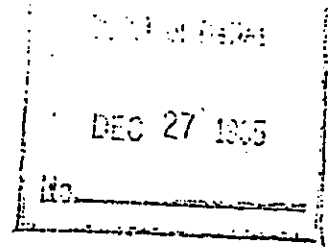

SAINT LUKE INSTITUTE

December 9, 1985

Your Excellency:

As you are aware from the news media and from some of your brother Bishops, the Roman Catholic clergy and members of religious communities are no longer treated in any special manner in the United States by the court system or by the local peace officers when the issue of child abuse is involved. Many states have changed their reporting laws recently and even the Seal of Confession has been legally challenged in the State of Texas.

Because I have been asked by many of your brother Bishops to aide in the evaluation of clergy and religious men who have difficulties in this area of child abuse and make recommendations for treatment, the St. Bernardine Clinic (our psychiatric outpatient department) has begun to evaluate a number of men using specialized testing procedures which may be helpful to them and their religious superiors in the legal process as well as in determining an appropriate treatment setting. We have also opened a small inpatient unit which will treat this highly specialized psychiatric disease for clergy and religious which includes a four year Aftercare Program. However, because of the limitation of size, we can only accept a few such clerics for treatment; we can offer, however, the specialized Evaluation Program for all men with this problem and refer them to appropriate treatment programs which we feel treat the disease using modern and tested treatment approaches.

You will find enclosed a copy of guidelines which I have assembled and which I consider my personal and professional opinion on this topic of sexual abuse involving clergy and religious. The purpose of these guidelines is to give you specific suggestions from the moment you have identified a cleric who potentially has this mental and medical disorder to the suggestions or guidelines for evaluation, inpatient treatment, vocational rehabilitation, aftercare suggestions, and even a lengthy commentary on the new Code of Canon Law as it relates to this problem and suggestions by a civil attorney concerning civil legal questions and problems.

I hope that these guidelines will be helpful to you. I have only sent it to the Ordinaries of each U.S. Diocese and Archdiocese. If you wish any further copies, I will be happy to send them to you for your Auxiliary Bishops. If you have any questions that are specific with respect to any aspect of the outlined problem and suggestions for treatment, please do not hesitate to contact me personally.

Please be assured of my prayers for you as we approach this Christmas Season in anticipation of the celebration of the Birth of Our Lord.

Your brother in Christ,

Michael R. Peterson, MD

(Rev.) Michael R. Peterson, M.D.
President/Executive Medical Director

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A non-profit organization

Thomas P. Doyle OP

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SUMMARY

CONFIDENTIAL NOTE: Please treat the contents of this document as confidential. Further, it is my opinion that the contents of this document are my professional and personal remarks and should not be construed as a national plan for the National Conference of Catholic Bishops, for Major Superiors of religious communities. The professional and personal opinions are given individually to each person who has possession of this document for their personal reaction and for one psychiatric approach to dealing with this complex moral, legal, and psychiatric problem.

(Rev) Michael R. Peterson, M.D.
President
Saint Luke Institute, Inc.

EXECUTIVE SUMMARY

INTRODUCTION: The purpose of this document is to provide to Bishops and Major Superiors of Religious Communities information concerning a growing problem of sexual abuse of children and adolescents by clerics and religious brothers. In this document, all references will be made to clerics and it is meant to include all male clerics (permanent deacons, transitional deacons, priests, bishops) and professed religious brothers.

As stated on the previous page, the contents of this document represent the personal and professional opinion of one person, Reverend Michael Peterson, M.D. Further, this document is not meant to be an advertisement for the Saint Luke Institute or the St. Bernardine Clinic which I head personally. I am also in no way trying to be an advertisement for any other program and I apologize profusely in advance if it appears in any way that I am detracting from any of the existing programs. This is not my purpose. I simply believe that the issues in this area are so complex that we need guidance from the Bishops of the U.S. as well as guidance from many other professional persons, including moralists, attorneys, psychiatrists, psychologists, psychiatric social workers, and many others. This document is a baseline for the beginning of the discussions which I pray will come from presenting some of these issues from my personal viewpoint.

CLINICAL/LEGAL PRESENTATION: In this section of the document, I define for you the three most common sexual problems in clerics that I have seen and that I am aware many of my colleagues have seen:

(a) Compulsive Heterosexual/Homosexual Acting Out
(b) Pedophilia or Sexual Molestation of Minors
(c) Exhibitionism

I point out in this section common ways in which these three sexual problems present themselves in Roman Catholic clerics.

LEGAL ADVICE: In this section of the document, I mention in an all too superficial manner the following issues with respect to civil law:

(a) Choosing an Attorney for Advice
(b) Reporting Laws in Your State
(c) What Advice Will Your Attorney Give You
(d) I Am Not An Attorney

This is a very important section that has a much more comprehensive treatment in the section called "Confidential Crisis Proposal" in this document.

