Appendix C. Brief Summaries of Interviews (*)

Dr. Gene Abel, M.D., is the Director of the Behavioral Medicine Institute of Atlanta and Professor of Psychiatry at Emory University School of Medicine and Morehouse University School of Medicine. The Commission spoke with him by a conference telephone call about the Abel Screen, which is described in more detail in Appendix H of this report.

Abusers put themselves in positions which enable them to access children. However, it is difficult to identify who might be a molester. Dr. Abel's Screen is an effective, cost-effective technique. It is easy to administer in a short time. There are a variety of other screens currently available in North America, but (a) their validity has not been tested and (b) the person being screened must be very honest for these screens to be helpful.

The Abel Screen is only a screen, not a final word. It is the first step in evaluating who might be at high risk to be a sex offender. If a person fails the screen, more intrusive procedures procedures would be the next step in the assessment.

The Behavioral Medicine Institute of Atlanta is the largest treatment program in the Southeast for sex offenders. It treats about 250 persons at any given time, 90% of them child molesters. The Screen includes a questionnaire which may be completed on a microcomputer or with pencil and paper and a physiologic portion. The person looks at slides in a microcomputer while his interests are being recorded physiologically. Then the person goes through the same set of slides and reports his interests.

Their sample included some individuals who exclusively molested boys, some who exclusively molested girls, and some who molested both boys and girls. The staff asked how effective the Screen was when they compared a group of 108 normals to the group who exclusively molested boys and the group who exclusively molested girls. In developing the Screen, it was important that the normals did not have too many false positives. The staff decided not to use highly invasive technology. While there were 2% of false positives in the group of normals, the Screen identified 96% of those who molested girls, and 100% of those who molested boys. This success rate has remained stable over the four years the Screen has been in use.

They are now running their next group of 200 normals and do not expect the results to be as accurate as the first group. One usually gets poorer results in a second discriminate analysis. They split the offenders' group and the normals into two each. The split-half discriminate analysis reduced the identification of those who molested girls to 86% or 88%, but the percentage of those who molested boys remained at 100%.

Dr. Abel has developed a formula to identify who is at higher risk of being a sexual abuser of children. The computer registers hits and misses. If the person has hits, it is recommended that a more thorough assessment be done of his high-risk potential to be sexually involved with children. This second assessment is more intrusive. And the 2% of normals with false positives also undergo it.

One might do a pilot program using the Screen with seminary students before they enter into ordination. Another option is to use the Screen for individuals already ordained. There are several preliminary considerations, however. What will the Church do with those who fail the screen? The individuals will need to sign a consent form, knowing what it will mean if they fail the screen. The Church will have to know whom they want to assess. It should not be used with people who have homosexual or heterosexual interests in adults. The screen is designed to identify those at risk to children.

At what age is the test reliable? While Dr. Abel would not recommend using it for anyone under 18, he has used it with adolescent sex offenders. However, there is no absolute cutoff. It can be used with a person of any age and of either gender.

The data which Dr. Abel gave the Commission about the reliability of the screen was in regard to pedophiles. There is probably a variation between screening pedophiles and ephebophiles. The Screen's accuracy will be decreased, but not greatly so.

To attempt to identify every pedophile would involve this cost: It would raise the number of false positive to as much as 20%. That would be rather

*An exception to brevity is made in regard to the interviews with five psychiatrists and expert psychologist.

expensive because it would involve more clinical interviews and invasive measures, and it would offend more people.

It has been reported that 70% of the problems in the Church involve sexual abuse with boys. This represents a significant problem because molesters of boys usually have a large number of victims, more than 200.

Is there any reliable profile of child sex abusers? Some organizations use questionnaires to identify child molesters, but they are not very reliable. They have not been validated, and they involve self-reporting only, and people lie. Those who conceal their problem are the most troublesome cases.

Dr. Abel's main objective is to impact child molestation. 14% of all sex crimes have been against children. The Abel Screen will not cure the problem but it will be a response to the difficult issue of child molesters putting themselves in positions with access to children.

Can a priest who has sexually abused a minor serve in any form of ministry in the future? Dr. Abel made two responses.

(1) What is the appropriate responsibility of the Church? Many treatment programs are quite successful in reducing recidivism by 20% or so. That is, out of a group of 100 treated, 20 of them will stop molesting. Of those who re-offend and are re-arrested, their victims average only two children. There is considerable financial cost in moving the abusers through the court system and sending them to jail for one year with no treatment. It costs $185,000 to do this per offender in the U.S. at present. If 20% of the 100 in the group in treatment do not recidivate, this saves about $3.7 million. That money would cover the cost of treatment for 924 patients. So, treatment is cost-effective.

(2) There is also a legal-political dimension to the question. It puts the church in a very difficult position to retain individuals in the church if it maintains coverage for those individuals. If a priest molested 20 boys, and the church knows only about 2, there is still legal liability for the remaining 18. Most programs can reduce recidivism to 10% or less, but that still leaves the 10%. The church is in a difficult legal position even with follow-up treatment every one to three months.

Child molesters will always be a risk. The goal is to try to minimize the risks. If the objective, however, is zero risk, "you've got a problem."

Is it possible for a person to have sexual arousal or interest in minors but never act on it? Dr. Abel and his colleagues studied a group of over 500 people in New York. It was subdivided into three groups (1) those who are attracted to children but never acted on it, (2) those who are attracted to children, acted on it, but have stopped doing so, and (3) those who are attracted to children, acted on it, but have not yet stopped. Ultimately, the staff did not discover a single person in the first subgroup. People who claimed that they had not acted on it had differing notions of what that meant — they did not have actual intercourse with the child but had only fondled him or her, or they used no force, etc.

Is there an equal propensity among homosexuals and heterosexuals for molesting children? He responded by citing studies which use the Kinsey scale of adult gender preference — with 0 representing exclusively heterosexual preference, 6 exclusively homosexual, and 3 bisexual (very rare). Among those who molest girls, there was no 5 or 6 among them. The majority were exclusively heterosexual. There were more 2,3,4 than there's supposed to be, however. Those who molest boys covered the entire scale from 0 to 6. This represents a noticeable tilt away from the general population, more drift to Kinsey's 6 side of the scale. But does an adult homosexual preference help identify those who will molest boys? No. Exclusive homosexual or heterosexual preferences will only help a little in such identification. Adult gender sexual preference is not the same as child gender sexual preference. 11% of child sex offenders indicate no adult arousal; 89% do.

We have to think about the children today. Child molestation is a very serious problem. Molesters want to put themselves in pivotal positions where they access children. The church needs to address this societal issue.

Adult Male Victim of Child Sexual Abuse. He told the Commission about the victimization and its long-term effects on his life. He explained that, despite a delay of twenty years, he eventually reported the incidents because he was concerned that the priest who abused him might still be engaged in sexual misconduct with children. He spoke of his anger

against both the priest who had abused him and the Church. Despite frequent attempts to learn how the matter was being handled, he was not provided with any information on the case in the period between his coming forward with the information and the priest's subsequent removal nearly five months later. The Church must do more to help victims and their families. It also needs to sensitize priests on how to deal compassionately with the victims of sexual abuse.

Archbishop Quigley Preparatory Seminary Staff. The Commission met with Fr. John Daley, M.A., S.T.L., Rector, and Fr. John Klein, M.A. (Cand.), S.T.L., President of this high school seminary, to review the seminary's recruitment and screening policies and procedures, its criteria for the evaluation of students, educational curriculum and formational programs in regard to sexuality, and faculty policies. In the future the seminary plans to use appropriate levels of the MPD (the Ministry Potential Discerner) with its 1st and 3rd year students. The MPD indicates if a student needs to take the MMPI. The preliminary level of the MPD consists of 39 questions used in recruiting candidates and is more affirming than evaluative.

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It is important to develop a model profile of the kinds of cases the Commission has reviewed in order to assess potential risks among seminarians and other priests. This could include checking the seminary files (also any test results) of the priests whose cases the Commission has reviewed. It is important to collect all the pertinent data in a central place, including data from the seminaries.

No test or combination of tests will predict if a person will commit a sex offense. However, Dr. Abel's new test may be the best available. Perhaps this screening process could be given to seminarians (a) when they enter Mundelein Seminary, (b) before they are ordained, and (c) after they have been ordained about five years. If a problem arises later, the screening results could be examined to see if they were predicted.

Dr. Becker asked whether anyone discusses a seminarian's sexual history, present sexual practices and fantasies with him. It would be important for him to know that this information will be held in confidence. Perhaps, it would be advisable to have someone outside the seminary do this testing and gathering of information.

It is also important for priests and seminarians to develop the necessary skills to establish relationships with their peers. If celibacy is the goal, what does one need to do to attain that goal? We need to be clear about what constitutes realistic treatment for offenders who are to be celibate. After ordination, priests face many responsibilities for the families and communities they serve. They often feel quite alone. Boys who are loners, sad, and vulnerable can easily become victims of priests who lack adult companionship and support. Some sublimate their sexual desires; others act them out. Structures of support for celibacy are becoming fewer and fewer in our society. It is very important for priests to have support, especially when going through difficult times, e.g., the loss of a parent. Does celibacy pose a problem in terms of treatment outcome? A person who is in a stable marriage is less likely to reoffend.

It is important to do sexual histories of those who enter the seminary to learn how they handle sexual urges and feelings in the past and now. Both the seminary and treatment programs need to include not only discussion about the goal of celibacy, but, especially, how to attain it.

Seminarians and priests should be told that, when they are in positions of power, some may become overly attracted to them — including teens (boys and girls) and younger children. They should know the importance of maintaining boundaries. When does a professional relationship become intimate? A young resident doctor might have sexual feelings for a patient. They are told how important it is not to act on these feelings because of the harm this would cause an already vulnerable patient. They should consult with a peer or a counsellor in order to help maintain the necessary boundary. Who is available to priests for this? Someone should be.

