexuality."	77%	72%	66%
"I look to Catholic priests to provide moral leadership."	95%	91%	88%
"If I had a son, I would be pleased if he wanted to become a priest."	81%	68%	57%
"I support the requirement that priests live a celibate life."	32%	23%	18%
"Overall, I am satisfied with the priests that we have in the church today."	69%	50%	34%
"Overall, I am satisfied with the Catholic Church today."	63%	47%	34%

For each of the survey questions listed in Table 1, there was a marked decline in confidence in the Church from Group 1 to Group 2 to Group 3. Thus, the laity's confidence in the Church and the priesthood was the highest when there

were no public incidents of priest-child sexual abuse. When a priest in the diocese had been charged, their confidence dropped. When their own pastor had been charged, it dropped even further.

In the wake of clerical-child sexual abuse, parishioners are more suspecting of priests. They are more likely to wonder if he has sexual problems or if they can trust him. They are less trusting of the Church with their children. They are less trusting of the Church to take care of problems with its clergy. They are less likely to look to the priesthood or to the Church for moral leadership, especially on issues of sexuality. Their support for celibacy drops and they are less likely to encourage a priestly vocation in their own children.

Perhaps most surprising is the drop in overall satisfaction with the priesthood and the Catholic Church. When the laity are not aware of any cases of priest-child sexual abuse, their overall support is relatively high, 63% to 69%. But when their own pastor is charged, it drops to 34%, almost in half!

The survey data demonstrate that, when a priest is charged with child sexual abuse, the resulting erosion of trust and confidence in the priesthood and Church occurs throughout the diocese. *The data also show that the harm is most acute in the parish where the priest was assigned.*

The Catholic priest continues to exercise a pivotal role in the life of a parish community. If he exercises his pastorate well, he is a blessing for the people. If he has significant personal problems that lead to scandal, the effects can be devastating.

The Second Injury

There are several significant factors that affect how traumatic an incident of sexual abuse will be for a victim. The longer the duration of the abuse and the more aggression that is used, the more traumatic the abuse is likely to be. Moreover, abuse by fathers or trusted father-figures has been shown to cause more

serious psychic damage in victims than with other types of perpetrators.¹⁵ And it has been shown that the reaction of the people to whom the victim first reveals the abuse is similarly important.

In his summary of the research, Finkelhor concluded that "negative parental reactions serve to aggravate trauma in sexually abused children."¹⁶ If the victim feels ignored or, even worse, blamed for the abuse, a phenomenon sometimes called "the second injury" is likely to occur. The original acts of sexual abuse cause the "first injury." The negative effects of the victim being ignored or blamed exacerbate the original trauma and inflict the "second injury."

When a pastor is charged with child sexual abuse, his parish responds as a victim does. It, too, has been traumatized and it, too, needs a sympathetic ear. If an affected parish's trauma is ignored or if they are blamed for the abuse, it will suffer the "second injury." In addition to being upset by the pastor's alleged actions, parishioners are traumatized by the lack of manifest concern for their pain.

My survey data suggests that affected parishes have been suffering such a "second injury."

TABLE 2¹⁷

SURVEY STATEMENT	PERCENT DISAGREEMENT		
	Group 1	Group 2	Group 3
"The Catholic church is dealing with the problem of sexual abuse directly."	36%	60%	70%
"The church's current response to the sexual abuse of children by priests is adequate."	43%	66%	80%
"I have been kept adequately informed by the church about child sexual abuse."	64%	71%	80%

Table 2 reports that many active Catholics did not believe the Church is dealing with the problem of sexual abuse directly, nor did they feel the Church's current response is adequate, and they did not feel they have been kept adequately

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informed.

What is striking about Table 2 is how strong the negative sentiment was among those who had some first-hand experience of a priest in their diocese being charged. The majority of Group 2 were dissatisfied with the church support they received in the wake of allegations. This dissatisfaction was even stronger among those whose pastor has been accused, i.e., Group 3. Fully 70% to 80% of Group 3 did not feel that the Church had responded adequately to their needs. It is likely that they suffered the "second injury." Privately, many have confided that they felt abandoned.

In our survey responses, I found that people were angry and disappointed with the priests who had molested young children. Catholics, like their peers in society, acknowledge child sexual abuse as a heinous crime. But an equal source of disappointment and anger was the perceived lack of responsiveness by the church. As one Catholic said, "I'm more angry at the church than I am at [the priest]."

Parishes suffer deeply when their pastors are charged with sexual misconduct. Whether they are able to reveal it to inquiring church officials or not, or whether they are fully conscious of it or not, parishes need help, and they need it quickly.

Parishioners Want Information

First of all, people want and need information. Many times, they receive little from church officials or the parish leadership. The diocesan response to inquiries is often "No comment" or a brief statement is read. To obtain information, parishioners are forced to rely on rumors and the secular media.

Many times diocesan attorneys recommend that church officials say nothing while civil and/or criminal proceedings are possible or underway. This may be good legal advice but it cripples the pastoral leadership that the Bishop should exercise in

a crisis. The November 1992 resolution passed by the American bishops recognized the people's need for information, "Within the confines of respect for the privacy of the individuals involved, deal as openly as possible with members of the community."

Diocesan leaders cannot reveal information that would prejudice legal proceedings nor can they speak of confidential details that rightfully remain private. Nevertheless, there is much that can be spoken by church leaders to stop destructive rumors, to correct false impressions given by secular sources, and to allay unreasonable fears. Using both legal and pastoral advice, it is possible for diocesan leaders to chart a course of action that is legally prudent yet pastorally sensitive to the needs of affected Catholic communities.

Parishioners who are forced to rely on the secular media for information often receive a superficial and sensational understanding of the church's response. It is difficult for the media to present the complexities of these cases. The secular media reinforce the parishioners' feelings that the church is covering up the problem and has abandoned them.

When a priest has been charged with sexual misconduct, parishioners want and need information, and they need to hear it directly from church officials.

Authoritative Presence Required

In addition to the need for information, parishioners whose pastor has been publicly charged with child sexual abuse need strong leadership. In most cases, an accused pastor will be temporarily removed from his pastorate and placed on administrative leave. The absence of leadership and the rumors of allegations of misconduct create confusion and turmoil. In such a crisis, the need for leadership becomes acute.

Chancery officials may be reluctant to intervene in such parishes. They

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often do not know how to help the parish. They might be aware the parish is struggling, but they often feel inadequate to the task. Chancery officials have sometimes said, "If the parish wants our help, they will ask." In addition, as noted previously, diocesan attorneys may be advocating silence.

On the other hand, parishes may not ask for help from the chancery but usually expect an offer to be forthcoming. When the offer is not made, there is considerable resentment ("Why didn't they come to help us? They must not care about us, or they simply can't face the problem.")