CLINICAL EVALUATION OF THE CLERIC: In this section of the document, I give my personal opinion as to what should be essential components of any evaluation of a cleric who is suspected of having a sexual problem as severe as pedophilia or exhibitionism. This is quite specific and again a personal and professional opinion. Mention is made of four Roman Catholic evaluation facilities which could be used.

INPATIENT TREATMENT PROGRAM: In this section of the document, I again give a professional opinion as to the components of inpatient treatment programs that should be present if you are planning to send any cleric for treatment of this complex paraphilia disorders.

AFTERCARE PLANNING: In this section of the document, I list six possible areas of discussion for Aftercare Planning, which is one of the most important aspects of any treatment program. This psychiatric disease is a lifelong disease and the treatment of it in the cleric, though there is new hope in some treatment modalities, must also be a lifelong treatment plan. It is here that much discussion will be generated and where you can be most helpful to us at the Saint Luke Institute and perhaps at the other programs where you have clerics now in treatment.

JOHNS HOPKINS PROGRAM: In this section, I have copied for you the literature packet that is given to potential patients in the Sexual Disorders Clinic which is Co-Directed by Dr. John Money and Dr. Fred Berlin; these two mental health professionals are considered by me and most people in the field as the two U.S. experts and ones who have had good success in treatment of the paraphiliac disorders in the past fifteen years.

CLERGY MALPRACTICE: In this section, there is a short article with which you may already be familiar. It is written by an attorney and is entitled "Clergy Malpractice". It is a lead story from a law journal called Case & Comment which is put out by the American Bar Association.

CONFIDENTIAL CRISIS PROPOSAL: This is a document produced by Reverend Thomas P. Doyle, O.P. (canon lawyer), Mr. Ray Mouton (trial attorney), and Dr. Michael Peterson. The "proposal" section is not meant to be a presentation to you. Instead, I felt that it could not be excluded from the document without detracting from the full effect of the document's questions that are posed. Much research went into the production of this document and the same disclaimer mentioned at the beginning of this section must be invoked in your reading it. I would ask that you be careful if you decide to reproduce any parts of these documents which I have assembled for you and that the disclaimer be clearly a part of the reproduction so no misunderstandings can develop among the treatment facilities and among the other Bishops who are not present at this particular meeting when the document was presented to you.

CLINICAL AND LEGAL PRESENTATIONS OF SEXUAL PROBLEMS IN CLERICS

INTRODUCTION

There are many ways in which sexual problems in Roman Catholic clerics may present themselves to the cleric himself, the Chancery Staff, or to the Auxiliary or Ordinary Bishops. Further, there are very different kinds of sexual problems which may present to these persons concerning the clerics in the Dioceses.

TYPES OF SEXUAL PROBLEMS

The following are the most common sexual problems that have presented to me personally and to my professional colleagues in Roman Catholic clerics.

(1) Compulsive Heterosexual/Homosexual Acting Out

It should first be stated that this is not necessarily a problem unique to Roman Catholic clergy because of our vow of celibacy/chastity; this is a problem among single and married people and is being addressed more and more in the psychiatric world. For example, a new group called S.A. (Sexaholics Anonymous) has begun under the philosophical principles of A.A. (Alcoholics Anonymous) and from the work of Dr. Carnes in his book, Sexual Addictions. In S.A., to which we send all of our patients three times per week, a large number of married and single persons are present in the group trying to deal with compulsive, repetitive heterosexual and homosexual activity, especially in terms of "anonymous sex" or "one night stands" or basically non-relational sexuality.

In Roman Catholic clerics, it is my moral and psychiatric philosophy that the vow of celibacy is what we are called to and that it can be accomplished only as perfectly as one struggles psychologically, spiritually, and with the help of grace in the Sacrament of Reconciliation and Eucharist. We do not usually recommend inpatient treatment in our own Saint Luke Institute for this problem in Roman Catholic clerics because this is not the "focus" or institutional purpose of the Saint Luke Institute. This does not mean that it should not be addressed at times in an inpatient setting. It is mentioned because of its frequency of presentation only in this document.

(2) Pedophilia or Sexual Molestation of Minors

This, of course, is the area which is the "newest" in the legal circles and the area that brings most panic and concern to the Bishops with respect to the clerics in their jurisdictions.

First, it should be made clear to all that pedophilia as described in psychiatry may be quite different from psychologists' definitions, lawyers' definitions, or your own personal definitions (To add a little levity to this document, 'a pedophile' is not, as one of our older clergy stated a few nights ago, a kind of bicycle!)