There is a broad spectrum of sexual abuse or misconduct with a minor, starting from developing an emotional, non-sexual (?) relationship (grooming), through touching them through their clothing, to touching their naked bodies, to sexual penetration. The law describes the parameters and degrees of

abuse. However, it is essential to take into consideration how the child felt. Had there been an escalation in the forms of abuse? Priests, like other offenders, will deny or minimize what they have done. A priest who is forming or has formed a special relationship with a youth should ask himself why he likes to spend more time with this individual rather than others. A clear risk is involved.

If a priest is developing an exclusive relationship with a youth, but no sexual acting out has become known, the situation still calls for an intervention. Perhaps he should take some time away from ministry. If he returns, he should be supervised. Showing children pornography is the prior step to acting out sexually with them. Likewise, fondling leads to graver forms of abuse. It begins with developing a special relationship, touching, pornography...

Pedophilia can be detected as early as adolescence. If a youth is 17 or 18 and has molested 2 or 3 boys, and has had no sexual contact with his peers, and has fantasies only about sex with younger boys, this is clear evidence of paraphilia. However, it can occur at all ages, especially in one's late 40's or even at the age of being a grandparent.

Does the fact that so many cases involving priests are ephebophilic indicate that the problem may be related to their entrance into the seminary? It would be helpful to examine the cases before the Commission to ascertain how many went through the entire seminary system (5 years at Quigley and 7 at Mundelein in the old system, and the present 4 years each at Quigley, Niles, and Mundelein). In many of these cases, the victims are at about the same age as a boy entering the high school seminary. Male bonding took place in the seminary, an all-male environment. After a priest is ordained and faces stress in his life, he may regress to this "happier" period of male bonding and act out in sexual misconduct with young teenagers.

The overwhelming number of cases before the Commission involve homosexual ephebophilia. Dr. Becker suggested that the Commission look at the priests' experiences before they entered the seminary, what happened at the seminary, and what happened after ordination. Young teenage boys probably offer priests a population with the greatest availability (as altar boys, students). Very rarely are girls alone in the presence of priests (that is, in a one-to-one setting). There are more social controls for girls. Parents react differently if their son or daughter goes somewhere alone with a priest.

Were the priest offenders themselves victims of child sexual abuse? Did they have consensual sexual contact with their male peers before entering the seminary, or in the seminary? More probably than not, they had early sexual experiences with males and were attracted to their fellow seminarians in the seminary. As they grew up, their sexual attraction stayed fixed. It is important to discern whether the attraction is situational or preferential. If a man has sexual contact with a youngster on more than one occasion, he is probably a preferential ephebophile. It is also probably part of his sexual fantasies also. Some of the priests have also had homosexual experience with adults, while not many have had adult heterosexual experiences. So, there are three types of cases: (1) preferential ephebophiles, (2) ephebophiles who are also adult homosexuals, and (3) ephebophiles who are also adult heterosexuals.

The current seminary policy has been that a homosexual preference of itself does not preclude someone from being ordained, as long as he has the capacity to live a celibate life. What role might "repressed" homosexuality play in these cases; that is, men involved with teenaged boys while preferring adult males? In Dr. Becker's experience, ephebophiles are not generally interested in adults.

Is it more possible to rehabilitate an ephebophile? If a person is sexually attracted to both pubescent and prepubescent boys, there is an enhanced risk; that is, he is more apt to reoffend. If he has an attraction to only one group, there may be less risk. Not many of Dr. Becker's subjects have been men who were sexually involved with teens. If a teen was involved, and the matter was "consensual", it often does not come to anyone's attention. Unfortunately, this means that, without becoming public, the abusive relationship often continues.

In a case involving an exclusive relationship with a teen age boy, the offender has the same risk of reoffending as someone who abuses multiple victims with less of a personal relationship. He runs the risk of serial monogamous relationships. While he may not abuse as many victims, he is still a risk.

Most of Dr. Becker's work has focused on individuals, not their families. In her work with adolescent sex offenders in Arizona during the past year, she estimates that about half of these juveniles came from very strict, religious families in which no dating was allowed and masturbation punished. The other half came from non-religious backgrounds, often from broken homes, and had no boundaries or morals. Neither background is a helpful environment for child or adolescent development.

Are there any studies regarding cultural differences and their implications for studies of child sexual abuse? It has become a great problem, along with alcoholism, among certain groups. The two are intimately related in those who are afflicted with fetal alcohol syndrome and, consequently, have problems controlling their sexual impulses. Moreover, their parents are often dysfunctional, so this means that both biology and learned behavior contribute to the problem. This may also be true of cocaine babies.

Alcohol or drugs never cause someone to offend sexually. Alcohol lowers inhibitions and gives courage or "permission" for abusive behavior. In treatment, offenders are told how important it is for them to remain clearheaded to control their sexual urges, and this means avoiding alcohol. Some attend AA groups while undergoing therapy. This is helpful because it provides a support community.

In Dr. Becker's experience with over 1000 cases of pedophilia, the offenders have very good memories except for the periods of their offenses. There are frequent memory "lapses" — part of the denial. It is important to have a cognitive behavioral component as well as relapse prevention. The cognitive behavioral component deals with both the cognitive distortion and the deviant or inappropriate arousal patterns. Administering Depo-Provera would also be important if the offender has had multiple victims.

Developing victim empathy is also an important goal of therapy. Offenders write letters to their victims (letters that are not necessarily sent because this could be intrusive and open old wounds in the victims). In the letters the offenders explain how they groomed their victims, how they set them up and made them targets. They also acknowledge that the victims were not responsible for what happened. The offenders also read books written by victims and, at times, victims (other than their own) are brought into the group sessions.

Priests could be mandated to take courses or seminars on child sexual abuse. To prevent relapse, they would have to return to the group once a month and report their fantasies and urges.

Offenders often claim that the teen benefited from the relationship and sexual behavior under the guise of having his needs for love, intimacy, and sex met. The offender can become very depressed when he loses this "love" relationship. One of the goals of therapy is to overcome this cognitive distortion and enable the offender to realize that he was meeting his own needs in the relationship and sexual interaction and having a deleterious influence on the child's sexuality. Abused children view themselves as being different — victims or special people, neither of which is the natural course of child or adolescent development.

There are limits to the therapy offered an individual. If a priest is highly sexualized, he must be faced with the question of whether he can abide with the requirements of celibacy. He may be able to be active in the Church, but not as a priest.

While there are approximately 600 treatment centers for adolescents in the U.S., and about the same number for adults, only 12 in the U.S. and Canada conduct research and engage in follow-up with their patients.

Relapse prevention theory is gaining strength among researchers and clinicians throughout the country. In the past, many thought that the paraphilias were untreatable, not simply incurable. This was later seen to be too simplistic an approach. Today, multiple approach treatment along with relapse prevention strategies offer more hope than formerly.

A supervisor must be trained and be required to receive continuing education (e.g., once a year, take a refresher course). Supervisors should have a list of standard questions to ask and things to watch for. A seminar could include typical cognitive distortions and rationalizations. They could be trained to drop in unannounced at any time. Supervisors must learn the concept of boundaries; they must be role models of such boundaries with those they supervised. They have to be strong and exhibit "magic marker" boundaries. It is also helpful to do surveys within the work environment, as is done, for example, at child treatment centers. The Church could tell those whom the priest serves that it wants feedback from them on a variety of questions.

Would it not be better and cause less trouble simply to laicize priest offenders? However, the Church has already invested considerable time and resources in them. These people do have problems, but, if we can help them, we will have learned something from this and from them. The two extremes would be not keeping them, on the one hand, and closing one's eyes to the risk they pose, on the other. It is not impossible to help them, but it will initially cost more in terms of financial resources and investment of time. However, in the long run, the investment may prove profitable.

In assessing the risks involved in each case, it is important to know whether or not the priest acknowledges that he committed the offense and whether or not he wants help. A written contract could be drawn up after initial treatment. If the priest is unable to meet all the conditions or violates them, the contract would clearly state, he would be permanently removed from ministry. The contracts must be strict. Because the collar is a sign of power and authority, a priest in treatment might be allowed to wear it during work hours (e.g., at a nursing home or archdiocesan pastoral center) but forbidden to wear it after work or on days off. He should not be allowed to identify himself as a priest or to visit parks alone.

The Catholic Church, not only the offender, is paying for his offense. This is also true of the entire presbyterate. As in individual matters, and as related to therapy, there needs to be some form of restitution. What are these priests going to give back? They may have an illness, but they were the instruments of harm. They knew they had a problem but decided not to get help. It's like a diabetic not following a diet or taking insulin.

It is estimated that 1 out of 4 girls is a victim of child sexual abuse, and 1 out of 6 to 10 boys. It is more difficult to estimate the number of boy victims because there is a cultural bias against males coming forward and acknowledging that they have been victimized. At the same time, the physical trauma is not so strong for boys as it is for girls.

About 40% of adult sex offenders, and 23% of adolescent sex offenders, were themselves abused as children. This is a higher percentage than the general population. It is essential to identify and treat the victims at an early age in order to reduce the risk of their abusing others later in their life. Not facing this disease allows it to become an epidemic. There is very little funding of services for these children. Only about 20% of the children who have been abused receive help, and, often, this is more generalized treatment rather than specifically for child abuse. In assessing the quality of such treatment, it is important to ascertain whether the center keeps outcome data and offers follow-up services.

A priest perpetrator is quite similar to a parent perpetrator: Both involve serious issues of trust. Moreover, a priest's abuse also has an important spiritual impact on his victim(s).

People do not always react or respond to abuse in the same way. About 20% of child victims (e.g., young boys) experience no immediate trauma. The pain may arise at puberty, when they establish their first relationship, or when they establish their first stable relationship. The impact on boys tends to be different than that on girls. For girls, the trauma is more turned inside. Boys tend to act out more. Children generally feel guilty. Boys ask, What did he see in me? Am I feminine? At times, they were victimized simply because they were the only ones available. Over 70% of abused girls experience guilt; no statistics are available on boys.