As a result, the parish is left in a leadership vacuum. The members of the parish leadership are sharply divided and confused, and they are likely to focus their anger on the diocese. If a temporary administrator is moved into the parish, he or she can be of some help. But what people want is for the bishop and his staff to be a direct, concrete presence during this difficult time. The people's need for leadership is clear, and they expect the hierarchy to respond.

It is understandable that one's natural inclination would be to shy away from the painful task of discussing clerical sexual misconduct with the perpetrator's parish. But people want to know the steps that are being taken by the diocese. They want to know that their anger, confusion and pain are heard. They want to know that, at this critical moment, the bishop personally is in charge.

Some bishops have made announcements from the parish pulpit. Others have offered a mass of healing in the parish. Still others have sent personal messages via an episcopal vicar.

In the early stages, the bishop may have few answers or can say little. However, his authoritative presence communicates the most important message: he is concerned with the parishioners' pain and wants to help.

Healing Always Needed

This paper has outlined the need for information and for leadership in victimized parishes. There is a third and obvious need: the need for healing.

Some time ago I went to a parish whose pastor had been charged with sexual abusing several adolescent boys. The cases had gone to trial in a civil suit and were eventually settled out of court. The priest was sent into treatment.

During the first night we gathered, there was the usual anger at the priest and the diocese. Many asked, "How could the diocese send in a priest when there had been rumors that something was wrong with him in his previous parish?" Some defended the priest and said that he had done a lot of good. A few wondered if he really was guilty; they distrusted the legal system. There was an undercurrent of guilt, especially among the parents; they wondered if they were not somehow to blame for what had taken place.

The parish leadership complained that the congregation had become dysfunctional. People did not trust the diocese or its new priests. It was difficult to find volunteers for parish projects. Many had become uncooperative and cynical. The parish was splintering into different groups and some had simply left.

The odd thing was that the priest-perpetrator had been charged and left the parish almost ten years ago. The subject of what had taken place had never been raised. For a number of reasons, the new priests and the diocese had never been able to address the issue. Because it had not been addressed, the trauma did not go away, not even after ten years. Rather, it became like a cancer eating away the vitality of the parish.

As noted previously, decades ago many people believed that children who were subject to sexual abuse would "forget." If there was some short-term upset, this would quickly pass. Pastoral experience and clinical research have proven otherwise. It is the same with victimized parishes. The pain and hurt do not go

away unless a healing touch is brought to the wound.

There are several persons who need healing in the wake of clergy-child sexual abuse. First and foremost, the children who were victimized are in need of our immediate solicitude. In June of 1992, as president of the NCCB, Archbishop Pilarczyk said, "The protection of the child is and will continue to be our first concern."

The victim's family members may also need assistance. They will be grappling with how to understand what has happened. The pain and trauma caused by such events has split apart even healthy families. With assistance, this need not occur.

In addition to the victim and the victim's family, the church must be concerned about the perpetrator. There is little doubt that perpetrators are suffering from some type of mental dysfunction. While the moral and legal consequences of his actions cannot be ignored, the offender is in need of healing.

The alleged abuser might also be offered pastoral assistance from the diocese. More than one priest has either committed or attempted suicide after allegations have arisen. A priest-mentor and/or mental health professional could provide ongoing support when allegations surface. Most often, the accused longs for direct contact with an understanding and compassionate bishop or religious superior.

As the church is slowly learning about child sexual abuse and the devastation it causes both victims and their families, church officials are becoming more effective in dealing with the victims, the victims' families, and the perpetrators. While the media still broadcast news of the failures, many more cases are being successfully handled.

But what is only now emerging is a general appreciation of the need for an *action plan* on how to help parishes after their priests have been charged. Diagram 1 depicts the widening circle of devastation caused by clerical sexual misconduct.

The ripples extend far beyond the injured child and family. It must be recognized that the parish and the wider church are also victims.

[insert diagram 1]

Action Plan for Parishes

This article points out the short-term and long-term trauma caused to parishes when their clergy have been charged with sexual misconduct with minors. In particular, it documents the resulting decline in trust and confidence in the priesthood and church among active Catholics. Contrary to popular wisdom, I do not believe that this erosion of trust and confidence must necessarily follow incidents of clergy sexual misconduct.

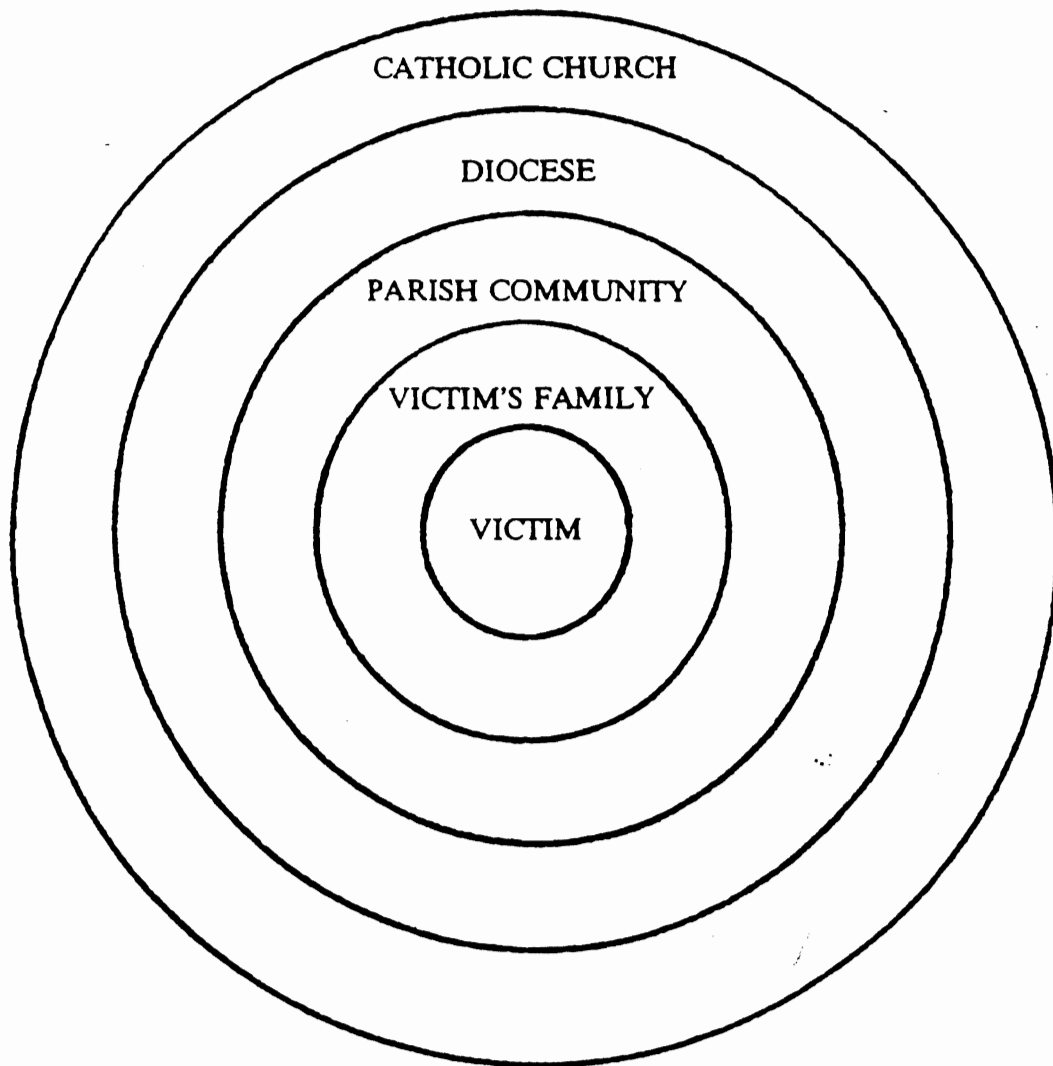
If church leadership took an aggressive, direct, and open response to the problem, I believe it would affirm the church's spiritual leadership in the minds of the people. They would perceive the mental illness that spawns pedophilia and ephebophilia as an exceptional occurrence in an otherwise healthy and concerned presbyterate. This could turn a crisis of confidence into an affirmation of support.