In the Diagnostic and Statistical Manual of Mental Disorders (Third Edition), which is accepted in the United States as the master manual or dictionary for mental disorders defines pedophilia as follows:

> "A. The act or fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement.
>
> B. If the individual is an adult, the prepubertal children are at least ten years younger than the individual. If the individual is a late adolescent, no precise age difference is required, and clinical judgment must take into account the age difference as well as the sexual maturity of the child."

Adults with the disorder are oriented toward children of the other sex twice as often as toward children of the same sex. The sexual behavior of these two groups is different. Heterosexually oriented males tend to prefer eight-to-ten year-old girls, the desired sexual activity usually being limited to looking or touching. Most incidents are initiated by adults who are in the intimate interpersonal environment of the child. Homosexually oriented males tend to prefer slightly older children. The percentage of couples in this group who know each other only casually is higher than in the heterosexually oriented group. Individuals with undifferentiated sexual object preference tend to prefer younger children than either of the other two groups. Most individuals oriented homosexually have not been married, whereas most individuals oriented heterosexually either have been or are married.

I have been surprised by the clinical ignorance of many of my own psychiatric colleagues in this area and by other mental health professionals. I state this to you so that we may put in a kind of context why the problem of sexual molestation of children may be such a "strange phenomenon" to you also. It is not that we are ignorant people in the area of human behavior; instead, it is that the public has allowed a greater tolerance for all types of sexual behaviors and discussion of different sexual behaviors in the past twenty years. In the past three years, I would say that the area of incest and specifically child sexual abuse has been a topic opened up in the media and now in all states with respect to changes in the law. Please do not feel "preached to" or that your past views and ways of dealing with this disorder have been "wrong." We, in the Roman Catholic Church specifically, have all been surprised by the abuse of the public image of the cleric that is now being challenged and "smeared" by the media in many ways. The purpose of this document and your discussion in Collegeville at Saint John's Abbey this past summer is to educate you as much as we can in our professional capacities and try to help keep you abreast of developments in this sensitive and devastating area of human behavior.

One natural question that should emerge as you read this first section would be: "If a priest has recurrent fantasies and/or sexual activity with a fifteen-year-old boy, does this fit the psychiatric definition of pedophilia?" The answer is no! However, it is inappropriate behavior from many viewpoints, not the least of which is that it is illegal in all fifty states. Another question related to this situation might be: "Does this mean that we are dealing with the same 'disease' as pedophilia even though it does not strictly fit the definition in the DSM-III manual I quoted to you above?" The answer is a difficult one, but generally we could say that we are basically dealing with a similar or parallel disorder with the age preference simply shifted to post-pubertal young adolescents instead of prepubertal children. According to the law in most states you are dealing with the same legal liabilities and questions.

Why would clerics or anyone prefer youngsters for fantasy and/or sexually acting out behaviors? To be a purist, I would have to say that this question is just being investigated in a scientific fashion. We have been hampered in our profession by extreme moral judgmentalism, if I may use the phrase, and it is only in very few medical schools in this country that the issue is treated or even addressed properly. The Johns Hopkins Hospital Sexual Disorders Clinic run by Dr. John Money and Dr. Fred Berlin is probably the "authority" scientific community. I know personally both of these highly respected scientists and I am very appreciative of their efforts to bring this psychiatric disorder out of the shadows and into the "scientific daylight" so that we can begin to see the disorder as a psychiatric disease and not a moral weakness. We are at approximately the same point in time with pedophilia in the medical/psychiatric world as we were with alcoholism in the late 1950's when the American Medical Association finally agreed that alcoholism was a disease of its own right and not a "moral weakness" or a "personality disorder" or "personality defect". I am professionally working with Dr. Fred Berlin, both in his research endeavors with this disease and clinically with respect to legal testimony in different jurisdictions to help educate the court jurisdictions about the "hope" for treatment and rehabilitation of persons with this disease.

Despite my disclaimer at the beginning of this page, I would say as a very careful "thinker" in this area and a person well aware of the scientific research in this area that the etiology of this disorder is most likely biological with a strong contribution of premature, early childhood introductions to sexual behaviors as being the environmental co-etiologic contributor. In the simplest terms, it is highly likely that <u>in utero</u> a type of programming of the brains of all persons takes place that contributes to the later expression of sexual behaviors in humans. This includes sexual orientation (i.e., heterosexual, homosexual, bisexual), sexual energy level (i.e., libido, a term coined by Sigmund Freud to describe sexual-erotic drive), and perhaps even erotic age preference (i.e., pedophilia vs preference for age appropriate partners).