Should the victim ever meet with the perpetrator? Yes, if the victim's therapist thinks this would be beneficial, and if the offender is at the point where he can listen to the victim and not cause more psychological harm to the victim. An offender's sensitivity to his victim(s) is a measuring stick of his progress in treatment, or lack of it.

There are no studies on what percentage of priests who have been treated relapse. In other fields, those who have molested children cannot continue to be a teacher or a pediatrician. In regard to a priest's return, that would pose too serious a risk to a parish. Moreover, he would not be able to concentrate on his ministry because so much energy would be used simply to keep his sexual attraction under control.

For the Church, it would be more humane not to dismiss a priest, if possible. He could be assigned to a position where he would not have power, control, authority, or contact with children. Could he function as a hospital chaplain? It might be possible if (a) he

were carefully supervised and monitored and (b) he would have no contact with children (having an assistant do that work). It would pose less of a risk if he were assigned to a nursing home, however.

There is so much we do not know about human sexuality. Surveys, interviews, and studies are very important. We need more information about the sexual behavior of both young people and adults.

Other professions mandate education regarding child sexual abuse for professional re-licensing. They are only beginning to deal with the issue of the impaired professional. Such a course could be incorporated into the seminary curriculum and the permanent diaconate program.

It should be clear to everyone that the Church will not condone this behavior. Nor will it hide anyone who engages in it. Some priests may want to leave if they know that they can never again return to parish ministry (thereby losing their access to children). Will they want to stay once they know all the conditions?

These issues are matters of trust, boundaries. If after intervention a priest is unwilling to undergo treatment and/or meet the necessary conditions, or if the treatment is unsuccessful or he fails to meet the conditions, he may no longer minister as a priest.

Because many priest who have engaged in sexual misconduct with minors expect to return to parish ministry after treatment, the Church will have to deal with their grief and depression. They may try to bargain. They should be told clearly, however, that returning to a parish setting would be a constant testing of themselves — like an alcoholic being a bartender. It is important to help them move beyond their grief and see alternatives.

The Archdiocese could get a male and a female victim of child sexual abuse to make a video, allowing themselves to be interviewed by a competent mental health professional. This could be used in many ways, especially at the seminary and in the diaconate program.

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The issue of child sexual abuse began to surface in the 1970's, and more since the 1980's. The medical/psychiatric profession did not handle it earlier because the public did not want to believe that the abuse was occurring. More recently, there have been significant changes in our society. Children are, and are seen as, more vulnerable — e.g., in families where both parents work or when children live outside the home.

There is an issue of credibility when children come forward later (in their late teens) and reveal that they have been abused. The fundamental dilemma we face is this: (1) it would be a terrible tragedy not to believe them, but (2) it would also be a terrible tragedy to presume the guilt of a person if he is falsely accused. What degree of credibility do young children bring in these cases? Very high. They are almost always certainly true.

At the same time, there are circumstances today which lead to false accusations: e.g., custody battles, divorce disputes. The matter can be resolved to some extent by being quite specific in interviewing the allegedly abused child, asking particular questions about matters the child would not be expected to know about. At times, it appears that the child has been coached to give specific answers.

General accusations coming later in life are more problematic. Some people simply have not thought about these matters for many years. Things they recall much later in life may not be true, even though they may believe that they are true. The human memory is fallible. General accusations about events in the distant past are not absolutely reliable. It is also terribly agonizing to be falsely accused of such behavior.

Repressing very traumatizing events is not the way the human memory usually works. For example, children who were in concentration camps have not forgotten the trauma of that experience. At the same time, we don't want to add insult to injury by not believing a person who comes forward with an allegation regarding earlier child sexual abuse. Would a person be capable of more easily repressing an experience like sexual abuse, however? It might depend on whether it happened during a sustained relationship or was only an isolated incident or two. The allegation must be taken seriously in order to

begin a healing process. But it is almost impossible to sort out the matter in the absence of an admission of guilt.

It is often said that "children don't lie." That is an oversimplification. One must look at the content. If the child is obviously distressed and is specific about what happened, there is more credibility. But it is also important to ascertain whether anyone is exploiting the child. The complaint must be looked at very seriously, but one must also look for corroboration. It is important to know to whom the child has been talking, what pressures or influences he or she may be subject to, how the investigation was conducted. Some well-intentioned people may lead children to say things that are not fully true, even though there may be a kernel of truth in what they say.

An adversarial approach retards the treatment for the victims. Such an approach focuses on punishing the offender rather than helping the youngster. Often, large amounts of money are involved in the litigation process. Setting up an adversarial role between the offender and the victim is the wrong approach. Coming together and working to solve difficult problems would be much more helpful.

The victim may not have been permanently scarred. Keeping victims as survivors for the rest of their lives can be very counterproductive. Their anger is understandable, but it is important to move beyond it.

Decades ago, alcoholism was seen as only a moral problem. Today, it still has a moral dimension, but it is also a scientific problem. Pedophilia is only a moral issue for most people. There are important moral implications, but, equally, the issue has medical concerns. Do we want the "safest" society or a "humane" society? If the former, then we will get rid of the offenders. If the latter, we will try to salvage and save some of them. If we want the safest society, then we will have to lock up all drunk drivers forever. Some people, whose families have been victimized by drunk drivers, may advocate such a position. If we want the safest society, then we can never let a priest who has sexually abused children to minister ever again. But if we believe someone can be salvaged, we would build a more humane society. Admittedly, sometimes we will make mistakes.

What are the ways of salvaging such persons? A pediatrician who has sexually abused children may become a pathologist or radiologist. In terms of salvaging priests, those who are attracted to children or adolescents cannot serve in parishes. It is a matter of taking a calculated risk. It requires moral leadership. The current societal attitude will be against rehabilitating such priests. But the Church can educate people to move in a new direction in confronting this illness.

People's sense of betrayal and anger is real. One can understand a certain "lynch" mentality. However, the Church can take a leadership role in raising people's consciousness about the nature of the illness and in advocating a more humane approach to people who are inflicted with it.

Some people are struggling and have not yet found a way to integrate their sexual needs into their lives. Many offenders were also abused as children. There are many such people in our society, and, unless we show concern and are helpful, their problems will remain hidden — and pose a risk to children.

At the Sexual Disorders Clinic, Dr. Berlin and his associates found that (1) mandatory reporting of disclosures about prior child sexual abuse deterred undetected adult abusers from entering treatment; (2) it deterred patients' disclosures about child sexual abuse that occurred during treatment; and (3) it failed to increase the number of abused children identified. The rate of self-referrals when such reporting became mandatory in Maryland (in 1989) dropped from about seven per year (73 over a 10-year period) to zero. The law, which was intended to protect children, deters persons who are abusers from coming forward. If they expect to be harmed by coming forward, why would they do so? Dr. Berlin made it clear that he is not opposed to all reporting requirements, only those which applied to psychiatrists.

Having a reward program for those who come forward would be a good approach. When a priest is involved in child sexual abuse, parishioners are outraged and demand retribution. Most people consider it even worse than incest when a priest is involved. When the matter becomes public, the community is polarized and healing retarded. Our priority must be to help the offender who comes forward and to have him identify the victims and their families so

we can assist them with therapy. This is more effective than seeking retribution or large civil suits for enormous amounts of money.

Of the cases which the Commission has reviewed, not a single one of the priests came forward and revealed his sexual misconduct. One can expect rationalization and denial in these cases. Often the complaint will come from the outside, and intervention is needed. But we should not lose track of human nature. When offenders build trust with therapists and know they will be helped, they divulge much. Not all of them will lie if they know they can trust someone with the information.

If we create two different tracks — those who come forward themselves and those who are accused by others — is there realistic hope that offenders will come forward? It will be necessary to raise people's consciousness. For many, it is a stigma to go to a psychiatrist. Also, some priests may fear what will happen to their future career in the Church if they come forward.

One needs to make a prudential, sound judgment in allowing such a priest to return to ministry, and some mistakes will be made. It is better to say this upfront. Tracking their cooperation with treatment and progress is the key. They should know how the Church will deal with failures to cooperate. In the past people were well-intentioned and thought that a change of venue was an adequate response to the problem of child sexual abuse. This is no longer the case. Today, we need a consistent feedback mechanism so that we can track each case. Ten years from now that will enable us to evaluate treatment outcome much more thoroughly and carefully. Over 600 patients have been treated at the Sexual Disorders Clinic — for up to five years and with follow-up. There has been a 5% recidivism rate (that is, of those who have reoffended and been caught), and this compares well with the population of those who have gone to prison and not received treatment.

An adult homosexual male is no more a threat to boys than an adult heterosexual male is to girls. Sexual preference involves an age range which elicits a response. Exclusive pedophiles are not attracted to adult males or females. They are recurrently attracted to children in a sexual way. The fact that a person is inflicted with homosexual pedophilia tells us nothing about the rest of his character. He may be characterologically flawed; he may not be. There is no personality profile for pedophilia. No known personality test will give such a profile. Patterns of behavior may provide clues of the illness. Pedophiles, for example, spend an inordinate amount of time with children. More often than not they really enjoy the companionship of children. They are often not like the proverbial "fox in the chicken coop." Very often the children like and trust pedophiles; a mutual affection exists. Problems arise when the adult is sexually tempted; acting on the temptation involves a breach of trust. It is very harmful when mothers or others tell victims of incest that their father never loved them — rather than explaining that their father expressed his love in an inappropriate way. The former statement can increase the child's sense of betrayal. If a person is not satisfied with an age-appropriate person, is it easier for him to approach a child sexually? It is easier for a pedophile because of the chemistry of his disorder. It is a question of abnormality, however, not simply immaturity.

Adolescents are much more vulnerable to be damaged because their sexuality is just emerging. They may be further trapped with secrecy about the betrayal of trust. An ephebophile sees adolescents as miniature adults (as pedophiles see children) — that is, capable of consenting, mutual enjoyment. This is cognitive distortion.

