Chapter Eight: Recommendations Regarding Return to Ministry

The Commission found this to be an exceedingly difficult mandate on which to develop a recommendation. It was discussed often. The issue was raised in most of the interviews we conducted. When we read the extensive literature about the nature of paraphilic disorders and the effectiveness of available treatments, as well as the policies of other dioceses and the requirements of the Church's canon law, it was with this mandate in mind. Most of the letters we received from concerned laity and clergy also addressed the issue.

We recommend that any priest who engages in sexual misconduct with a minor not be returned to parish ministry or any kind of ministry which would give him access to minors. We have identified no conditions in which an exception can be made to this.

If the Permanent Review Board believes that sufficient mitigating circumstances exist to create an exception, they would have to weigh those against the rationale for our recommendation.

Some people have pleaded with us not to "write off" these priests. Do everything to rehabilitate them, they urged us. These priests have given their lives to the Church, and many of them have ministered effectively. They have many friends in the parishes they have served. Approximately 25% of the letters we received from concerned laity and clergy who addressed the issue of return to ministry took this position. However, all but a few of these correspondents also recommended that, if the priest were returned to parish ministry, he be supervised and restricted from access to minors. In addition, most of the policies and procedures of other dioceses we reviewed appear to allow for a possible return to ministry. However, most of them are rather vague and do not distinguish among the various kinds of ministry to which a priest might return. A notable exception is that of the Archdiocese of St. Paul/Minneapolis which helped shape our own position to a great extent. (Cf. Appendix I for a copy of that archdiocesan policy.)

Others cautioned us that priests who have engaged in sexual misconduct should never be allowed to return to parish ministry. Of the letters we received which addressed this issue, 57% took this position, while an additional 19% added, no ministry of any kind. Thus, a total of 76% of these letters said, in effect, no parish ministry. Victims we spoke to, and literature about victims, had especially strong feelings about this, feelings we respected. One of adult survivors of child sexual abuse by a priest from another diocese shared with us her strong feelings and those of her family when the priest not only continued his public ministry, but celebrated the Eucharist in her home parish.

Several archdiocesan officials who have worked on this problem for the past several years volunteered to us that, while their approach was optimistic and compassionate, it was easy to lose some objectivity. Their experience has led them to question the validity and/or effectiveness of that approach.

The Church faces competing interests in attempting to resolve the issue of a possible return to ministry: (a) the safety of our children, (b) the need for people to have confidence in the Church and its ministers, (c) the belief that behavior can be modified and/or controlled, (d) the importance of forgiveness and healing. The "bottom line," however, is this: What risk would this priest pose? How much risk is reasonable? It is also important to keep in mind that the risks are not diminished with age for pedophiles and ephebophiles.

The Commission cannot offer the Archdiocese of Chicago a simple solution for handling all cases. Each will have to be decided on its own merits and in the light of its particular circumstances. However, we are able at this point to raise some important questions and recommend certain principles that should be part of the equation in any decision-making in regard to these cases.

To consider even the possibility of return to a limited non-parochial ministry by a priest who has engaged in sexual misconduct with a minor would require that he first undergo a minimum of two years' of intensive individual and group therapy. This means that he would need the minimum of a two-year break from priestly ministry for treatment. People in sex offender treatment undergo considerable stress and distress. It is not the same as being in an alcoholic rehabilitation program. During this period his cooperation and progress should be closely monitored by the Archdiocese, working closely with the psychiatric treatment facility.

Nevertheless, two years of treatment will not of itself

cure the priest or resolve the underlying problem. There is no completely successful treatment for pedophilia or ephebophilia at present. This is not to say that there is no hope. Every study we reviewed concluded that those who underwent treatment were less likely to commit sexual abuse again, but this does not mean that they never reoffend. The rate of recidivism (reoffending) runs from 5% to an often much higher rate. Dr. Fred Berlin told the Commission that the Sexual Disorders Clinic where he works has treated over 600 patients for up to five years and has conducted follow-up studies with them. He reported a 5% recidivism rate, but this is based on those who have reoffended and been caught. Most studies we read indicated a higher recidivism rate for those who have undergone treatment. The problem can often be controlled, but this is an individual matter and varies from person to person.