If, and when, this biological basis for human sexual behaviors becomes more accepted scientific "fact" in the future years, the Roman Catholic Church is going to have to look very hard at our current "constructs" in moral theology and reassess some of our basic "statements" which have been codified and accepted without question for many years, if not centuries in some cases. But my point is not one in the area of moral theology; my point is that if there is a biological contribution to the behaviors, such as pedophilia, there is likely to follow biological "helps" to these persons and hope for better treatment modalities can be envisioned. This is already the case in the use of medroxyprogesterone (Depo-Provera) which is a drug which has brought new hope to this area of treatment in psychiatry and something that will be discussed in depth in another section of this document.

Finally, I would like to make a point about the "behaviors" that present as pedophilia or present as illegal behaviors to minors on the part of clerics. Obviously, performing oral sex (fellatio) on a minor or child or having anal intercourse with a male child or vaginal intercourse with a female child are sexual acts that fall in the category of pedophilia or sexual molestation of minors.

However, in my clinical experience, this is not the usual presentation of pedophilia or sexual molestation of adolescents. Some of the following would be examples that may surprise you:

(a) A cleric who touches the toes of a minor with a Q-Tip, explaining to the young child that it is a scientific experiment, while sexually excited by this, constitutes an unusual presentation of pedophilia.

(b) A cleric who has young children act in plays with their shirts off and playing ostensibly "games", touching the child's chest only or hair may be a presenting form of pedophilia.

(c) A cleric who sleeps in the same bed with a child without touching the genitals but just holding the child in an affectionate manner is a common presenting form of pedophilia.

(d) A cleric who touches the hair, chest, buttocks of a sleeping child without the child awakening ever or responding sexually in return or ever being aware of the touching could be a common presenting form of pedophilia.

These four unusual examples would represent only the "surface issues" for these clerics in terms of their sexual proclivities or psychiatric disease. It takes a psychiatrist or psychologist with great skill and patience to be able to obtain from such persons the "real story" of their preference for children or adolescents. This disorder may begin at any time in adulthood; most frequently it begins in middle age. In my experience, most of the pedophiliac clerics I have seen and my colleagues have dealt with are homosexual pedophiles and not heterosexual pedophiles; this is surprising since the greater percentage in the general population is the opposite.

As will be discussed later, the recidivism (relapse) rate for pedophilia is second only to exhibitionism, particularly for homosexual pedophilia. This is whether the person has received "traditional psychiatric treatment" or not.

(3) Exhibitionism

This is a very fascinating disorder and is defined as a psychiatric disease by the DSM-III referred to previously:

> "The essential feature is repetitive acts of exposing the genitals to an unsuspecting stranger for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the stranger. The wish to surprise or shock the observer is often consciously perceived or close to conscious awareness, but these individuals usually are not physically dangerous to the victim. Sometimes the individual masturbates while exposing himself. The condition apparently occurs only in males, and the victims are female children or adults."

This disorder is not seen that frequently in clerics, but enough that it should be mentioned here in this document. It represents one of the "victimless crimes" but the legal sanctions and prison sentences for these individuals may be long and unfair with reference to the lack of harm it does to the "victim." It is the most resistant paraphilia to treatment in any form, followed as mentioned above, by homosexual pedophilia as the second paraphilia most resistant to treatment.

TYPES OF PRESENTATION TO THE DIOCESES

The most common way that it is made known to the Ordinary that a cleric may have a sexual disorder such as pedophilia is for a parent of a child to go to their local Pastor, Chancery official or the Bishop himself and express concern or make an accusation against a cleric for sexually touching or molesting their child. To date, this kind of presentation has been the most helpful one for us all since usually the parent is Roman Catholic and confused, concerned about the child and also confused and concerned about the priest or cleric.

Another presentation may be simply an attorney calling the Chancery and informing the Bishop that a criminal action has been filed or a civil suit has been filed against one of his clerics. This is a most distasteful and dangerous way in which the information can come to the attention of the Ordinary. In general, and please make sure you understand me here, it has been my experience that such presentations come only when the Ordinary has already been aware of sexual misbehaviors before and no action has been taken in the past except perhaps to move the cleric to a new assignment.

The least common, but most helpful, presentation is when the cleric himself comes to his Ordinary and admits that he has sexual difficulties that could endanger himself legally as well as jeopardize the Diocese as an entity. We have only seen this in the recent past where Ordinaries have done workshops in their Dioceses educating their clerics and administrators or schools about the disease of pedophilia, incest, physical child abuse. Clerics have come forward after such compassionate presentations and asked for help. It is for this reason, and many others, that I would advise that every Diocese in the U.S. in the next year have such a presentation done by an attorney, a psychiatrist who is familiar with this disease (very few psychiatrists know anything about pedophilia), and the Ordinary himself.