Narcissism could be true of any group one studied. Tests can detect narcissism, but not pedophilia. There is a tension between (a) a drive pushing a person and (b) inner forces (conscience, intelligence) which fight the drive. Some people lack these inner forces. The intensity of the drive, cognitive distortion, and rationalization all contribute to a lack of sensitivity toward the victim. It is important to know, once an offender sees the reality of what he has done, whether he shows signs of guilt or remorse. A narcissist would still be more worried about his own pain.

When a priest offender is removed from pastoral responsibilities, takes Depo-Provera, and receives therapy, more structure and supervision will mean he is less at risk (than if there is less structure and supervision). Most ephebophiles do not look for or approach strangers. Usually they are not coercive with their victims. Usually they tend to have the

need for an emotional bond with a youngster first, and then turn a caring relationship into a sexual one. Each case needs to be treated in accord with what the pattern of the offender is. A priest in treatment who has enduring relationships with young people or is away for the weekend may be at risk. Being reminded about the consequences of reoffending is not an unreasonable risk, but never think there is no risk at all.

If the behavior is compulsive and follows a repetitive pattern, there is no cure. It's like an addiction to alcohol. Any offender will need support and assistance in chronic care for the rest of his life. Depo-Provera lowers the intensity of the sexual drive (where it is successful). It makes it easier for the person to control the drive. However, when the medication is discontinued, the drive returns. If a person has made enough other changes in his life, he may be able to control himself. An individual might not need Depo-Provera for the rest of his life. However, he should be cautioned and closely followed. It is better to err on the side of safety.

Would a hospital chaplaincy be appropriate for a priest who has engaged in sexual misconduct with a minor and successfully undergone treatment and therapy? The Archdiocese would need to get a good sense of the kind of hospital it is, the circumstances in which he would work. It would not be wise to expose the person to temptation. How would his ministry be supervised? Would the supervisor be physically present? Would the work be exclusively administrative? Would the priest have any access to minors? The situation is similar to that of impaired physicians who have to compromise in order to protect public safety.

How much control would public disclosure of the priest's past be? It is absolutely necessary to disclose a history of sexual misconduct to others in the treatment program. Making a disclosure to the general public when a priest is returned to ministry would subject him to public ridicule. However, it would be useful for someone to know (e.g., the police, a group of responsible local leaders).

Would it be helpful to polygraph people who have completed treatment and returned to some kind of ministry? Polygraphs are not perfectly reliable, but it could act as a deterrent if people think they will have to undergo it. So, it has both advantages and disadvantages. The same is true of the plethysmograph. Some may be able to suppress their reaction to an erotic stimulus but are still acting out sexually. Others may be aroused and never act on it. It is easy to misuse this technology, but it can be helpful.

Like any medication, Depo-Provera has side effects, but they are about the same as birth control pills. Psychotropic drugs (appetite suppressants) are no more dangerous than others. Lowering the level of testosterone usually results in a decrease of sexually motivated behavior. There have not been double blind experiments (with a placebo) because of the risk such study would pose to children. Depo-Provera appears not to cause damage to any vital organs. It has never caused a clinical case of diabetes. Like birth control pills, it can cause blood clots in the legs — which could lead to a stroke or pulmonary embolism, but so far has not done so. One must weigh the risks of taking Depo-Provera against the risks of not taking it. No one should be forced to take it. Patients should give informed, willing consent before the drug is administered.

What causes pedophilia or ephebophilia, nature or nurture, or both? Probably both play a role. We do not choose what will sexually attract us; we discover it. A pedophile discovers that he is afflicted with an attraction to children. Because we are biological in makeup, we are sexual. So biology always plays some role. Do life events or biological events lead to a homosexual preference? There is more evidence today that there may be a biological predisposition. The presence or absence of early life experiences may or not contribute to a person's homosexual preference. Such a person did not choose to experience these feelings. Neither can a person simply decide to change his or her sexual preference. Once a sexual orientation is established, it cannot be changed. What sexual attraction we experience is not under our volitional control.

If a phenomenon like this causes suffering or damage, we call it a "disease." Because pedophilia can cause great damage and suffering, we refer to it as a disorder. Like an alcoholic, a pedophile must be accountable for his actions, but he is still afflicted with a disease. The Church could provide the necessary leadership in educating people about this.

Adults are attracted to adult men or women. There is no evidence that adult homosexuals or heterosex-

uals are more predisposed to pedophilia or ephebophilia. The overwhelming number of known cases involving priests who are ephebophiles or pedophiles involve an attraction to adolescent or prepubescent boys. About 90% of the cases in the Archdiocese are homosexual ephebophiles.

Penile plethysmography can be helpful in determining (a) whether a person is an adult homosexual who is attracted at the lower end of the age spectrum and, through opportunity or immaturity (making poor judgments) may become sexually involved with an adolescent boy or (b) whether he is a homosexual ephebophile whose range of attraction is narrow, limited to postpubescent youths.

A person can also have a homosexual pedophilia of a non-exclusive type, and be heterosexually attracted to adults. Could they be repressed homosexuals? That is a plausible theory, but it can be misleading. It has not been validated by objective evidence.

Archdiocesan seminaries ask candidates about their sexual preference. Their evaluation and recommendation for ordination depends on their capacity to live a celibate life as priests. Is it more difficult for someone with a homosexual preference to live a chaste life? They are more vulnerable, more tempted, in the all-male environment of the seminary. There is no objective data to verify this, but common sense suggests that this would be true. Many priests probably live chaste lives.

There are varying degrees of homosexual and heterosexual arousal. Many heterosexuals are exclusively so. A certain percentage of homosexuals are also exclusively so, but not all of them. Pedophilia and ephebophilia are not simply the results of a person's struggling with celibacy. This is a misperception. These are problems in their own right. Controlling such behavior is more complicated than Just Say No! The problems which many men face in talking with one another about sex needs to be resolved. Sex is a powerful force in human lives, and we need to address it seriously. Men need to discuss how to deal responsibly with their sexuality.

It is important to check out seminarians' background carefully. Past patterns of behavior, or a criminal background, would be very revealing. It is important to keep records of these matters even if a person is falsely accused. If a person is "falsely" accused more than once, the probability of there being some truth to the allegations rises significantly.

Is there any personality profile to ephebophilia? No. Some claim there is, but others disclaim it. Upon the results of various psychological tests, the staff at the Sexual Disorders Clinic could not identify, from various profiles, who was or was not a pedophile.

Do pedophiles or ephebophiles begin to act out as teens or does the problem emerge later? Most individuals become privately aware of sexual attractions in their early teens. The next step is to begin to act on these desires. While most eventually marry someone, few go back to where they were in prepubescence or early postpubescence. An ephebophile may be aware of his sexual preference during adolescence, but may not act on it. A person may experiment with homosexuality without being a homosexual. As a person progresses and acts more fully on his pedophilic or ephebophilic desires, however, he will not go back to simply being aware of the desire without acting on it — without an intervention.

If a person has been been sexually involved over a period of years with one person rather than hundreds, he may be less of a risk in the future. If he has been involved with great numbers, he will probably spend a long time in prison. The best predictor of risk is a person's past pattern of behavior. Did treatment fail in the past? The consensus of impressions of clinicians is that a longer, habitual involvement with sexual misconduct is more difficult to break, but no empirical studies have demonstrated this. We are still at step one; all this is very new.

The best approach is close monitoring and regular feedback. This begins with the treatment phase. Is the person cooperating with treatment? Is he showing up? Is he taking prescribed medication?

In making a decision about whether a priest can return to any kind of ministry, some settings may be clearly inappropriate, while others may minimize the risk to others. Some advocate throwing all these priests out, while others believe that everyone can be saved. Not all need to be thrown out. The issue is under what circumstances, with what feedback, someone may be able to be saved. Is laicization the best way of handling these cases? Why did the person want to be a priest? If there are virtuous reasons

for wanting to be (and remain) a priest, you have to talk to him about the risks and what will heighten or diminish the risks.

If a person is returned to ministry, he needs tracking and regular communication. Supervision and monitoring are key, but they may break down at the most obvious level. We can't depend that Big Brother is always watching him; that would be an untenable position from the outset. It is important to define what level of supervision is required and then to determine whether it is possible or feasible.

Is a homosexual ephebophile more likely to recidivate? The older literature predicted this, but Dr. Berlin's data do not find a recidivism rate among this population any greater than others. Cooperation with treatment is very important. If a priest is returned to ministry and recidivates, he probably can no longer minister.

Will the risk be diminished with age? Generally not with pedophilia or ephebophilia. In his late 70's, such a person may be less driven sexually and may not himself experience orgasm, but he may still fondle kids. The frequency of the behavior may drop off, but it will remain a problem, and there will be more victims.

Alcohol can disinhibit a person and impair his judgment. It allows persons to act on what they were already predisposed to do. So, alcohol is not the only problem. One must still deal with the pedophilia or ephebophilia.

Plethysmography is clinically helpful in identifying effective arousing stimuli and in confronting deniers. However, is is not a predictor of therapeutic success or failure, nor is it useful in a court of law. Is it critical for diagnosis and treatment? It is important to persuade the patient that it is useful. A rectal exam is embarrassing too, but also very helpful in medical diagnosis. It helps reveal areas of vulnerabilities and strengths. It is important for a clinic to respect the background and moral values of the patient.

Treatment for sex offenders is much like dealing with any craving disorder (e.g., alcoholism). Group therapy is important. It is used to confront and break down a person's denial and rationalization, and to develop an empathy for the victim(s). It establishes a supportive environment for therapy which encourages a person to admit his behavior. It includes relapse prevention strategies through education, counselling, teaching. It identifies a support system; others whom the patient trusts can help him. It gives feedback to the individual and the treatment team. Pharmacological therapy helps take the edge off a person, lessens his sexual preoccupation. Peer pressure is also a part of group therapy. Being accountable to others is important.