This aggressive action plan must necessarily include an action plan for parishes. The needs of the parishes, previously mentioned in this article, include (1) information, (2) an authoritative presence, and (3) healing. As noted earlier, the Bishop or his designed representative can be that necessary authoritative presence to the affected parish. To provide additional information and to begin the healing

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DIAGRAM 1

VICTIMS OF CLERICAL SEXUAL MISCONDUCT



process, the diocese may want to make available the services of qualified and trained pastoral, psychological, and legal professionals.

Parish Assistance Team

A small team of professionals at the diocesan level should be trained and be "on call." This team might include a public relations person, a mental health professional, a civil lawyer, and a pastoral person. Whenever a situation of clerical misconduct arises, chancery officials would contact the parish and ask the leadership if they would like the assistance of this team.

The public relations person would help the parish leadership deal with the media, which may deluge the parish with requests for statements and interviews. He or she might assist the parish leadership in drafting a public statement and in identifying one member of the parish leadership to interact with the media.

The mental health professional and pastoral person might hold listening sessions or parish meetings. They would schedule educational programs to provide information on child sexual abuse. They would help the parishioners process their hurt, anger, and disappointment. They would also make referrals to psychotherapists and pastoral counselors when indicated. For example, public allegations of clerical-child sexual abuse may stir up old wounds in parishioners who themselves were sexually abused in childhood; they should be referred to a mental health professional.

In addition to the public relations and mental health professionals, the Parish Assistance Team should include a civil lawyer if the accused priest were brought up on civil or criminal charges. The lawyer would provide general information to the parishioners on the legal process and any discussable information related to the case.

Parish Assistance Teams are already in place in a few dioceses. It has been

edifying to discover that many fine professionals are willing to donate their time for such service. They only need to be asked!

For example, under Bishop Marshall's personal guidance, the Diocese of Springfield has established a Parish Reconciliation/Healing Team and outlined procedures for the team to follow when intervening in affected parishes. When a public allegation occurs, the Bishop activates the team to lead the parish in the process of healing.

The Diocese of Springfield's written policy stresses the need for a swift response. The policy states, "It is imperative, therefore, that a process of reconciliation and healing be initiated as soon as possible" and "The Parish Reconciliation/Healing Team should meet without delay."

Empowering Parish Leadership

The Springfield policy includes an important realization: "The Parish Reconciliation/Healing Team begins the process of healing and aids the parish leadership in continuing and maintaining this process." The Parish Assistance Team is not designed to take over the leadership of the parish. Rather, its task is to provide necessary professional help at a critical moment. But the ultimate goal is to empower parish leadership to take charge of its own healing process.

Victims of child sexual abuse suffer in many ways. One of the most debilitating effects is often an enduring sense of helplessness. Through their victimization, these children may come to believe that they are powerless and cannot defend themselves. This is one of the reasons why victims of child sexual abuse are at greater risk for being abused as adults. They were "taught" to be passive, powerless victims and continue in this role until an intervention in their life teaches them otherwise.

It is the same with victimized parishes. The parish mentioned previously, whose pastor had been charged with sexual misconduct ten years ago, was not

able to move out of its stance of learned helplessness. They remained in this stance for ten years waiting for someone to come from the outside to help them.

The process that I used with this and other affected parishes is first to meet in a one-day session with the parish leadership including the parish council and parish staff. After allowing them an opportunity to vent their feelings, we work together to establish a series goals and objectives on how they plan to deal with this crisis. After this session with the leadership, educational and interactive sessions are scheduled with the wider parish.

My goal is to assist affected parishes in recognizing that they can shake off the role of helpless victim and can work together in their designing and implementing their own healing process. Once they are so empowered, the parish is well on its way to a stronger and healthier future.

As one Canadian sister wrote in her survey response:

Our pastor was convicted of sexually abusing boys.
Our parishioners were compassionate and understanding
of his weakness. It was edifying, and it brought our
parish together in prayer for him and for his victims.

Competing Rights

A difficult situation arises when the allegations of sexual misconduct have not been made public. The pastor has been placed on administrative leave and perhaps is undergoing psychological evaluation. The allegations appear to be founded but have not been substantiated in a court of law. Should the diocese make a public statement?

Parishioners are aware that something unusual is happening. The priest usually leaves the parish suddenly and may have told people that he is leaving because of "medical reasons" or for "personal reasons." Members of the parish suspect there is something amiss.

There is no obvious right answer to the question of making the allegations

public because there are a number of competing and contradictory rights. Canon 220 states: "No one is permitted to damage unlawfully the good reputation which another person enjoys nor to violate the right of another to protect his or her privacy." This canon recognizes the right of each person to privacy and to a good reputation. One could argue that it is the accused priest's right that allegations remain confidential and not be revealed by church authorities.

However, the priest's right to privacy and a good reputation are not absolute. The good of the church can supersede the rights of the individual person. Canon 383 states, "In the exercise of his pastoral office, a diocesan bishop is to show he is concerned with all the Christian faithful who are committed to his care...." One might argue that it is ultimately to the good of the parish community and for the healing of other victims that the allegations become public knowledge.