SUGGESTED GUIDELINES TO ORDINARIES WHEN REPORTS OF SEXUAL ABUSE OF CHILDREN BY THEIR CLERICS COME TO THE ORDINARIES ATTENTION:

(1) Interview with Parents

My first suggestion is that theparent(s) be asked to see one Chancery official immediately and for the official to be a compassionate, understanding, sympathetic individual who (hopefully) has had some experience in interviewing disturbed parents. Such an individual can without "grilling" the parents get a good feeling for the veracity of the accusation against the cleric. I would not suggest that the child be interviewed immediately as the first step and generally such interviews with potentially molested children should be done only by mental health professionals who are very familiar with the presentation of the disease in different age groups of children.

(2) Interview with Cleric

If the appointed Chancery official feels that there is any possible substance to the accusation of the parent, the Ordinary (and I would exclude personally any Auxiliary Bishops or other Chancery officials), if feasible, should IMMEDIATELY ask the priest to come to see him within a few hours. The Ordinary should make known to the cleric that the accusation has been made against him and that the Diocese will do everything to be helpful to the cleric. Unfortunately truth, guilt, innocence, or procedure are not the issues that we have the leisure to entertain on behalf of the clerics in this point in time in 1985. In general, the adage that "where there is smoke there is fire" is almost always true. I am not saying that it is impossible for a false accusation to be made; I am saying that in general the "tip of the iceberg" is being exposed with a single accusation and that the cleric will generally need some kind of professional and legal help in a very short period of time.

(3) Immediate Action of the Ordinary

If the cleric admits to any kind of sexual misconduct, the Ordinary should "reward" him with his support and reinforce the important and "sacred relationship" which we believe exists between the Ordinary and his clerics.

If the cleric does not admit to any type of sexual misconduct to his Ordinary it is my suggestion that the Ordinary tell him of his obligation to support and try to help him. However, he should remind him of the "spiritual bond" and other aspects of the relationship of Ordinary and cleric that we believe exist in grace and exist in Canon Law.

*** IT IS MY PERSONAL OPINION that in either case, the Ordinary, if convinced initially by his "trusted" Chancery interviewer of the parent(s) that the allegation has any possible merit or truth, should suspend immediately the cleric. This may be done without a trial and by means of an extra-judicial decree (Canon 1342).

The purpose of this "temporary suspension" is to indicate clearly that the Ordinary in his relationship with his cleric believes that an investigation of the accusations are warranted and that the cleric must have a psychiatric evaluation in the near future. This is a form of "protection" for the Ordinary and the Diocese. For example, if the Ordinary is called to the witness stand and asked what he did when he learned of the sexual allegation against that eight-year-old boy made by a responsible parent, the Ordinary may point to the procedure in the Code of Canon Law and state that he did the first responsible action that the Code allows. Namely, he formally informed the cleric that he could not function as his representative in the diocesan assignment until an investigation revealed his guilt or innocence; this is done to protect the Diocese and to protect the general public, especially the family or families that had the courage to come forward and inform the Ordinary of the possible misconduct.

I would next suggest that the cleric be moved IMMEDIATELY from the parish rectory and into a retreat house, monastery, Bishop's residence and not allowed to function in any priestly capacity in that domicile until the next steps of investigation, legal inquiry with a civil attorney, and

*** See Canonical Revision, pp. 61-62, 7-28-86.

more information is obtained concerning the allegations in an appropriate fashion.

The cleric should be reassured that because suspension and moving to a "safer place" is being demanded of him immediately that this does not indicate in any fashion that the Ordinary believes he is "guilty". It is simply a legal, social and psychiatric fact that some action must be taken immediately which indicates to the families, legal authorities, reporting agencies, and future litigating attorneys that the Ordinary takes such accusations with great seriousness.

The cleric should be reassured further that legal consultation with an attorney by the Ordinary will be done immediately and the attorney will be notified of those two actions as part of a "standard policy" of the Diocese.

Because the reality of the accusations are so frequently true, the Ordinary should be concerned about suicide and other impulsive self-destructive behavior. It is my suggestion that he be moved to a place where a friend could remain with him on a temporary basis until other actions are taken. The "friend" should be sworn to confidentiality so that defamation of character of the accused cleric could never be claimed against the Ordinary by the cleric. Further, the conversation between the Ordinary and the cleric should be immediately documented by the Ordinary in the format of a Memorandum and the suspension should be typed and handed to the cleric as outlined in the Code.

LEGAL ADVICE

INTRODUCTION: It is again my personal suggestion that each Ordinary in the coming months consider carefully the development of a Diocesan Internal Policy concerning cleric personnel files and their contents, the procedures to be followed uniformly when sexual accusations are made against clerics in that Diocese, clear legal opinion documented concerning the reporting laws in your respective States and how the reporting is to be done with reference to a cleric, your guidelines concerning interviewing parents and children, your guidelines concerning evaluation of the cleric, your guidelines concerning suspension, your guidelines concerning treatment programs and other pertinent policies that will be followed when the next unforseen accusation is made against a cleric. It has been my experience that when such policies are determined and written that better treatment of the families, clerics, and the dioceses themselves have better outcomes.