The Sexual Disorders Clinic does not rely much on behavioral therapy. The challenge which behavioral therapists face is this: Is what happens in the lab indicative of a person's behavior in the community? The bottom line is: How do people conduct themselves outside the lab and in the community?

Can confrontation between the perpetrator and the victim be therapeutic? It can be if the victim wishes to do so, and the perpetrator agrees. However, the best therapy is not simply getting revenge. Load the decision in favor of the victim's wishes. Some use victims not abused by the specific perpetrator, but be careful of vindictiveness. Such a confrontation may give the offender a better insight into his behavior and motivation to change. There are other ways of doing this, however, just as there are many ways of making amends. Having the offender personally make amends to his victims can be very invasive of their privacy, very intrusive; it can open up old wounds.

If the offense takes place within a family, does the family stay together, or is the perpetrator removed from the home? That depends. It may be very helpful for parents to apologize to their children and to assure the youths that they are not responsible for what happened. However, children should not be subjected to undue risk. It may seem to be a matter of common sense, but it is often very difficult to judge what would be most helpful and therapeutic.

The challenge is how to deal with these issues in a discrete fashion without it appearing to be a cover-up. We are often amazed at the loyalty of many people to individual priest offenders. It is important to share the Church's dilemma with parishioners. Are they willing to support the Archdiocese if it tries to salvage some of these priests? There are no absolute guarantees, but the Church is interested in getting their feedback. While it is important to ask for their

support, not everything can be decided by a majority vote or by having everyone share the responsibility.

What kind of education do the seminaries give about sexuality? It is important to create an appropriate atmosphere in which seminarians can discuss openly issues of sexuality which concern them. These discussions must go beyond everyone simply agreeing on the goals. They must include the ways of achieving them — how to be celibate, chaste. Some may be uncomfortable with such a discussion, but it is very important. It is also important to have professionals available to assist people who need more than discussion groups.

Confidentiality can appear as a cover-up. However, it is very simplistic to equate confidentiality with a cover-up. We need a way of intervening and confronting individuals, letting them know that a mechanism exists to help them. The most effective approach is therapeutic, not punitive. However, how do we lead people to understand this? Shielding defendants does not mean avoiding one's responsibilities to their victims.

The Commission needs to make its case very persuasive. Having a different point of view, especially one considered politically "incorrect," can be misinterpreted as not caring for children or victims.

The issue of a possible return to ministry is the most difficult part of the Commission's mandate. Dr. Berlin advised the Commission to contact the AMA and the ABA to see what kind of policies and procedures these professional organizations have for responding to sexual abuse cases and determining whether an impaired professional can return to practice.

Ms. Barbara Blaine, M.S.W., told the Commission about her sexual victimization by a priest when she was in junior high and high school in another diocese. The priest belongs to a religious order and is still ministering in a hospital setting and celebrating Mass at various parishes. She said that he should have gone through a full program of treatment and never allowed to return to ministry. She still feels helpless and angry about this. She has not wanted to give up on the Church, but she has been disappointed with the Church's response. Recently, she founded SNAP, Survivors Network for People Abused by Priests. It has over 200 members who were abused as children. Only one of these persons thinks that the Church responded well in his case.

Mr. Ralph Bonnacorsi, M.A., is on the staff of the archdiocesan Office of Catholic Education (OCE) and a member of the Advisory Committee of the Vicar for Priests since last October. The Commission interviewed him about the procedures used by OCE in regard to allegations of child abuse and about the possible return to ministry of priests who have a history of child sexual abuse. The Church faces competing interests: (1) the safety of our children, (2) the need for people to have confidence in the Church and its ministers, (3) the belief that some behavior can be modified and/or controlled, and (4) and the importance of forgiveness. While some clergy and laity appear willing to allow a priest, who has been removed because of sexual misconduct, to return to ministry eventually, their attitude might well change if they knew the details of his history. Every archdiocesan school should have in-service training for teachers, parents, and children. OCE needs a system to monitor what is being taught about sexual abuse in our schools. The Archdiocese needs to develop a professional responsibility seminar for parish staffs.

Dr. James Breling, Ph.D., is a Psychologist in the Violence and Traumatic Stress Research Branch of the National Institute of Mental Health in Rockville, Maryland. At the present time he handles all grants and activities in regard to sex offender issues. He is also on the Advisory Board of the Association for the Treatment of Sexual Abusers. His current research areas are on juvenile sex offenders and adolescent delinquents. The Commission interviewed him by a conference telephone call.

There is no simple profile of pedophiles or ephebophiles. Those profiles which do exist have not yet been tested enough. Often they are very similar to anyone on the street. Even if if we could draw an accurate profile, it would not be of much help. We know that many pedophiles or ephebophiles are unassertive, passive-aggressive individuals, but people with such characteristics are not necessarily sex offenders.

Would ordinary psychological testing (MMPI and projectives) pick up this profile? Only weakly. It would not be very effective to use this as a screening process. Are we more able to pick these things up

after a person turns thirty? Dr. Breling is aware of no studies which reach that conclusion. He told the Commission that Dr. Gene Abel has developed a screening procedure for the assessment of paraphilia.

Can pedophilia and ephebophilia be cured? The results to date are quite pessimistic. Considerable data points to a long-term management/supervision approach instead. Ultimately, there appears to be little difference between treated and untreated groups in regard to recidivism, although it usually takes a much longer time for treated groups to reoffend. In regard to the success rates of adolescents in treatment programs, after 3-5 years of follow-up, there appear to be high rates of not reoffending. But it is difficult to say if adolescents are easier to treat than adults. Sex offenders tend to minimize the extent of their misconduct. They often deny the behavior even after being rearrested, so self-reports alone are not reliable.

In regard to the success rates of treatment, health care professionals often make claims they cannot substantiate, and may mislead the public. We do not have highly powerful or successful treatments at present. A recent task force of 25 professionals recommends long-term treatment, even lifetime, with close monitoring.

People in sex offender treatment undergo considerable stress and distress. It's not the same today as being in an alcoholic rehabilitation program.

Dr. Breling has not had clinical experience with clergy sex offenders. However, he is familiar with the ministerial life-style and work, and the kinds of relationships — often one-on-one — which are part of priestly ministry. When, through sexual misconduct, a priest has breached the trust which people have in him, can he ever return to effective ministry? The critical factor is the thoroughness and competence of the people who do the psychological and psychiatric assessments. Was the behavior situational or does it represent a pattern? Does the person have a high degree of sexual interest? Were the circumstances situational or unique? If so, maybe something can be done to help such a person return to ministry. What's the base rate? If it is chronic, long-term, there is a likelihood of recurrence, a high rate of recidivism. Persons often develop more stable or set patterns of behavior as they grow older.

A treated priest's return to ministry would not be free of risk. The question is, How much risk? He may be able to work in a setting in which he does not have access to children. However, there are other considerations — his residence, his discretionary time. Actually, we are taking risks with everyone. Problems will vary with circumstances, stress, drinking habits. Surveillance and monitoring drinking would be of some help. Over a longer period of time, and in more varied circumstances, perhaps everything will be okay. But that is also the time when we often let down our guard.

In regard to some pedophiles, a strict surveillance monitoring system has had good effects for the past year or so. The Church has made a substantial investment in its priests. How can it address the needs of the priest offender and public safety at the same time? A doctor can be continuously monitored by his staff, and patients can be asked to fill out standard questionnaires after each visit. Can the Church set up a similar surveillance system for a priest, or is his ministry too open and unstructured?

It's important to guard against further victimization. No one has an easy solution to this dilemma. It is not clear what all would be involved in long-term management of a priest who returns to ministry. Perhaps the Church could arrange periodic meetings of people in a parish to ascertain their level of satisfaction with the parish, ministry, ministers. However, victims may not come forward in a group — or at all. Breach of trust destroys or seriously impedes the possibility of future ministry.

Are homosexual and heterosexual preferences about equal in regard to the incidence of sexual misconduct with minors? Those exclusively attracted to young boys (12-15 years of age) are very difficult to treat if they are fixated. However, some victims say that the reaction of other significant people to the incidents can be worse than the experience itself. At times, physical organic problems trigger a crisis and lead to sexual misconduct. In regard to clergy, most are not the predatory or violent kinds of persons who engage in such acts.

Those who acted out sexually with young boys are not necessarily homosexual. While there may be some biological origin to homosexuality, the environment of seminaries, with their all-male environment, may influence a person's preference and/or

behavior. Do heterosexuals and homosexuals run the same risks or have the same chances of being perpetrators? If they are attracted to boys, they are neither. Assessments in the past were poor. They were usually based on official records. We do not have a good empirical base to answer this question.

Seminarians and priests need to know how they can express warmth and caring for others without sexual expression. Social support and caring are very important. The priesthood is a lonely vocation with considerable pressure. How can priests handle intimacy in appropriate ways? To whom can they turn when problems arise? Can you have a socially supportive group of lay people in the parish?

There is a high correlation between dysfunctionality of the family and sex offenders. How much interaction is there among family members? How good a predictor would this be in regard to potential for sexual misconduct? It is not clear. We need more perspectives on what normal family life is.

Depo-Provera does not work in all cases, but it helps in many cases. It is not a cure. There is a high relapse rate after it is discontinued. That's why many are moving towards long-term management instead. Prozac has also been helpful to some extent in these cases.

The relationship between substance abuse and sexual misconduct may be situational. Alcohol can impair a person's judgment. Among true pedophiles, there is not a high rate of alcohol abuse.

There are no good studies on male victims, although there are some on female victims. How people respond to a situation can make a big difference in the kind of impact which the victimization makes. Do parents support the child or blame him or her? Is their reaction hysterical or calm? Studies are difficult to make because there are often legislative prohibitions against using children, who are already traumatized, in such studies.