In part, it depends on the severity and duration of the problem. It also depends on the individual's ability to overcome cognitive distortion and patterns of denial, feel remorse for his abusive behavior, acquire adequate social skills, and develop empathy for his victims. It obviously depends upon his willingness to cooperate wholeheartedly in the treatment program.

At the end of this initial period of treatment, the therapeutic judgment of the treatment team is an important, but only partial, basis for deciding whether or not someone may return to ministry. Moreover, because humans make therapeutic judgments and administrative decisions, they are not always perfect or correct. The Isaac Ray Center staff, among others, pointed out that other considerations — legal, pastoral, moral/ethical, and financial — must also be part of this kind of administrative decision. The therapists have experience in assessing the pros and cons of each case and pointing out the risks involved. But their information is only part of the balancing to be done by the Cardinal in making decisions.

Frank Valcour, in *Slayer of the Soul*, lists five factors that enhance the reliability of such a formal opinion from a treatment facility:

(1) Acknowledgment and acceptance of the nature and extent of one's condition manifested by a capacity to describe it to a superior in simple terms.

(2) A commitment [in writing]... to do whatever is necessary to prevent the recurrence of problematic behavior...

(3) An awareness of one's own risk factors so thorough that the person... can list and describe these factors to another person...

(4) A willingness...to disclose fully to a small group of individuals the nature and extent of his or her problem so that he or she might ask for support and behavioral monitoring.

(5) A participation in a formal aftercare program of the treatment facility. (pp. 63-64)

In other words, prognosis is better if the person admits he has a serious problem, if it can be established that the abusive behavior occurred only once, and if the behavior was situational and not a pattern.

So, criteria for a possible return would also include the degree of severity of the abuse, its nature (e.g., exhibitionism, fondling, penetration), the number of incidents, the number of victims, the frequency of the misconduct, its circumstances, the degree of the priest's sexual interest, past patterns of behavior, and the degree of scandal associated with the misconduct. If someone has abused only one victim but over a long period of time, the prognosis is poorer. Naturally, there may be mitigating circumstances in individual cases.

Accordingly, we recommend that, after a priest has cooperatively completed initial treatment (over a period of two years), and if the recommendation of the treatment team is positive, the priest will enter a four-year supervised aftercare program, all the elements of which will be under written contract between the priest and the Archdiocese.

We recommend that the Cardinal include these four components in the aftercare program: (1) appoint a supervisor or monitor who will work with the priest in regular accountability meetings; (2) establish a supervised living arrangement based on recommendations from the treatment source; (3) design a vocational rehabilitation program of up to four-years in non-parish min-

istry (in which he will not have access to minors) while participating in on-going treatment; (4) require that the priest participate in a one-week annual evaluation and therapeutic workshop over this four-year period, in addition to weekly group and at least monthly individual therapy. Failure to cooperate with this contract will result in the priest's removal from active ministry, subject to applicable canon law.

We further recommend that, four to five years following diagnosis, evaluation, and successful aftercare, the individual priest will be eligible for consideration of a permanent contractual assignment, excluding ministry to minors and others at risk, unless professional evaluation indicates otherwise.

Why do we say that a priest who has engaged in sexual misconduct with minors should not be allowed to return to parish ministry or any ministry which would include access to minors?

Parishioners assume, and rightly so, that a priest assigned to their parish is trustworthy. Moreover, priestly ministry in a parish setting is highly demanding in today's Church. Priests often receive little gratification for all they do. There is considerable stress. Because most parish priests live where they work, they are available seven days a week, at all hours of the day and evening. In most rectories, people come and go constantly. Nevertheless, priests often face loneliness. It is easy for many to be overwhelmed and revert to earlier problems; e.g., substance abuse or paraphilic behavior.