CHOOSING AN ATTORNEY FOR ADVICE:

Frequently, it is common practice for dioceses to have one or more legal firms represent them in different matters. However, ignorance among attorneys can be as great in this very specialized field of sexual abuse law as it is among mental health professionals who do not deal with it everyday.

It is my strong personal opinion that you inquire immediately of your legal firm for the name of a CRIMINAL-TRIAL ATTORNEY who is either in that same legal firm or another firm who is familiar with child sexual abuse laws in your State. In dioceses in the U.S. which are very small or who have very infrequent problems in this area, it may be necessary to request immediate legal advice from the USCC or the Papal Pro-Nuncio. There are a number of trial lawyers in the U.S. who have handled many of these complex cases who can immediately be of help to any attorney who is willing to listen to the voice of experience.

I cannot emphasize strongly enough the importance of being confident that the attorney you turn to immediately as the Ordinary will give you the most current and correct and prudent advice on your behalf and that of the cleric at least in the beginning. It may be necessary, as your attorney will inform you, that if criminal proceedings are initiated against the cleric himself that a separate attorney should be sought for the cleric so that there can be no conflict of interest with the attorney who is representing the diocesan entity.

REPORTING LAWS IN YOUR STATE:

One of the most difficult concepts for all of us to understand at this time is that reporting laws concerning physical, psychological and sexual abuse of children are changing rapidly in most states and that clerics are NEVER an exception to the reporting laws. Our dependence in the past on Roman Catholic judges and attorneys protecting the Dioceses and clerics is GONE.

You should immediately have a trial attorney write for you personally the reporting laws in your State concerning sexual abuse of children. You will find, almost without exception, that very few persons are ever exempt from reporting SUSPECTED CHILD ABUSE. In the case of diocesan agencies, Catholic Charities routinely in most jurisdictions have attorneys that they work with everyday with respect to reporting suspected physical or sexual child abuse to the appropriate agency. If the perpetrator or accused person is a cleric, this means nothing in the law in almost all jurisdictions.

However, THERE IS REPORTING.....AND THERE IS REPORTING! This adage which I have coined means that there are different ways in which the Diocese or the diocesan agency (including the Ordinary himself) can make the report and fulfill the law. Failure to report the child abuse suspicion by a cleric by the Diocese is probably the most common error and greatest vulnerability in the long term with respect to civil suit against the Diocese and Ordinary in the future.

WHAT ADVICE WILL YOUR ATTORNEY GIVE YOU:

I DON'T KNOW! However, it is my personal experience again that 'seasoned' trial attorneys will give you advice instantly and competently and I would STRONGLY suggest that you follow their advice to the letter for your protection and that of the cleric.

It would be my suggestion that the attorney meet with the cleric IMMEDIATELY following the meeting the cleric has with his Ordinary. Such a meeting is PRIVILEGED and he may learn from the cleric much more factual information that will be helpful within 24 hours concerning decisions of evaluation of the cleric, how and when to report to the state agency or local law enforcement agency, etc. The attorney may not, however, be able to reveal to you any of the information gained during that PRIVILEGED interview with the accused cleric, but his advice may be stronger and give you a better time line or time frame.

Certainly the attorney should be asked if he has a psychologist or psychiatrist who is familiar with child abuse cases and interviewing the victims. Such a person should be sought rather quickly so that the family will be reassured that the Diocese is beginning to take action on the accusation and that it is on behalf of the child. The reporting laws and procedures, however, may make this not feasible and this is the reason why the attorney's advice should be sought first.

It has been our experience that following an interview with a trial attorney of the cleric, referral for evaluation is generally the next step and is almost always looked on favorably by the state or local agencies as a positive step by the Diocese to help the cleric as well as responding positively to the family cry for help in the identifying of the cleric as a potential child molester.

I AM NOT AN ATTORNEY! This is obvious to you all. I would only implore that you rather quickly investigate and have a written opinion by a trial attorney for you personally on behalf of your Diocese about reporting laws for diocesan school teachers, janitors, employees in schools, other clerics (outside of the Seal of Confession) who "counsel" in their rectories or give advice to Principals of their schools.

You might also remind the civil attorney that "transitional deacons" and "permanent deacons" are now considered in the new Code as clerics and that 'legal responsibility' for these individuals is something that will inevitably have to be dealt with at some time time in the future.