Retrospective accounts from adults who were sexually abused as children may involve reinterpretation. Adults who were abused 20-30 years ago often are at risk for sexual exploitation today. A researcher needs to ask explicit questions and conduct a life history interview to cut through any reinterpretation of the events. Dr. Breling cited the case of a woman who claimed to have been "sexually abused" by her father. Under closer examination, it was merely a matter of her interpreting how he had looked at her. When claims of "sexual abuse" are made, frequently a description of the experience is lacking. Was it or was it not?

When sex offenders in prison were asked whether or not they had been sexually abused as children, 85% replied that they had been. When they were told that they would have to be polygraphed and plethysmographed, the number of positive respondents dropped to 25%.

In regard to young victims, shame may become their primary state of mind. There has been no work yet done on this. Tell them: You did no wrong. Ambiguity about sexual orientation can be very confusing for older children or young adolescents.

Does an all-male environment provide a greater chance to develop a homosexual preference? A person who grows up in this environment may be more prone to develop a sexual attraction for boys unless there are counterbalancing influences.

There are a half-dozen centers in the U.S. which deal with these problems, among them the Johns Hopkins Hospital, the Behavioral Medical Institute in Atlanta, a center in Portland (Oregon), and the Isaac Ray Center. The Archdiocese is very fortunate to have the Isaac Ray Center readily available in Chicago. They are a great resource in both assessment and therapy. The Center is "state of the art," and they also know their limitations. In evaluating treatment centers, beware of descriptive labels. Is the program carefully structured? What actually is taking place in terms of coherent philosophy, structured environment and program, integrity, and the like?

When asked if any other profession is looking at this problem in as determined a fashion as we are, Dr. Breling replied that the Church and the Archdiocese, in particular, are on the cutting edge.

Fr. John Cella, O.F.M., M.B.A., J.C.D., is the Director of the archdiocesan Office for Religious. There are about 1,200 men religious in the Archdiocese, 800 priests and 400 brothers. Many do not have a direct ministry with the Archdiocese but are employed by their religious community. Some are employees of the Archdiocese, while others simply live here, with or without archdiocesan priestly faculties. A bishop can deny priestly faculties to a religious. Some dioce-

ses insist that they must be informed about a history of sexual abuse when a religious community requests faculties for one of its members. When a religious priest has been given faculties by the Archdiocese, this local church assumes certain responsibilities for his life and ministry. It is vital that the Archdiocese receive all the pertinent information it should know about every religious priest who applies for faculties. It is essential that every school in the Archdiocese staffed and/or sponsored by religious communities has policies and procedures for sexual abuse, and that they correspond with archdiocesan policies and procedures.

Fr. Edward Fialkowski is the Executive Secretary of the Archdiocesan Priests' Personnel Board. The Commission discussed with him the placement procedures for diocesan priests and the fairly minimal relationship between the Board and the Vicar for Priests. Traditionally, the Board has resisted submitting for the Vicar for Priest's review the names of potential priest assignments in order to protect the confidentiality of those applying for pastorates or other assignments. Up to now, the Vicar for Priests could also place a priest in a parish without consulting the Personnel Board. At the same time, the Personnel Board needs a mechanism that respects confidentiality but allows the Vicar for Priests to keep priests with sexual problems from being assigned to parishes.

Fr. Robert Flinn, S.V.D., J.C.D., is the Assistant Chancellor of the Archdiocese. The Commission's discussion with him focused on the status of the 90 extern priests in the Archdiocese. An extern is a priest living outside the jurisdiction of his diocese or religious community. Most are diocesan priests, but some are religious whose communities do not have an established house in the Archdiocese. When externs apply to the Archdiocese for faculties, they must submit a letter from their bishop or major religious superior, including a description of their current status, permission to come to Chicago, the length of time for that permission, an assessment of the priest's skills and abilities, and a description of other special considerations which pertain to his stay here.

Bishop Raymond Goedert, J.C.D., an Episcopal Vicar in the Archdiocese, was Vicar for Priests from 1987 to 1991. The Commission discussed at length with him the procedures used when allegations of sexual misconduct by a priest with children or teens arose. While the procedures became more standardized with time, there was considerable subjectivity and discretion in the process, as well as a great canonical concern about preserving confidentiality. Especially during his tenure as Vicar for Priests, the role changed dramatically, from being a "pastor" of priests to being an investigator and reporter of child sexual abuse cases. He and the Commission also discussed whether and under what circumstances a priest who has been removed because of such a matter could ever be returned to ministry as well as the Vicar for Priests' relationship with the Personnel Board and the archdiocesan seminaries.

Isaac Ray Center Staff. The Commission met with Dr. James Cavanaugh, Jr., M.D. (a Forensic Psychiatrist, Professor of Psychiatry at Rush Medical College, and Chairman of the Board of the Isaac Ray Center in Chicago), Dr. Jack Green, Psy.D. (Consulting Psychologist), and Dr. Jonathan Kelly, M.D. (Psychiatrist and Medical Director of the Center) to discuss the important components of the Center's diagnostic and treatment protocols which pertain to issues of sexual misconduct. The Center, which has been working on paraphilia since the mid-1980's, has conducted evaluations of archdiocesan personnel since 1986. The discussion included a bedrock concern of the Commission: under what circumstances a person with a paraphilia could be allowed to return to professional practice. There was also a discussion of the priestly life-style with its particular stress, and the importance of aftercare once a person has completed treatment.

Fr. Robert Kealy, J.D., J.C.D., was the Chancellor of the Archdiocese from 1985 and 1992 and a member of the Advisory Committee to the Vicar for Priests during that time. This interview revolved around his experience on the Advisory Committee and provisions in the Revised Code of Canon Law in regard to sexual misconduct by priests. In 1985, child sexual abuse was a fairly new issue for the members of the Advisory Committee, and the underlying intent was to rehabilitate the priest offender as much as possible in order to return him to ministry. There was inadequate awareness of the intractability of this problem, as well as an insufficient understanding about the devastating impact it can have on victims' lives. The discussion with the Commission

revealed several possible canonical avenues a bishop may take in regard to a priest who has engaged in sexual misconduct. Fr. Kealy said that a future "Advisory Committee" to deal with misconduct cases should include the laity.

Bishop John R. Keating is the Bishop of the Diocese of Arlington, Virginia and former Vicar General of the Archdiocese of Chicago. The Commission spoke with him by a conference telephone call about past archdiocesan practices in responding to allegations of priests' sexual misconduct with minors. During his tenure, there were no established written procedures for dealing with complaints against priests, which very rarely involved sexual misconduct with minors. When the Vicar General received an allegation, he, or someone appointed by him, would follow up on the matter. Bishop Keating left the Archdiocese in 1983 when he was appointed the Bishop of Arlington.

Detective Brian Killacky is a member of the Chicago Police Department with considerable experience in regard to violent crime and child abuse. The preliminary investigation of a complaint of sexual abuse is very important, and it should be done by a professionally trained investigator. Mr. Killacky stressed the importance of careful screening in the seminaries and clarification of the professional standards expected of a priest. Illegal sexual behavior may be treated as a misdemeanor instead of a felony, if there has been a considerable time delay between the alleged incident and the outcry, or if there is a lack of sufficient evidence. At times, it may be wiser and cause less harm to children to get them counselling rather than put them through the trauma of the full judicial process. The Department of Children and Family Services does not consider a priest to be a "caretaker" as defined in Illinois statutes and currently refuses to get involved in an allegation against a priest unless he is a teacher or counsellor.

Fr. Andrew McDonagh, M.A., has served in the Vicar for Priests' Office on a part-time basis since 1988. Since 1966, he has served on an archdiocesan alcohol and drug addiction committee, running three life-management groups a week for the past quarter century. He continued this work when he began to assist the Vicar for Priests and also served as a sounding board for the Vicar for Priests in matters relating to sexual misconduct. Fr. McDonagh said that laity need to be involved in whatever body advises the Archbishop on matters of sexual misconduct by archdiocesan personnel. The discussion with Fr. McDonagh also explored the interface between alcoholism and sexual misconduct.

Fr. Francis Morrisey, O.M.I., J.C.D., a member of the Faculty of Canon Law at St. Paul University in Ottawa, Canada, is an internationally recognized expert in canonical matters, especially those pertaining to sexual misconduct with minors by priests and religious. The Commission met with him for an extensive interview; Fr. Robert Kealy, the former Chancellor of the Archdiocese, and Fr. Thomas Paprocki, the current Chancellor, also participated in the discussion. Two topics dominated the conversation: (1) the procedures being developed in Canada to be applied in cases of alleged sexual misconduct by a priest and (2) canonical considerations in regard to the Commission's proposed procedures for the Archdiocese of Chicago.

The Canadian episcopal conference appointed a national Central Commission which had been meeting once a month for two years. The Commission consisted of three Archbishops and four psychologists (one of whom is a priest. This is the same Commission which issued *Breach of Trust, Breach of Faith* [mentioned on p. 40 of this Report]. The Central Commission appointed chairpersons of four subcommittees and allowed these persons to select their own membership. One of these subcommittees, chaired by Fr. Morrisey, developed procedures to be applied in cases of alleged sexual misconduct by priests. He also was a member of another subcommittee which dealt with reintegration to ministry.

The revised Code of Canon Law was not drawn up with child sexual abuse in mind. Fr. Morrisey is a consultant to the Pontifical Council for the Interpretation of Legal Texts.

In regard to a possible return to ministry, it is important to have clear criteria. The extent to which scandal took place is a consideration, also the extent to which the matter has become public. The therapy reports and ministerial history of the person are also helpful. If a priest is returned to parish ministry, some key people need to know about the priest's

past behavior: the parish council, or at least its chairperson.