Canon 220 includes the phrase "to damage unlawfully." It could be argued that revealing allegations of clerical sexual misconduct is not "unlawfully" damaging the priest's reputation since the common good may require it. In addition, if the priest has done something illegal and immoral, i.e., sexually abused a minor, one may reason that his right to privacy and a good reputation are mitigated by this transgression.¹⁸

Canon 220 applies to all Christians. It should be added that the priest has the additional responsibility of performing a public ministry in the church. As a public figure given a sacred trust, one might reason that the parish community has a special right to know about substantial violations of the trust they have put in him. Do they not have a right to know why their spiritual leader has suddenly left?

If the diocesan leadership makes a public announcement of the allegations of clerical sexual misconduct, perhaps some people will be scandalized by the allegations who otherwise would not have been. But if no announcement is made, the parishioners will wonder what is happening, they may feel uncared for by the

diocese, and rumors will circulate. As one lay minister from Pennsylvania who completed our survey wrote, "We have had two priests in our parish over the last three years who were here one day, packed and gone the next. No explanation given. Rumors flew."

In the final analysis, unfounded rumors may be more damaging to the priest's reputation and the spiritual life of the parish than directly and honestly revealing the truth.

Allegations Sometimes Secret

Some pastoral situations are easier calls. If the allegations are about to surface in the media, an immediate public statement by the diocese is warranted. This would be the situation if the allegations were soon to be a matter of public record in the legal system. This would also be true if a victim were planning to release a statement to the press. If the allegations will inevitably reach the public forum, it is better that the diocese make the first announcement.

It would also be a simpler decision for the diocese if victims' families or victims who are now adults are adamant about wanting the situation to remain confidential or if the allegations of sexual misconduct appear to be highly dubious. Unless civil reporting requirements dictate otherwise, it would seem appropriate for the diocese to handle these cases discreetly.

The tough call is when a victim either does not object to the allegations becoming public or desires that the diocese makes a public revelation. If the allegations of sexual abuse appear to have some merit, the diocese is caught between competing rights. Should an announcement be made or not?

There is no obvious answer. Victims' groups lobby for public announcement. Church officials often believe that maintaining confidentiality is the greater good. Each situation calls for a prudent pastoral judgment.

However, instead of all the burden, and the possible public blame, falling

only on the shoulders of the Bishop, I recommend that a team of professionals review each situation and present a recommendation to the Ordinary. This group might be the same team of lay professionals that most dioceses' have constituted as a review board on clerical sexual misconduct cases.

If the review board recommends that a case be dealt with discreetly, this would make the Bishop less open to public criticism if the case eventually becomes known. It would also take some of the increasingly ponderous burden of clerical sexual misconduct cases off his shoulders.

In making a decision regarding public announcements, I offer the following guidelines for making such a judgment:

Err on the Side of the Victims. If the decision comes down to protecting victims or protecting the accused, and the allegations appear to have substance, we should err on the side of the victims. In each situation there will be competing rights. However, I believe the church has a special responsibility to come to the aid of victims.

Better to Hear Bad News from the Church. When the parents of a family have bad news, such as an impending divorce, it is better for the children to hear the news from their parents than to learn it on the streets. In a similar way, it is better for the parishioners to hear about allegations of clerical sexual misconduct from church officials than to read about such allegations in the newspaper.

Both of these guidelines suggest that the church tell the truth to the parishioners. It is worth repeating the words of the November 1992 resolution of the American bishops: "Within the confines of respect for the privacy of the individuals involved, deal as openly as possible with members of the community."

I think it would be an exceptional case if secrecy were the best course of action, particularly if the allegations were substantiated. However, if the allegations remained questionable and the alleged victim asked for anonymity, a prudent

silence might be most appropriate.

Silver Lining in a Dark Cloud?

One Canadian mother revealed that the pastor of her parish had telephoned one morning at 3:00am and asked for her son to be sent to the rectory to assist the priest. She dutifully woke her son who went to the rectory where he was sexually molested by the pastor.

The Winter Commission report, which investigated incidents of clergy-child sexual abuse in the Archdiocese of Newfoundland, repeated one of the testimonies it received:

The power, status, prestige, and lack of accountability at the parish level in particular, may have created a climate in which the insecure, power-hungry, or the deviant believed they could exploit and abuse victims with immunity from discovery or punishment.¹⁹

In the past, some Catholics have blindly trusted their priests. While trust between priest and parishioner is essential for a successful ministry, an atmosphere of blind trust does not hold a priest sufficiently accountable for his actions. A trust that is blind to the presence of human failings in a priest also makes parishioners excessively vulnerable to exploitation and abuse, as it did for the family that sent its son to the rectory at 3:00am.

While public awareness of clergy-child sexual abuse has caused much trauma to affected parishes and the wider church community, it also has the potential of being a positive force promoting a deeper understanding of faith and a more mature response to the person of the priest. In the earlier stages of faith in Fowler's model, people confuse the symbol with the reality: they have difficulty reconciling the humanity of the priest with the sanctity of the Lord he symbolizes. My study of Catholics suggests that parishioners are now more willing to recognize the flawed humanity of the priests they receive into their parishes.

Public allegations of clerical sexual misconduct have challenged Catholics to move to a deeper faith. Awareness of these allegations is also likely to make people somewhat less vulnerable to being abused in the future by clerics with problems. Catholics are challenged to develop a well-formed, mature trust in the sacred office of the priest and yet to hold the man in the office accountable for his actions.

A little skepticism is a healthy thing.

Signs of Progress

An increasing number of bishops are recognizing and responding to the trauma of parishes after allegations of clergy sexual misconduct. One of the first was Bishop Harry Flynn, formerly from the Diocese of Lafayette, Louisiana.

In 1984, Father Gilbert Gauthé became the first priest in the United States to receive national public exposure as a child molester. The Diocese of Lafayette was assaulted with months of devastating national media attention. The media explored the details of Father Gauthé's behavior, revealed the names of other suspected priest-perpetrators, and charged the church with a cover-up.

The court system gave Father Gauthé twenty years in prison at hard labor, without parole. The diocese lost millions of dollars in lawsuits. Parishioners were devastated. Eventually, the church sent Bishop Flynn to Lafayette.

Bishop Flynn made it a personal priority to deal with the trauma that clergy involvement in sexual misconduct caused to the diocese. He met, and continues to meet, personally with victims. He visited affected parishes. He offered mass and spoke to parishioners directly about the problem. He publicly announced his willingness to meet with anyone who had been victimized and encouraged victims of clergy misconduct to come forward. He offers an annual mass in the cathedral for all victims of violence and abuse.