You will note in the "Confidential Crisis Proposal" that there is a rather complete canonical treatment of these issues and you might find that section rather interesting reading when you have a free moment. There is also a very interesting civil law section written by one attorney who has had a very "famous" cleric recently indicted for pedophilia and he asks many questions that your civil attorney may be interested in. The case law in this area, as you may already know, is not very well developed, but the legal article in the last section of this document called "Clergy Malpractice" promises us all that they are seeing in particular the Roman Catholic Church in the U.S. as a potential "deep pocket" now that the trial lawyers have begun to exhaust medical malpractice. I am sure you have all seen the article, but it sent "shivers" down my spine since I have lived personally through the development of case law in medical malpractice and have watched it in some instances destroy fine physicians. I pray daily that we will not be treated is such a fashion by our legal system in the future, but the article would imply otherwise.

CLINICAL EVALUATION OF THE CLERIC

INTRODUCTION: "Your favorite place may not be the appropriate one!" This is the most sensitive area for me as a professional person and it is this section which I will make brief but will state clearly my opinion concerning evaluation of clerics accused of pedophilia or exhibitionism in particular.

(1) The cleric should be evaluated at one of the facilities EXPERT in the evaluation of these disorders and EXPERT in the treatment of these disorders. I personally would like to recommend for the majority of instances that it be one of the Roman Catholic Church agencies such as:

-- *Saint Luke Institute (JCAH approved)
-- *Institute of Living - Thomas Conklin, M.D. (JCAH approved)

-- Southdown
-- The Foundation House
-- Houses of Affirmation

(2) Guidelines for how to make a choice of a facility, whether a Roman Catholic facility or not, could be (a) Accreditation by the Joint Commission on Accreditation of Hospitals; (b) Good past experience with a cleric with this disorder; (c) Knowledge of a psychologist or psychiatrist at one of these facilities who is particularly good at evaluation from your past experience; (d) Good reports in the past in detail and specific content with recommendations that are specific for treatment.

(3) I am afraid that I personally am not impressed with the criteria that I have listed in (2) above. For that reason, I will tell you what I believe a competent evaluation should include:

(a) Physical Examination and Neurologic Examination by an Internist

(b) Basic laboratory work that would eliminate common disorders that could be contributing to the misbehaviors of the cleric (Examples: AIDS testing, liver function tests, kidney function tests, hepatitis testing, Dexamethasone Suppression Test for presence of depression)

(c) Interview with Certified Alcoholism Counselor who can make an exhaustive clinical evaluation of whether or not alcohol or other drugs could be a mitigating circumstance with reference to the sexual misbehaviors

(d) Interview with a psychiatrist who is familiar with the paraphilias both in evaluation and in treatment and who would be willing to testify on behalf of the Diocese or the cleric if necessary

(e) Neuropsychological assessment to determine if there is any neurologic pathology that would be contributing to "imprudent behavior" or that would help in the diagnosis of chemical dependency

(f) CAT Brain Scan to rule out any possibility of brain tumor, subdural hematoma or other intracranial pathology

(g) Electroencephalogram which would detect any abnormal brain electrical or seizure activity which is occasionally associated with the paraphilias and other imprudent sexual and behavioral acting out

(h) Serum levels of Follicle Stimulating Hormone (FSH), Luteinizing Hormone (LH Testosterone (Free and Total), Routine Chromosome Analysis

(i) Complete, secret sexual history written by the cleric himself which is not available as part of the medical record but which details from birth to the current time sexual ideation, fantasy life, sexual activity, relationship to use or abuse of alcohol/drugs, relationship to peer relationships or lack thereof

(j) Routine psychological testing (projective testing and personality assessment) including the WAIS-R

(k) "Spiritual History" to evaluate growth over the years of the cleric with respect to his prayer life, views of God, views of position as cleric in the post Vatican II Church, etc.

(l) Urine and blood screening for alcohol and drugs of abuse without informing the cleric on arrival at the evaluating institution

(m) A complete written report to the Ordinary/Attorney with a copy to the cleric that reports on all of the findings of the evaluation and makes clear psychiatric diagnoses and recommendations for treatment and follow-up.

INPATIENT TREATMENT PROGRAMS

It is here that I have even stronger professional and personal opinions about the quality of treatment programs. I believe that any program that purports to treat adequately pedophilia or exhibitionism and perhaps any of the serious illegal paraphilias should have the following modalities of treatment in that program and available for individual treatment planning:

(1) The rehabilitation program should be a psychiatric facility, preferably approved as a psychiatric facility by the Joint Commission on Accreditation of Hospitals

(2) It is inappropriate for any mental health professional to treat alone a cleric with pedophilia in an outpatient, private practice model; the treatment of this serious legal, moral, and psychiatric disorder must be treated with a multi-modal approach and the treatment is LIFELONG. Recidivism is so high with pedophilia and exhibitionism that all controlled studies have shown that traditional outpatient psychiatric or psychological models alone DO NOT WORK.