There are three possible scenarios in these cases.

(1) If, after cooperating with treatment and receiving a positive prognosis, a priest is assigned to a parish that does not know about his prior sexual misconduct, how will he be able to minister effectively, living under the constant threat of exposure? To what extent would he be able to concentrate on his ministry because so much energy would be used simply to keep his sexual attraction and desires under control? It would be very naive to assume that this is simply a question of the priest's good will or high motivation.

This approach has been tried in the past. In effect, this has meant that archdiocesan officials have precluded the right of parents to protect their children by sending these priests back into parishes without notifying the parishioners. Parents and parish councils responded recently that archdiocesan officials had no right to take these actions without informing them.

(2) If a priest is commonly known to have engaged in sexual misconduct with a minor or minors, or if the parish is informed of this before his assignment, how could trust be restored between himself and a parish community to the extent that he could ever effectively minister there? How many parishes would welcome such a priest into their midst? Would he be subject to public ridicule? And how much should the parish be told, in what detail? To what purpose? Knowing that he would always be under public scrutiny, how could the priest minister confidently and competently?

(3) If a priest who has a past history of sexual misconduct with minors is assigned to a parish and only parish leaders (pastor, principal, Director of Religious Education, parish council, and/or school board) are informed of this, would this not be the perfect solution to the dilemma the Church faces in reassigning him to parish ministry? Two factors lead us to believe that it is better in theory than it would ever be in practice. The more people who are told, the more chance there is that the information will not be kept confidential. That is not an indictment of anyone, simply a fact of human nature. Moreover, would this not place an enormous burden on the shoulders of a few, especially if the priest were to victimize another child or teenager in the parish? If this became known, the rest of the parish might well hold those who knew about his history accountable.

There is another important consideration. Experts in psychiatry, psychology, and law whom we interviewed raised the analogy of the "impaired professional" — the "impaired physician," the "impaired dentist," the "impaired lawyer." They pointed out that a doctor who had engaged in sexual misconduct with minors could no longer practice as a pediatrician. He might have to change his specialty to another area, pathology or radiology for example. Or if he continued to see patients, a system could be set up which precluded his ever being alone with a patient.

Patients could be surveyed from time to time on a variety of concerns, including whether or not they had ever been allowed to be alone with him.

At first, this seems attractive as an analogy. However, a second look revealed that not much research has been done about the effectiveness of this approach. Moreover, when we approached the American Bar Association, the American Dental Association, and the American Medical Association — all headquartered in Chicago — we were told that none of them had any policies or procedures for dealing with impaired professionals specifically relating to child sexual abuse. They are only beginning to deal with the issue of the impaired professional in regard to such sexual misconduct.

We also reflected on what parochial ministry was truly like. People who come to see a priest do not expect someone else to be in the room with him at all times. It is not possible to monitor a priest 24 hours a day, denying him access to minors. Moreover, reassigning him to parish ministry would mean exposing him to temptation. He would be faced with a constant testing of himself. After all, as was remarked to the Commission, one would not ask an alcoholic to become a bartender.

Our recommendation also means that the priest may not work in a parish on weekends. He may not work in a high school or seminary. He may work in a hospital only if this gives him no access to children (e.g., a V.A. hospital) or if he is closely supervised. Other ministries may be open to him. He may do administrative or charitable work, say Mass in convents or minister in nursing homes (but not any which include handicapped children), homes for the aged, retreat houses (only if he would work solely with adults), retirement homes, and the archdiocesan pastoral center. Admittedly, in time, this could give these ministries an unsavory reputation, and people might draw false conclusions about others who minister in these settings. However, as we have noted, the Church has invested considerable time and resources in all its priests, and has an interest in their rehabilitation. We see no better alternatives. They cannot return to ministry with access to children, and not all of them deserve to be forbidden ministry of any kind.

We further concluded that any priest who has engaged in sexual behavior with a minor reside in a supervised setting, not a rectory. Moreover, we recommend that he be mandated to stay away from children and adolescents.