Bishop Flynn has the added gift of being able to understand the anger of

victims and the people. He is able to listen compassionately and not become defensive as they vent their anger at the church. Throughout the exchange, Bishop Flynn maintains a steady pastoral response of care and concern. He has been a healing presence.

The Catholic church in the United States is coming to realize that a priest who sexually molests children has a mental illness. He needs to confront his illness and accept assistance; his goal is to find recovery. We recognize that victims of sexual abuse must learn to face and overcome their trauma; their goal is to move from being victims to becoming survivors. The church is starting to offer them support. But the parish community is also a victim. By confronting the problem openly and directly, with assistance from the bishop and his staff, it too can become a survivor.

These goals are not beyond reach. The pastoral and professional skills are available. Stories like those of Bishop Flynn and the Diocese of Lafayette have shown us what can be done. What remains for us is to recognize the wider trauma of clergy sexual misconduct and to mobilize our resources.

Clergy involvement in child sexual abuse has been a source of declining confidence in the church. It need not be so. If we are able to maintain a steady pastoral response of care and concern while we face this tragedy directly, we can affirm the age-old confidence that people have had in the presence of Christ in the Catholic church.

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NOTES

- ¹ Kinsey, A.C. et al. *Sexual Behavior in the Human Female*. Philadelphia: W.B. Saunders Co., 1953, p. 122.
- ² Ibid., p. 121.
- ³ Kinsey, A.C. et al. *Sexual Behavior in the Human Male*. Philadelphia: W.B. Saunders Co., 1948, p. 167.
- ⁴ Portions of this paper were excerpted from an article by Stephen J. Rossetti in *Human Development Magazine*, Winter 1993, no. four, Volume Fourteen, pp. 15-20. Subscriptions to *Human Development* can be obtained by writing directly to *Human Development*, PO Box 3000, Dept. HD, Denville, NJ 07834.
- ⁵ Canadian Conference of Catholics Bishops (CCCB). *From Pain to Hope*. A report of the Ad Hoc Committee on Child Sexual Abuse. Ottawa, Ontario: CCCB, 1992, p. 63.
- ⁶ Winter, G, N. Kenny, E. MacNeil, F. O'Flaherty, and J. Scott. *The Report of the Archdiocesan Commission of Enquiry into the Sexual Abuse of Children by Members of the Clergy*, Vol. 1, St. John's, Newfoundland: Archdiocese of St. John's, 1990, p. 124.
- ⁷ Dempsey, J. Q., J.R. Gorman, J.P. Madden, A.P. Spilly. *The Cardinal's Commission on Clerical Sexual Misconduct With Minors: Report to Joseph Cardinal Bernardin, Archdiocese of Chicago*. Chicago: Chicago Catholic Publications, 1992, p. 7.
- ⁸ *From Pain to Hope*, p. 50.
- ⁹ Hopkins, Nancy. "Congregational Intervention When the Pastor has Committed Sexual Misconduct." *Pastoral Psychology*. 39, no. 4 (1991): 247.
- ¹⁰ Ibid., p. 251.
- ¹¹ Fowler, James W. *Stages of Faith: The Psychology of Human Development and the Quest for Meaning*. New York: Harper & Row, 1981, p. 163.
- ¹² This survey was conducted in March and April of 1992. Of the 7,201 surveys sent out to a random sampling of *Twenty-Third Publications* mailing list, 1,810 surveys were returned for a response rate of 25.13%. Of the 1,810 respondents, 1,013 were members of the laity.
- ¹³ These statistics were originally reported in the September and October 1992 issues of *Today's Parish Magazine* published by *Twenty-Third Publications*. The sample sizes of the three groups were as follows: Group 1 = 349; Group 2 = 545; and

Group 3 = 98. These numbers do not add up to the entire group of 1,013 laity because of miscellaneous and unusable responses.

¹⁴An Analysis of Variance (ANOVA) was conducted on each of the survey statements in Table 1 comparing the three group means. In each case, the group means were statistically significantly different in the hypothesized direction. The probabilities were all less than .002 ($p < .002$) except for the statement "I look to the Church to provide guidance on issues of human sexuality" in which case $p = .0338$.

¹⁵Browne, Angela and Finkelhor, David, "Initial and Long-Term Effects: A Review of the Research," in Finkelhor, D. et. al. *A Sourcebook on Child Sexual Abuse*. Beverly Hills: Sage Publications, pp. 143-179.

It is likely that a priest in whom the victim and/or the victim's family trusts would fall into the Finkelhor's category of "father-figure." Thus, abuse by a priest would likely be especially traumatic.

¹⁶*Ibid.*, p. 174.

¹⁷An ANOVA was conducted on each of the three survey statements in Table 2 comparing the three group means. Again, the group means were significantly different in the hypothesized direction. In each case, $p < .001$.

¹⁸My thanks to Rev. John Beal, J.C.D., for his advice on the application of Canon Law.

¹⁹Winter, G.A., O'Flaherty, F., Kenny, N.P., MacNeil, E., and Scott, J.A. *The Report of the Archdiocesan Commission of Enquiry into the Sexual Abuse of Children by Members of the Clergy*. St. John's, Newfoundland: Archdiocese of St. John's, 1990, Vol III, p. 14.

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**THE ARTICLE ON INSURERS WILL BE FURNISHED
TO YOU IN THE NEAR FUTURE WHEN IT IS AVAILABLE**

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EXPECTATIONS OF TREATMENT FOR CHILD MOLESTERS

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Introduction

In the last decade child molestation has emerged as a major societal concern. In the context of the Church this destructive behavior evokes intense feelings and discussion from an array of perspectives. These include law enforcement, child protective services, victim's rights, civil liability, canonical process, pastoral care, candidate assessment, morale of priests and the faithful and on and on. If this article on the "reasonable expectations of treatment" is to have any coherence and substance, an important question must be faced squarely. In what way is pedophilia (or any form of child molestation) an illness?

Even in physical medicine the definition and classification of diseases is more complex than what might be implied by a simple dictionary definition of the word. Diseases might be classified by the organ system affected such as cardio-vascular, endocrine, pulmonary, neurologic and so forth. If the emphasis is on a known etiologic agent disease definition takes a different slant and may be called viral, bacterial, toxic, hereditary, etc. Consideration of the disease process itself leads to yet another naming scheme: infectious, neoplastic, developmental, degenerative, auto-immune to name a few.

Psychiatric diagnosis must deal with all of these complexities plus a few more. The human brain might well be one of the most complex structures on earth. Although its anatomy, cell types and neuronal pathways are well known, scientific understanding of its physiology and function is primitive compared to what is understood about many other organs. Moreover, theories of mind and personality development abound and what is defined as abnormal is contingent on what is viewed as normative. Lastly, what gets labelled as psychiatric illness, particularly when that illness has behavioral manifestations, is conditioned by cultural practices and values.