If a priest is returned to ministry, he must be assigned a proctor or supervisor for life. This person cannot be his confessor or spiritual director. The supervisor does not work in the internal forum and needs direct access to the bishop. The priest may also need ongoing therapy. He may be returned to ministry if the bishop and others are convinced of his remorse and good faith, if he has undergone both individual and group therapy, if he is assigned a supervisor who watches for patterns of behavior (not necessarily 24 hour supervision); e.g., loneliness, feeling sorry for himself, grooming someone.

Mundelein Seminary Staff. The Commission met with Fr. Gerald Kicanas, Ph.D., Rector, Fr. John Canary, D. Min., Vice-Rector, Fr. Martin Zielinski, Ph.D., Academic Dean, and Fr. Thomas Hickey, D. Min. (Cand.), Dean of Formation. The discussion covered five areas: recruitment, screening of candidates, criteria for and five processes of evaluation, education and formation in regard to sexuality, and faculty policies. When a priest is ordained for the Archdiocese, how much information about him is passed on? The Cardinal receives a report on each candidate, and it is up to him to decide whether or not to distribute this information to anyone else. The underlying philosophy is that a new priest should be given a "clean slate" upon his ordination.

New England Clinical Associates. Dr. Suzanne Sgroi, M.D., is Executive Director of New England Clinical Associates, a private office devoted to the treatment of child sexual abuse, and the director of the Saint Joseph College Institute for Child Sexual Abuse Intervention, both in West Hartford, Connecticut. Ms. Norah Sargent, a doctoral candidate in clinical psychology at the University of Rhode Island, works very closely as a therapist and consultant on spirituality with Dr. Sgroi.

The Commission interviewed Dr. Sgroi and Ms. Sargent, by a conference telephone call, especially to discuss the effects of child sexual abuse on its victims and the treatment available to help them whether they are still minors or have become adults.

Until recently, (the last ten years) there has not been much research on the victims — juvenile or adult — of child sexual abuse. The field is young, then, in terms of empirical studies. Dr. Sgroi recommended two articles in particular (cf. articles by Dr. Diane Schetky and Joseph Beichtman et al. in Appendix D). Both are well-referenced and objective. They acknowledge how difficult it is to be sure to what extent a person's problems are only long-term effects of sexual abuse and to what extent they may also be the results of other familial or environmental problems.

The effects cover a considerable range. For some, there does not appear to be any obvious serious emotional trauma as a result of the victimization. For others, one can identify very serious emotional trauma — including suicidal depression, very serious problems with alcohol or drugs or self-injurious behavior, eroticization of the child, Post-Traumatic Stress Disorder or some form of it (involving intrusive memories, flashbacks, nightmares triggered by minimal cues in the daily environment). Dissociative phenomena are reported in some people who were seriously traumatized. To protect themselves, they may have been very good at "closing the door" on the memory of the abuse, until their 30's or 40's or older. Some are almost amnestic for the trauma.

There are two ways in which child sexual abuse victims may come to the attention of clinicians, law enforcement personnel or other professionals: as early presenters or as late presenters.

Early presenters range from school-age children to young adults (6 years - 25 years) and exhibit one or more severe symptoms which draw attention to the traumatization: e.g., severe depression, suicide attempts, substance abuse, delinquency, etc. If a very careful history is taken, one often finds a history of forcible sexual abuse (child rape) coupled with other types of trauma: physical abuse, severe neglect, poverty. These individuals also may suffer the trauma of impaired parents or broken homes. The early presenter may not identify the sexual abuse they experienced as abuse or as playing a significant part in their acting-out behaviors. When young abuse victims present in early life in this way, it is difficult to separate out the effects of forcible sexual abuse from the effects of other traumas in their lives.

Later presenters may approach a therapist anytime after young adulthood. These persons would not have been institutionalized and may not have experienced severe trauma in their early lives; instead,

they appear to have a fairly conventional, often successful life history. Later presenters are more likely to have a history of non-forcible sexual abuse perpetrated by a child molester rather than by a child rapist. They often have very serious problems with relationships, intimacy, and trust. However, they may not appear for clinical help for childhood sexual abuse issues until they are in their late 20's, 30's, 40's or older. Unlike early presenters, later presenters probably were not victims of multiple types of childhood trauma.

If a child is sexually abused by a clergyman, it would be important to ascertain what the life context of that abuse was for the individual child. Was it the only form of abuse he or she experienced? Prognosis might be better if it were the only form of abuse. But if the abuse took place in a more severe life context, where there was multiple abuse, the prognosis would be poorer. There would be the greater likelihood of having severe difficulties. If the child were not in a severe life context, it also would matter if the child abuser was a molester or a rapist.

The history of the relationship between the child victim and the abuser also would be an important factor. If it was continual abuse, and the child was threatened, the road to healing would be harder. However, when children live in a home, school or parish environment where there are people to whom they feel free to disclose a matter such as an incident of sexual abuse, the prognosis may be better also. For example, the existence of a support person who will believe and support a child after such a disclosure could mitigate against a more traumatic outcome for the child. Church personnel should be mindful that not all child victims of a clergy abuser will have such support persons in their lives. However, disclosure by one victim may lead to the discovery of other victims (perhaps those who did not feel safe to disclose earlier or who lived in an environment where disclosure did not seem possible).

It also is important to ascertain, in an individual case, whether physical violence was used to engage the child in sexual behavior. The majority of cases of sexual abuse are perpetrated by nonviolent abusers (child molesters). Probably 20% or fewer of all cases of childhood sexual abuse are perpetrated by violent abusers (child rapists). The violent abuser uses force or threat of injury to engage a child in sexual behavior. It is important to know if it was part of a pattern of violence which the child had witnessed earlier, for example, the child's father physically abusing his wife in the child's presence. In terms of the contemporary complaints against clergy or religious, the majority of cases do not involve complaints of forcible sexual abuse. At this time, it is reasonable to suppose that the majority of clergy abusers are child molesters rather than child rapists. However, the association of clergy with "power" over good and evil also may influence the impact of clergy abuse on a child.

Victims of sexual abuse by clergy are deeply hurt and angry — not only at the priest, but usually with the Church also. Anger is like an umbrella. It is important to discover what lies beneath it: e.g., hurt, humiliation, fear, a sense of betrayal. The person has a right to be angry and to feel outraged. The therapist joins the person in his or her distress at the early stage of treatment. However, there are stages beyond this, and it is important not to be trapped by one's anger for the rest of one's life.

Dr. Sgroi said that she tells the adult survivors, "You were a child victim. You are an adult survivor. When you finish working through the issues surrounding your abuse, you will be a human being with a history that does not drive your life." It is counterproductive to be locked in dysfunction. Memories may crop up in the future, but they need not continually drive the person's life — to the extent that she or he has worked through the trauma, developed healthy relationships, better self-esteem, and the capacity to trust. Some will take longer to be healed than others.

Some feel the need to punish the perpetrator. Regardless, there needs to be a visible accountability process that may or may not include legal punishment. Victims need to hear clearly that something did happen, and that it should not have. Even in regard to victims of abuse that took place a long time ago, there still needs to be accountability. When the process of accountability is exacting, but not extreme, an abuser may have a greater capacity to admit what she or he has done. If the process is extreme, it may drive abusers further underground. In regard to clergy abusers, it may be important to remember that a significant number of child molesters admit what they have done, even though they may try, initially, to minimize the abuse or its effects.

There is a full spectrum of victim responses. At one extreme, some want to see the perpetrators imprisoned for the rest of their lives. Most adult survivors of childhood sexual abuse are more moderate. People also displace a lot of anger on the priest and the Church, especially when they are going through their own spiritual struggles. For example, they may be negotiating normal spiritual developmental stages but because boundaries were, indeed, violated by the clergy abuser, there is additional confusion.

The Church is human. Victims should be reminded that they were abused by a single individual, and he is only part of the whole Church. We must be both honest and humble about this. Both the offender and the Church must be accountable.

Being in a longer abusive relationship, or victimization, compounds things. If there is multiple abuse — e.g., by a priest and a parent — there are diverse reactions. If the abuse is recognized, reported, and confirmed, it would be an extreme reaction to say that the victim should forgive the offender immediately and go on with the relationship. If the abuse is recognized, reported, and confirmed, it would also be an extreme reaction to say that the victim should harbor the anger for the rest of his or her life and consider the offender as good as dead. Both of these extreme approaches cause more problems for the child.

If a priest is the abuser, there should be an opportunity for him to apologize. The apology may be in the form of a therapeutically supervised face-to-face meeting, in the form of a letter and sent to the victim (through the victim's therapist or parents), or audiotaped or videotaped. The latter can be reviewed in a paced way in a therapeutic setting. If the abuser had a significant relationship with the victim, the child may feel relief that the abuse is over, yet, may miss the abuser and feel guilty about reporting the offense.

The Church should take the lead and offer professionally-led support groups to the victims of sexual abuse by clergy or religious, and to their families. In addition, the victims also would be in touch with their individual therapists and with their pastoral ministers or spiritual directors. The diocese needs to accept responsibility for not seeing the abuse or the potential for it sooner. A clergyman or similar representative of the local church should be included in each group along with a mental health professional.

It is important to keep several things in perspective. Being sexually abused by a priest, while potentially traumatic on a number of levels, is not the worst thing that could happen to a child. The needs of adults who were abused as children or adolescents are different from those of children or adolescents who recently have been abused. And the needs of the parents of a child who has recently been abused are different from the other two. Sometimes the same pastoral counsellor or minister might work with all three populations, but sometimes not. In a diocese as large as Chicago, it would be feasible to establish several support groups for parents, several for adult-survivors, and several for child and/or adolescent victims. At times it may be appropriate to bring a parent group and an adult survivor group together. Planning and oversight in the management of these groups would enable the counsellors or ministers to decide whether this would be timely or not. However, it would not be helpful to combine child victims groups with adult survivor groups.

These support groups would require careful planning. It would demand use of the resources of those who are very familiar with both pastoral ministry and clinical issues. It could be a very healing process. As noted above, these groups would need a representative of the clergy. This priest should be cycled out of the group regularly to avoid vicarious traumatization.