While this may seem harsh to some, the analogy of the impaired professional may help explain why we recommend going to this extent to minimize risk to children. An impaired physician has to compromise in order to protect public safety. If priests who have sexually abused minors want to continue to minister in the name of the Church, the community of faith cannot allow them to put other children or adolescents at risk. At the same time, a supervised residence will help the priests cope with their problem and provide the kind of supportive atmosphere which will enable them to continue to minister and serve the Church.

Other long-term management components include belonging to a support group and, if indicated, ongoing treatment. It is important to feel the support and challenge of a group of peers, similar to an alcoholic who attends AA meetings. Ongoing treatment will depend upon the recommendation of the therapeutic team who treat the priest in the initial two-year period.

> **We recommend for each priest who has successfully completed the four-year aftercare program: restricted ministry, a mandate restricting access to children, supervised residence, participation in a support group, assignment of a monitor or supervisor for life, and, if indicated, ongoing therapy.**

The monitor or supervisor will work in the external forum and needs direct access to the Cardinal or his delegate. He may not be the priest's confessor or spiritual director. The supervisor watches for patterns of behavior which pose risks: e.g., loneliness, self-pity, substance abuse, workaholism, or "grooming" a youth. Supervision or monitoring is key, but it can break down at the most obvious level. That is why the archdiocesan case manager will train and monitor the supervisors.

In short, if the priest admits his problem, apologizes, cooperates with therapy, is capable of age-appropriate relationships, and receives a hopeful prognosis from the therapeutic team, the Archdiocese may consider some kind of return to ministry as long as it does not provide access to minors.

Many suggest that optional celibacy today would reduce the incidence of sexual misconduct with minors by priests. Pedophilia and ephebophilia are not the results of a priest's struggling with celibacy. They are problems in themselves.

In addition, not all current treatment avenues are open for a celibate, for example, redirecting one's sexual energies toward acceptable sexual behavior with an adult. Moreover, studies have shown that sexual offenders who are married or separated but not divorced are less likely to recidivate than those who are single or divorced.

There are also some cases of sexual misconduct with minors which, we do not think, allow a return to any kind of ministry. If a priest is convicted of sexual abuse, has abused multiple victims, has committed multiple offenses, has abused a single victim over a long period of time, has become a public scandal, or is a poor risk for change, he should not be allowed to return to any kind of ministry.

He could never function effectively again as a priest in a public setting. The same is true of a priest who is allowed to return to ministry and engages again in sexual misconduct with a minor. It also holds for priests who are unwilling to undergo treatment or whose treatment is unsuccessful, or for those who are unwilling to meet the necessary conditions set down by archdiocesan leaders or who fail to meet these conditions. Moreover, anyone who needs medication long-term to control his sexual urges is an appropriate candidate for resignation or laicization.

Priests who fall into this category should be encouraged to resign from the priesthood. If they refuse, the Archdiocese may initiate a canonical procedure to laicize them or send them to a residential facility in which they will be allowed no public ministry.

For those who leave, the Archdiocese, working with the therapeutic facility, should develop an exit program which includes vocational counselling and enough financial assistance to enable them to cover minimal living expenses and continue therapy. There should be a severance agreement, a therapeutic program, and escrows to cover the therapy. The priest should be expected to find gainful employment. If he follows through on therapy, the Archdiocese will gradually diminish its financial support.

At this point, as a Commission, we do not feel that "low risk" is acceptable. Five to ten years from now, after a long-term study of archdiocesan priest offenders (with the assistance of a therapeutic facility), this entire issue may be revisited. Moreover, no one can predict today what new forms of treatment or therapy the future may hold.

We recommend that the Archdiocese make this policy clear in the early days of the theologate so that all future priests will know that sexual misconduct is totally unacceptable, and these are the consequences for anyone who engages in it, especially with minors.

It should be clear to everyone that the Church will not condone this behavior. Nor will it simply hide or protect anyone who engages in it. The People of God have a right to be able to trust those who minister to them.

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