That psychiatric diagnoses continue to evolve is evidenced by the successive editions of the Diagnostic and Statistical Manual (DSM) IV. This publication of the American Psychiatric Association contains official diagnostic nomenclature used by mental health professionals. New editions have attempted to be more precise and specific in presenting criteria sufficient to make a given diagnosis.

Advancement in psychiatric understanding of sexual behavior disorders is reflected by changes in the DSM. The second edition coded pedophilia as a manifestation of an anti-social personality. In the DSM IV, as in DSM III-R, pedophilia is accorded a specific diagnosis as a sub-type of the broader category of Paraphilias. The latter is defined as having the following essential features "... Recurrent, intensive sexually arousing fantasies, sexual urges or behaviors generally involving 1) non-human objects; 2) the suffering or humiliation of oneself or one's partner, or 3) children or other non-consenting person, that occur over a period of at least six months." Additional features addressing subjective

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symptoms and types of impairment are described. In diagnosing pedophilia, the DSM IV specifies that the child victim is pre-pubescent which is generally understood as age 13 or less.

Facilities with a significant experience in treating priest and religious child molesters have come to recognize that these individuals much more commonly abuse adolescents rather than pre-pubescent children. A ratio of 4 to 1 is commonly cited. Thus, in the majority of cases the criteria for pedophilia are not met. Most clinicians, however, recognizing that it is not normative for adults to experience "...Recurrent, intense sexual arousing fantasies, sexual urges or behaviors" towards adolescents, code these conditions as paraphilias.

The normative outcome of the genetic, pre-natal, psychological and cultural/experiential processes that is called psycho-sexual development is sexual interest in and behavior with opposite sex partners of roughly the same age. What appeals to us is a matter of discovery not choice. How we act in response to that appeal obviously moves us into the realm of personal responsibility and morality. It would appear that sexual object preference, i.e., sexual orientation, once established, is not amenable to change. Some would argue this point and can cite a number of individual cases where a change of orientation has apparently occurred. This possibility does not have acceptance among most mental health clinicians.

For a most unfortunate few their sexual object preference turns out to be children. For pedophile/ephebophile individuals the sexual allure of children varies widely in its intensity, exclusivity, gender orientation and behavioral expression. Regardless of this variability it is clear that sexual attraction to children is a formidable human burden from which most of us are spared.

In no way is a medical/psychiatric understanding of pedophilia a substitute for a moral perspective. It is not a contrived variant of "the insanity defense" for very destructive, felonious behavior. On the other hand, viewing pedophilia and ephebophilia as definable, diagnosable psychiatric disorders had led to the development and application of a number of therapeutic strategies. These in turn have yielded more consistent behavioral change than criminal prosecution alone. Sincere repentance would imply the use of available, licit means to prevent the repetition of immoral acts.

If sexual object preference is unchangeable it is unreasonable to expect treatment to effect a cure. Acceptance of this clinical reality has led to the development of treatment approaches that focus on management. This is analogous to what is done for any number of incurable maladies such as diabetes, epilepsy, hypertension and alcoholism. The concepts of sexual addiction, relapse prevention, and empathy training as well as pharmacologic approaches have all contributed to a therapeutic optimism that a child molester can be helped. Cure is not possible, but recovery is.

Evaluation

Rational and effective treatment pre-supposes a careful and comprehensive assessment. This evaluation must be sufficiently comprehensive to:

- a. Accurately diagnose primary and concomitant illnesses. An evaluation is typically precipitated by official reception of an allegation of child sexual abuse. As a clinical process, an evaluation cannot be relied upon to determine if a particular act did or did not occur. Within this limitation, it should be able to trace the history of the individual's psycho-sexual development. A clinical history taken by experienced evaluators, appropriate psychological testing and the careful review of collateral information, permit a fairly reliable diagnostic conclusion in the majority of cases.
The assessment process must be broad enough to detect concomitant illnesses such as chemical dependency, mood disorders or personality diagnoses. The comorbidity of such disorders with paraphilias is significant.
- b. Identify risk factors and pre-disposing conditions. Although the cause of pedophilia cannot and may never be completely understood, a significant list of risk factors has been accumulating. These include chromosomal abnormalities, congenital defects, developmental trauma, early and/or extensive sexual activity, unusual repression of sexual awareness, hormonal abnormalities, neuro-psychological deficits and a history of being sexually abused. Some of these risk-factors can be directly addressed in treatment, others can be mitigated through the learning of compensatory strategies.
- d. Acknowledge, at least in broad outline, extrinsic factors that may impinge on the recovery process (number of victims and extent of harm, court matters - criminal and civil, reporting obligations, media publicity, family and personal resources.)
The referring official can reasonably expect a substantive report of the results of the evaluation. These results should be presented in lay language and in sufficient detail to support diagnostic conclusions and treatment recommendations.

Goals of Treatment

The effectiveness of the treatment of child molestation is measured by the achievement of goals. The essential, non-negotiable goal is the reliable, consistent arrest of harmful behavior. Although essential, this goal is a negative one and purely from an emotional perspective represents a loss to the pedophile. Recovery is supported and enhanced by other therapeutic goals involving the physical, psychological and spiritual healing of the abusing individual.

Pedophiles often have distorted body images. Their dislike of their physical selves may lead to bodily neglect or physical problems related to unhealthy life styles. Obesity, poor-conditioning or poor cooperation with medical management of physical illness are common.

Psychological damage may include low self-esteem, a deep sense of victimhood, immaturity, particularly as it affects peer relationships, authority conflicts, and little empathic understanding of others.

The perceptual distortions and cognitive rigidities and peculiarities that are associated with the denial so characteristic of child molesters limit spiritual development too. Pietism and spiritualizing are sometimes used to shield the pedophile from the serious behavioral changes they must make. The outward observance of a spiritual discipline may obscure the lack of a true relationship with a transforming God. An enduring recovery includes spiritual conversion.

The Process of Treatment

The structure and form of treatment for pedophilia/ephebophilia must be intense and comprehensive. Intense, both, because denial and minimization are such common features of these illnesses and because the consequences of treatment failure are so dire. It must be comprehensive to deal with all the identified risk factors and to insure as much personal growth as possible for the individual so that sexual sobriety is experienced as not only attainable but also highly rewarding.

Treatment must feature confrontation and support. The child molester must be pressured to look directly at what they have spent years avoiding. Yet they must be supported so that this self-inspection is not self-destroying. When denial crumbles and rationalizations fade and the pedophile/ephebophile faces the destructive lustfulness inherent in their abuse they are shamed and saddened. They are at risk for a major depression and suicide is a realistic concern.