A ritual could be developed to bring these groups to closure — that is, for those who wanted some sort of healing ritual. One of the therapeutic goals must be forgiveness. But this is a very individual issue. One cannot rush this and should avoid communicating to the participants that this is an automatic process or expectation. The timeframe of each participant must be respected, but a healing ritual often is more effective when experienced in the company of others. A more open-ended goal or theme of a closing ritual for these groups might be witnessing to pain in the lives of the Church community. Again, any such closing ritual must be conceived sensitively by someone familiar with the spiritual, Church, and clinical issues of the potential group members. Ideally, the group members themselves would plan their own ritual within the framework of the group and the guidance of the mental health professional.

It is important to distinguish between Church-sponsored support groups and therapy groups. A *therapy* group should consist of 5 to 10 people, no less, no more. The participants have a legitimate expectation of receiving therapy, and their attendance must be consistent. The group monitors the therapy needs of the individuals. *Support* groups have more flexibility. A support group could consist of more than 10 people. If there are 15, for example, there should be three professional leaders. Support groups do not require the same need for consistent attendance. They have more of an educational, self-help focus. Their orientation is toward ritual healing, not a therapy modality, and this needs to be made explicit.

Dr. Sgroi and Ms. Sargent offer time-limited cycles of peer group therapy. The co-therapists meet for 1 1/2 to 2 hours with staff members before each group meeting. The group then meets for 1 1/2 hours over a cycle of about 14-15 weeks. Everyone knows when it will stop. There is no "solo" leader. Two leaders are needed. In the case of a therapy group for victims of clergy abuse, it might be desirable to have a male and a female co-therapist for the group. What level of training do the leaders need? At least one should be a clinician experienced in group work and in work with child sexual victimization (with a Ph.D. or an M.A.).

Dr. Sgroi and Ms. Sargent were asked if they were aware of any kinds of groups that do long-term therapy with the victims of clergy sexual abuse. They were not aware of any. However, they highly recommended the chapter on "Psychological Intervention for Parishes Following Accusations of Child Sexual Abuse" by Drs. Carroll Cradock and Jill Gardner [both of Chicago] in Fr. Rosetti's *Slayer of the Soul.*

Creating groups solely for victims of clergy abuse could communicate that these victims endured a particularly stigmatizing form of childhood sexual abuse and contribute to their feelings of isolation. If the groups are mixed with members whose histories included sexual abuse by parents and other family members, clergy, religious, or other extrafamilial abusers, this might bring about more balance. There will be similar issues, pains, and needs for healing. In determining the goals for a group it is important to include God issues as well as Church issues. However, being the only person who was abused by a priest in a group where all other members were victims of intrafamilial sexual abuse may decrease the effectiveness of the group experience for that person. (The reverse also may be true.)

Niles Seminary Staff. The Commission met with Fr. J. Cletus Kiley, D. Min., Rector, and Fr. Kenneth Simpson, M.A.S., Vice-Rector, to discuss recruitment of students, screening of candidates, criteria for evaluation of students, education and formation in regard to sexuality, and faculty policies. Beginning this year, Niles requires that every incoming student take the Ministry Potential Discerner (MPD) rather than the traditional MMPI (Minnesota Multiphasic Personality Inventory). Niles' formation programs are becoming more explicit in regard to sexual issues.

Mr. John O'Malley, J.D., an attorney, was appointed the archdiocesan Director of Legal Services in mid-January 1992. His previous work was as the Administrator of the Attorney Registration and Disciplinary Commission (ARDC) of the Supreme Court of the State of Illinois. The purpose of the discussion with him was to learn how the legal profession is regulated and its possible implications for the Commission's interests. The code of professional responsibility (the Rules of the Supreme Court of Illinois) is enforced by ARDC. Such a centralized system takes pressure over the local courts and the Supreme Court itself. Investigators need to be professionally trained. The inquiry board, not the investigator, should have discretionary power. Some see the process as a whitewash, others as a witch-hunt. It is important to remove conflicts from the system and ensure fairness, objectivity, consistency, and credibility. The integrity of the Archdiocese has been impugned by the cases of sexual misconduct and the way they were handled. The important ingredients for investigation and prosecution of allegations of sexual abuse include: expertise, lay involvement, appropriate records, the judgment of peers, and the decision by the Archbishop. The investigator of such cases should have no relationship to the Vicar for Priests; they are entirely different offices and functions.

Fr. Patrick J. O'Malley, Vicar for Priests (1991-), discussed his understanding of his role, the resources available to him, and his relationship to

the Priests' Personnel Board. The Archdiocese needs a consistent plan to deal with cases of sexual misconduct. It needs a system or follow-up with both the victims and the priests involved. The Vicar for Priests' Office is overwhelmed with work and understaffed at present.

Fr. James P. Roache is a former Vicar General of the Archdiocese of Chicago (1983-1990). The Commission discussed with Fr. Roache how allegations of priests' sexual misconduct with minors was handled in the past. He noted that labeling the phenomenon "pedophilia" is both unfortunate and misleading. The vast majority of these cases do not involve pedophiles. During his tenure as Vicar General, priests were dealt with honestly, forthrightly, and sensitively. There was also great sensitivity toward the victim, the victim's family and community. Should the parish leadership be notified of a priest's past problems? It will not work. It will not be kept a secret. Moreover, that places an unfair burden upon them, especially if the priest recidivates. Fr. Roache urged that forthright, direct action be taken in defense of a priest who has been falsely accused of sexual misconduct with children.

Sr. Catherine M. Ryan, S.S.S.F., is an attorney-at-law and worked in the State's Attorney's office in Chicago for twelve years, much of that time in the Juvenile Division. During her work in that office (1973-1985), there was an increase in sexual abuse cases; that is, more cases were being reported. When more kinds of evidence become permissible, this put more pressure on the children when they were the only witnesses. The person who conducts interviews with young children has to be specially trained in order to avoid putting ideas in the children's minds, wittingly or unwittingly. Society is only at the beginning stage of treating sex offenders, and it is not clear to what extent any of the treatments or therapies are effective. The Commission also discussed with her the issue of the possible return to ministry of a priest who has engaged in sexual misconduct.

Fr. Edward P. Salmon, Vicar of the Permanent Diaconate Community since 1984, works with the nearly 700 permanent deacons and their wives in the Archdiocese. The Commission discussed with him the preparation of candidates, his relationship with the Vicar for Priests, and ongoing formation. The Permanent Diaconate Community does not have in place a policy on criminal offenses and professional censure.

Mr. James Serritella, J.D., archdiocesan attorney and an attorney with Mayer Brown & Platt, has also served as a consultant to the Advisory Committee for the Vicar for Priests since its inception. He discussed the policies and procedures in place for such entities as the Office of Catholic Education, Office for Religious Education, and Catholic Charities. He pointed out that the Vicar for Priests' office is seriously overburdened and understaffed. He also discussed various methods of risk management and prevention. The pivotal issue is an archdiocesan policy regarding a priest's return to ministry after engaging in sexual misconduct. If such a priest is ever to be returned to ministry, there must be authentic lay participation in that decision-making process. During the past year, the credibility of the Vicar for Priests has been destroyed within the presbyterate because of his dual role of being an advocate for the priests and an advocate for the Archdiocese. This role needs to be changed.

Fr. John P. Smyth, M.B.A., Executive Director of the Maryville Academy since 1970, discussed how Maryville deals with accusations of sexual abuse. The Archdiocese needs an internal investigation that is professional and reliable; that is, a professionally trained investigator to handle allegations of sexual abuse. Maryville has several rules and procedures in place to protect its young charges. There are ways for priests to protect themselves when they are with children or teens. Traditionally and currently, the Archdiocese invests considerable resources in the seminary system, but virtually nothing to support and supervise priests after ordination. Priests themselves are often isolated from one another. Priests are vulnerable to false accusations; some children can be seductive, and priests naive. Laity need to be included in any board which advises the Cardinal on cases of sexual misconduct.

Mr. Joseph J. Stevens, J.D., an attorney with Burke, Wilson & McIlvaine, met with the Commission to review the existing Policies and Procedures of the Archdiocese of Chicago for Addressing Accusations of Child Abuse. He demonstrated that these policies and procedures could be considerably improved. For example, the document does not distinguish

between a priest who voluntarily comes forward and reports his sexual misconduct and one who simply gets caught. What are the benefits of volunteering this information? The same professionally trained person(s) should conduct all investigations of allegations of sexual misconduct. Every employee of the Archdiocese should receive a copy of the archdiocesan policies and procedures and should sign a statement that they've received them; this statement should be kept on file.

Fr. Thomas Ventura, S.T.L., former Vicar for Priests (1983-1987), discussed the historical background of the office and the development of the Advisory Committee. As more and more procedures were being developed across the nation in regard to sexual abuse cases, Fr. Ventura began to develop a policy for dealing with (1) the victim and the family, (2) the parish, (3) the Church as a whole, and (4) the individual priest — in that order. In many cases the family of the victim wanted the priest to get the needed therapy but did not want to cause him harm. There were some early criteria to guide decisions about a priest's return to ministry, but there is less confidence in them now than in the past. While the archdiocesan process was optimistic and compassionate, it was easy to lose objectivity to some degree. The presumption should be that a priest who has committed sexual abuse will not return to ministry unless circumstances indicate otherwise.

VOCAL (Victims of Clergy Abuse Linkup). The Commission met with Jeanne Miller, M.A., the Founder and President of VOCAL, Ms. Christine Clark, and Mr. Richard Springer, both members of VOCAL. Ms. Miller and Mr. Springer were sexually abused by priests when they were minors. They told the Commission about the severe impact of the abuse on their lives. When asked what the Church could do to improve its response to child sexual abuse, Ms. Miller said that people need to see that the Church is participating in efforts to help them, that it supports them. There is still too much of "we" and "they" in the Church's posture in dealing with this issue.

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