(3) Insight oriented psychotherapy ALONE has been shown to be ineffective in the treatment of these two disorders. I know that most of my psychiatric colleagues will not agree if you inquire of them; however, the literature and data in follow-up studies show clearly that this single modality is virtually useless in treating pedophilia. It is, however, ABSOLUTELY important as one modality of treatment of the disorder in order for the cleric to learn to develop better self-esteem, deal with the real issues of ministry in the future, deal with the guilt of his behaviors, etc.

(4) Group psychotherapy ALONE as a modality has limited usefulness in treating pedophilia. However, any adequate program should be group psychotherapy oriented because the cleric will learn age appropriate behaviors with other clerics, learn to improve peer relationships, learn to deal with the rationalizing which is so central to pedophilia.

(5) It is my personal and professional opinion that any cleric who is a pedophile or exhibitionist should never drink alcohol again for the rest of his life and that he should attend A.A. once weekly during the treatment inpatient program to learn how to adopt a lifestyle which will exclude alcohol.

(6) S.A. (Sexaholics Anonymous) should be a mandatory part of the program if available in the area of the treatment facility. This is a self-help group which we require our patients attend three times weekly for the rest of their life.

(7) Behavioral modification programs have not proved in longterm follow-up studies to be particularly useful modality of treatment. If used as one of many modalities of treatment, it can be helpful particularly the use of cognitive restructuring techniques, relaxation techniques, biofeedback. ALONE, however, no program to date has proved to be helpful in reducing recidivism in pedophilia and exhibitionism.

(8) NO PROGRAM SHOULD BE CONSIDERED if the use of Depo-Provera is not a possible modality of treatment available to the appropriate patients and where the side-effects are not disabling. In dealing with celibate clerics, it is my opinion that it should be considered a modality that should be tried for a minimum of one year in conjunction with all of the other modalities mentioned in this section of the document. It is also a treatment modality that should never be used ALONE. It is my opinion that it should be administered weekly in the context of a group support meeting and that no cleric should return to a Diocese where such a group and administration of this drug weekly could not be a reality or a serious consideration.

(9) Any serious program should include the "religious family", more specifically the Ordinary/Diocese officials, in the longterm treatment planning. This should always be done in person with the treatment program, the Bishop or his knowledgeable representative and the cleric himself.

(10) At this time, I would recommend that the minimum period of inpatient treatment should be six months.

AFTERCARE PLANNING

INTRODUCTION: This is without question the most important aspect of the entire treatment approach for persons with these lifelong psychiatric diseases. Because none of our programs now have elaborate and well thought out Aftercare Planning specifically for pedophilia and exhibitionism programs, I would like to outline concerns for our discussion.

(1) These are lifelong diseases for which there is now much hope for recovery and control of the disorders, but NO HOPE AT THIS POINT IN TIME for "cure."

(2) Following an inpatient treatment program, it is my opinion that halfway house living near the inpatient treatment program should be almost MANDATORY for six to twelve months following inpatient treatment. The purpose of the halfway houses are:

(a) Less structured living with other priests where "temptations" will be available and will test during that six to twelve months the skills developed in the inpatient treatment program and, if on Depo-Provera, see if it is helpful for the rest of the cleric's life

(b) Develop active vocational rehabilitation programs during that six to twelve months' period where the cleric can be educated in prison ministry, ministry to the elderly, hospital ministry, Newman Club ministry, etc. When they return to their own dioceses or "cooperating dioceses" to begin ministry, it would be advisable for them to be in one of these non-parish ministries for the first two to four years.

(c) Arbitrary Rule of Thumb: Especially in small dioceses, the cleric should not return to his own diocese until the youngest child has reached the age of majority plus two years.

(d) IT IS A FACT THAT TREATMENT CAN HELP REHABILITATE CLERICS SO THAT THEY MAY RETURN TO ACTIVE MINISTRY IN MOST INSTANCES IRREGARDLESS OF JAIL TIME OR NO LEGAL COMPLICATIONS. However, the Ordinaries in the U.S. must be willing to discuss a systematic method of "alternative placement" for time periods until it is safe in some instances for the cleric to return to his own diocese.

(e) A CONTRACT MUST BE DEVELOPED TO WHICH THE ORDINARY AND THE CLERIC WILL ADHERE TO. An example: perhaps a contract, drawn up following six months inpatient treatment and one year halfway house rehabilitation living, would include as one stipulation the taking of Depo-Provera weekly. If the cleric misses two weeks, he will incur automatic suspension, removal from active ministry, and consideration of forced laicization by the Holy Father. This is simply an example, nothing more.

(f) Aftercare Program with the inpatient treatment program should include return for one week workshop every six months for FOUR YEARS MINIMUM.

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