The necessary combination of confrontation and support is best accomplished in a group setting. It is difficult to "con a con" so peer confrontation is invaluable for realistic self-appraisal. Moreover, seeing the progress of peers in achieving personal honesty and successful behavioral control is a major incentive for participation in treatment.

The concept of sexual addiction only received clinical attention in the early 1980s. It has not become an accepted official diagnosis. Nonetheless, it has yielded much of value to those struggling with sexual behavior problems. It has been especially helpful in providing a comprehensive structure and method of operation for support groups.

Aside from the "official diagnosis" issue, one thing is abundantly clear. Sexual behavior disorders behave like addictions in the following manner. They thrive in an atmosphere of isolation and secrecy. They wither with disclosure and healthy relationships. Thus the treatment process must promote openness. As an abstract value, the affirmation of openness does little for recovery. What is needed is repetitive practice of self-disclosure. The treating community must facilitate the experience of healing which truth-telling occasions. The subjective signs of this healing are feelings of confidence, peacefulness and an increase of self-esteem. The outward manifestations include acknowledgement of harm done and a more collaborative relationship with superiors.

Denial is nurtured by naivete and ignorance. Good treatment includes a strong educational component. Knowledge is needed about normal human sexuality, addictive processes, family dynamics, stress management and a variety of physical and mental health issues.

The educational component of effective treatment should include detailed instruction about the harmful effects of sexual molestation. Individuals with sexual behavior problems talk much more comfortably about the motivations for their behavior than its effects. Treatment must bring about a change in perspective so that the consequences of one's behavior is accepted as a crucial issue.

The quest for insight and understanding is very seductive and in a heady, highly educated treatment population it can be a therapeutic dead end. Paraphilias are primarily behavior disorders and successful treatment presupposes behavioral change. Why one performs a destructive act may be interesting but what is needed is to stop doing it.

In a schematic way, treatment addresses thinking, feeling and actions: the cognitive, affective and behavioral realms of human experience. In a clerical population, verbal facility is often over-learned. In restoring some kind of balance and assisting the individual in identifying and dealing with feelings, non-verbal therapies are valuable. Expressive therapy using art materials, psychodrama, bio-energetics, movement therapy and massage are among the techniques employed. Individuals respond variably to these methods but the application of one or more of them is commonly crucial to therapeutic breakthroughs.

Successful treatment brings clarity to the abuser about the "process nature" of their behavioral troubles. In the mind of the child molester the destructive act is often bracketed in the flow of his cognitive and affective life. He usually has a poor grasp of the behaviors, attitudes and circumstances leading up to the abuse and even less awareness of the consequences. The grabbing of unknown youngsters for quick, brutal sexual gratification is very rare among clergy molesters. What is much more typical is a sequence of behaviors,

based on inadequately examined attitudes and feelings, that eventually lead to the betrayal of sexual abuse. The basic plot outline of this tragic drama, this modus operandi, might be called a "seduction ritual" or "grooming behavior". The treatment process should be able to define it as a "relapse scenario" and assist the individual to identify the specifics of their own pattern.

Child molesters undergoing treatment have enormous pastoral needs. Even though some have long maintained a certain devotional discipline, their spiritual development is typically arrested. Given the extent of denial in their lives, their detachment from significant areas of affectivity and their relational impoverishment, how can their spirituality be healthy? There is a deep spirituality embedded in the process of 12-step recovery. In paraphilias, psychological healing is often accompanied by a spiritual conversion as well. Opportunity can be given for a guided examination of how the development of one's behavioral difficulties interacted with spiritual development and distorted one's relationship with God.

Medications have a useful role in the treatment of paraphilias. They work best as a component of an overall program and should not be regarded as an alternative to a comprehensive approach. Depo-Provera has been used for many years as an adjunct in the treatment of child abusers. It consistently lowers blood levels of testosterone and may have other effects on the brain itself. An individual taking this drug usually notices a diminution in sexual interest and reactivity. Physiologic responses to sexual stimuli are reduced and patients report a sense of comfort and control which they sometimes describe as a kind of freedom.

With doses in the 200 to 300 milligram range, given by weekly injections, the profile of side effects is very low. It is most helpful when taken voluntarily as a clearly understood component of an overall management and recovery plan. Clinically it is very useful to observe how a patient processes a recommendation that he take Depo-Provera. It is a powerful drug with significant effects both physically and psychologically. Abrupt refusal to consider its use raises questions about the abuser's commitment to healing. Knee-jerk acceptance may betray a superficial compliance that is unlikely to produce long term behavioral change. Grappling with the decision and cultivating a knowledge of and desire for expected benefits is consistent with a serious commitment to recovery.

Severe diabetes, significant cardio-vascular disease, advanced age and poorly controlled hypertension are among the medical contraindications for Depo-Provera use. It is also of limited value when the child molester has a low level of sexual drive and a history of few sexual acts spaced years apart. For such an individual there is little subjective sense of benefit. It is undoubtedly a useful drug overall, but its value for a given individual varies widely. Its prescription should be a careful clinical discernment and consent to use it should be thoroughly informed.

A variety of anti-depressants have value in treating paraphilias. Sometimes these are used specifically to ameliorate a co-existing mood disorder. Some of the drugs in this class moderate anxiety and some have been approved for treatment of obsessive-compulsive disorders. A sub-set of the child molester population features a great deal of obsessive, ruminative mental activity. In these individuals anti-depressants, particularly those in the serotonin influencing group, can be very helpful. Some individuals report significant improvement in behavioral control with drugs in this class. This effect is variable and not as specific and reliable as that produced by Depo-Provera.

The need for treatment to be both intensive and comprehensive makes a residential setting the most reliable format. Arguments can be made for and against a specialized treatment for priests and religious. When clerical patients are treated together the defensive use of ministerial role to disidentify with one's fellow patients becomes irrelevant. The sharing of faith assumptions can facilitate a certain relational base with the treatment team. On the other hand, a more varied treatment group can bring different challenges and perspectives to the therapeutic task. Pooling of experience and measurement of outcomes will be needed to answer more persuasively the question of how important specialized treatment is.

The scope of treatment sketched above gives some understanding of why competent residential treatment is so costly. Before committing to paying for such a venture, a religious superior has several reasonable expectations. The evaluation process should yield not only good diagnostic validity but some statement as to the pedophile/ephebophile capacity to benefit from the recommended treatment. Such feedback is best given in a face to face meeting among the assessing agency, the patient and his superior. In those situations where there is doubt about an individual's treatability, a trial period can be proposed with an agreed upon time frame for re-appraisal.

It is important that a religious superior be a working partner in the treatment process. They are entitled to regular reports describing progress in treatment. By providing new information about the patient to the treatment team, they can facilitate the therapy. Two way communication regarding administrative decisions affecting treatment are also desirable. Confidentiality is an important value in psychiatric care. The complexity of sexual behavior problems and their impact on others besides the perpetrator and victim requires suitable modifications about how the value of confidentiality should be served. An agreement on this point should be based on open discussion and clear agreement among patient, treating agency and responsible superior.

Continuing Care

The chronic nature of sexual behavior disorders requires that an organized continuing care program be a part of their management. Recovery that may appear solid in a residential treatment setting must prove its durability in a real world environment. If residential treatment has been successful then the recovering person should be an active participant in designing their continuing care plan. They should have a working knowledge of their risk factors, budding signs and support requirements.

In the wisdom of 12-step recovery there is a saying "We get sick alone, we recover together." A hallmark of sexual sobriety is a new kind of relatedness. It is expressed not as a clinging dependency but as a deeply felt need for involvement with others and a willingness to express that need in appropriate ways. It includes a reciprocal awareness of the rights and needs of others.

This awareness of the need for others finds concrete expression when a support group includes members of the major dimensions of the recovering persons day to day life. For a recovering priest this might include a personnel director or other hierarchical representative. A co-worker, a long term friend, a family member, a 12-step fellowship sponsor, a pastor or other person with whom one lives would all be good choices for members of a support group. Once they are selected and they accept membership they should be apprised in some detail of the recovering person's problem, his recovery plans and what he is asking of them to support that plan. Free communication among support groups members should be negotiated as well as a clear understanding of what they should do if concerns arise.

An effective support group takes effort. Guidance in its assembly and function can usually be provided by a treating agency. It has a vital role both in promoting personal growth in the individual and in providing early warning signals if movement towards relapse starts to occur. A major factor in good support group function is the commitment of the individual to his own recovery. On the other hand, the practical love expressed by support group membership enhances resolve when the recovering person encounters times of struggle.

Accountability is a key concept in recovery. One expression of willingness to be accountable is coming to periodic continuing care workshops. Residential centers typically require some sort of scheduled return to the place of treatment to formally review the experience of recovery in one's home setting. This practice helps to reinforce the fact that recovery is a long term process. It is not a task, like a course of study, that can be finished and left behind.

As in evaluation and intensive treatment the ecclesial superior should be a valued collaborator in continuing care. A vicar for clergy, personnel director, bishop or provincial can provide valuable observations to the treating agency. Conversely, he should be provided ongoing assessment of the quality of the individual's recovery from a clinical perspective.

He should be advised of any modifications of the continuing care plan or of any other changes that impact his role as responsible authority.

Results of Treatment

In achieving the essential goal of treatment, the cessation of molestation, church affiliated centers report very good results. Overall, the relapse rates are much lower than those reported in much of the professional literature. Despite struggle, inconsistencies and media frenzies over some dramatically horrible cases, the fact is, that countless instances of child abuse have been prevented by the Church's activism around treatment of child abusers. All would wish that such activism had begun earlier but it is only in recent years that diagnostic precision and effective treatment approaches have been available.

The impressive success in achieving the essential goal of treatment has not been met in meeting the secondary yet important goals of physical, psychological and spiritual healing. Some child molesters are seriously damaged individuals with limited internal resources to bring to the task of treatment. Such individuals, with great support, may be able to maintain a fragile recovery. Little remains, however, for them to spend outside themselves either in a restricted ministry or some type of meaningful employment. At the other end of a very broad spectrum is a priest whose recovery is so solid that much is left over after basic recovery commitments are met. For some such people their recovery itself may represent an enhancement of the resources they bring to the service of others including ministerial service.

All of these factors bear on any discussion of the possibility of a child abuser returning to ministry. In such a discussion it is important for all parties to stay in role. Ministry assignment is unequivocally the responsibility of the ecclesial authority, be he bishop or provincial. The role of the clinician is to offer opinion to assist the Church authority in making such a weighty decision. The clinician should be able to give some broad assessment of the quality of the individual's recovery - weak, good, excellent and so forth. Along with this assessment is an implicit statement of risk of relapse. Behavioral prediction in the mental health professions has not been impressive. Despite this, a reasonable prognosis can be given, especially if it is conditioned on the meeting of the stipulations of the continuing care plan. To the degree this plan is described in behavioral terms its adherence can be observed by others. To those who say the recovery person can't be watched twenty-four hours a day the reminder is necessary that priest child molesters commonly have a grooming ritual that extends over long periods of time. A properly prepared continuing care plan allows the perception of early warning signals. The workability of this system has been verified many times in instances where movement towards re-offending was recognized and interrupted in a timely way.

Another area where the mental health professional can speak appropriately about return to ministry is assignment fit. By "fit" is meant how the circumstances of a particular assignment

might support a given individual's recovery or how its challenges might pose special threats to a less than robust recovery. To do this the clinician has to have a working understanding of priestly function. This is obviously a situation best served by good three way communication between superior, treating agency and recovering individual. Incidentally, it is supportive of the position that clergy child molesters are best treated in a specialized, church affiliated institution.

The assessment of risk involves the weighing of a number of factors. Some of these pre-date treatment, others emerge in the treatment process. The best predictor of human behavior is past behavior, so good recovery maintained over years is a very favorable prognostic sign. But even here it is not a certainty. The following table describes some basis on which a prognosis can be formed.

<u>Good Prognostic factors</u>	<u>Poor Prognosis</u>
Older victims	Younger victims
Little overt aggression	More overt aggression
Few victims	More victims
Better neuropsychological function	Poorer neuropsychological function
Conflicted about behavior	Little conflict over what was done
Remorse/victim empathy	No remorse/empathy
Improved peer relationships	No improvement in relationships with peers
Active in constructing support for on-going recovery	Passive in constructing post-treatment support

Although treatment provides excellent results in meeting essential goals and variable, but usually good, results in achieving subsidiary goals, success can't be guaranteed. This is cited by some, including victim advocacy groups, as a reason for never allowing a child molester to officially minister. There is a certain stark logic to this position but it dismisses other values such as compassion, forgiveness and redemption.

There is a contagious quality to solid recovery that should not be overlooked. Solid recovery typically augments ministerial effectiveness. There is also a need to honor certain realities. If no risk could be tolerated it isn't just in cases of pedophilia where ministerial assignment would be impossible. What seems more reasonable is to make such decisions with extreme care and prudence using appropriate disclosure to enhance the safety of all.

**THE ARTICLE ON RECIDIVISM WILL BE FURNISHED
TO YOU IN THE NEAR FUTURE WHEN IT IS AVAILABLE**

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