

NEW CREATIONS: THE TREATMENT OF PRIESTS

A Manual for Religious Superiors
What We Do & Why We Do It

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“It is not by sidestepping or fleeing from suffering that we are healed, but rather by our capacity for accepting it, maturing through it and finding meaning through union with Christ, who suffered with infinite love.”

— Pope Benedict XVI (Saved in Hope: Spe Salvi)

TABLE OF CONTENTS

Introduction	5
Chapter One: Recognizing and identifying problems	9
Depression	11
Compulsive behavior	14
Sexual difficulties	15
Sexual difficulties II	16
Interpersonal difficulties	17
Chapter Two: Now What? Intervening when problems are reported	19
Chapter Three: Assessment	24
Approaching the possibility of an assessment	25
The assessment proper	30
Chapter Four: Intensive Treatment Programs	40
Chapter Five: Treatment from the Inside: What it's like for the client	49
Chapter Six: Miscellaneous considerations	56
What can treatment accomplish?	56
Thoughts on medication	59
Final thoughts	59

Introduction:

In recent years, revelations of sexual misconduct on the part of priests have thrust religious superiors into the spotlight in many unwelcome ways. This has resulted in multiple demands placed upon them: caring for the victims of sexual abuse; dealing with the offending priests; repairing and restoring the reputation of the larger Church; and facing the financial consequences of ruinous payouts to victims. None of these tasks has been pleasant and all remain important.

This book is an effort to address one of these domains, the one with which we are most familiar: the treatment of priests. For while sexual misconduct has consumed the lion's share of media attention, the reality is that priests suffer in many ways, most of which do not include sexual malfeasance. Like everyone, priests are prone to the common maladies of contemporary life: depression, anxiety, addiction, and a variety of personal and interpersonal difficulties. Unlike everyone, however, these conditions in the lives of priests have a very public dimension. As such they require special care and attention. Hence this book.

The quotation on the previous page by His Holiness Pope Benedict XVI captures a profound and basic tenet of our approach to healing: that only by facing suffering, identifying it, claiming it, and sharing it can one begin the journey of recovery that is at the heart of our work with clergy and religious.

The Saint Louis Consultation Center was founded in 1992 to provide an Intensive Treatment Program specifically designed for Catholic priests and religious men and women who struggle with psychological, psychiatric, or behavioral difficulties. At that time, the concept was to provide an intensive treatment experience on an outpatient basis. It was believed that such a program would provide a more realistic setting for priests to examine their lives. It would emphasize personal responsibility and autonomous ownership of one's own recovery. It would create a venue that was more similar than not to how a priest lived his life. And it would do so at significantly less cost relative to residential treatment. Outpatient service covers many if not most of the difficulties commonly encountered among priests whose lives need attention. As will be seen, residential centers provide a sometimes needed measure of safety and as such play an important role.

The fact that we are still in operation attests to the value of that original concept. Twenty years on, we are now looking for ways to share our experience with those we serve. That is, we want to provide useful information to religious superiors who deal with troubled men and women in their jurisdictions. This electronic book, or eBook, is part of that effort.

The intent of these pages is to be practical. We will describe problems common among the clergy and describe the mechanisms we believe are most helpful in dealing with them. This is a process that entails considerable time and energy, but it has proven invaluable in the vast majority of cases we have seen over the years.

Leadership in the Church is a shifting responsibility, and a clear, common-sense introduction to understanding priests who are experiencing difficulty in their lives and understanding how to address them is in our view a helpful way to build on all these years of experience in a way that would assist Church leaders in pursuing their ministry of caring for priests and religious for whom they are responsible.

This book is neither a complete treatise nor a definitive statement of all the kinds of problems which plague priests and religious men and women. Priests are, after all, human beings, and whatever can afflict a human being can show up in the life of a priest. But there are common problems encountered among priests, and it is these that are the target of this book, along with ideas about how to deal with the people and the problems they have.

An advantage of publishing this work in eBook format is that it can be easily updated. Periodic revisions are planned.

Background

In my capacity of Clinical Director of a residential treatment facility and then in a similar position in an outpatient facility, it has been impossible not to learn some basic truths. Basic truths such as: There are no magic answers to the human condition--no pill will alleviate all distress or change one's behavior or make a bad behavior go away; no meditation will cure depression. This is offset to a considerable degree by another basic truth: With proper attention and a variety of carefully planned experiences, almost anyone can improve his behavior, his adaptation, his sense of commitment to his life and restore a sense of joy and wholeness. I have seen it time and time again. There is a

third, sometimes confounding truth as well: It is nearly impossible to predict who will benefit and by how much from treatment. This helps keep practitioners humble. We know that the overwhelming majority of our clients improve significantly, some even dramatically, but we also recognize that some do not. But, as has been demonstrated by years of research as well as practice, psychotherapy and behavioral intervention have been proven as reliable as medicine, education, and other major enterprises of humans, and the fact that it is not one hundred percent effective hardly means abandoning the effort. Providing treatment is an activity worth pursuing; it is holy work and warrants care, respect, and understanding.

Preliminary thoughts:

This tradition of providing care to priests who suffer from mental or behavioral difficulties is a long one. Gibbon reported the founding of a monastery for 'lunatic monks' in sixth century Jerusalem. In the mid-twentieth century, several religious orders and dioceses founded programs specifically for the task of caring for troubled priests. Treatment centers have been founded under religious auspices not only in the US but abroad as well.

The establishment of these institutions grew out of a legitimate need as well as a genuine concern. Treatment is a sensitive activity that has a long history in Western literature, medicine, and social service traditions. In the past century, the work of Sigmund Freud, a noted atheist who felt that religion could be explained away by psychological analysis, laid the groundwork for subsequent psychotherapeutic models. His anti-religious bias slanted the views of generations of subsequent therapists. In fact, a common occurrence—and a common problem—for priests who seek individual treatment via the phone book or from a referral from a call center is this: they may meet with a therapist who has little or no regard for religious values in general or for celibacy in particular and may well not understand important aspects of being a Catholic priest. They may not even regard the Church as a serious or legitimate institution. In the mind of many treating professionals, these may be minor points of information that do not figure prominently into the daily task of listening to a man work out the conflicts of his life.

But the beliefs, biases, and knowledge base of treating professionals are important. Even if the Mental Health Practitioner (MHP) restricts his behavior to merely thinking

that celibacy is an outmoded or unhealthy way of living, this attitude is likely to seep into the comments, reflections, or behaviors on which he directs the client to focus. Even more damaging is the MHP who actively encourages a priest to abandon the ideal and engage in sex acts to satisfy his “needs.” This is disastrous for the mental health of a priest and is based upon a mechanistic and irreligious understanding of humans. Tolerating a double life, where a priest publicly espouses celibacy but is involved in an ongoing, sexually active relationship prevents an integrated life. Yet it happens, often with no confrontation from—and sometimes with the active support of—a therapist.

Hence the need for a treating professional or a treating institution to have a thorough grounding in the nature and expectations of the Roman Catholic Church and a commitment to her values. It is only by aligning him or herself with those expectations that a therapist can be on the side of health for a priest or committed celibate. This is one of the principal reasons that specialized programs are so valuable: they guarantee that there will be no conflicts between the values of treatment and the values of the Church.

A second consideration is the role of programming. Both in residential centers, such as St. Luke Institute or St. John Vianney, and in intensive outpatient centers such as the Saint Louis Consultation Center, the emphasis is on providing a holistic, multi-modal treatment environment that is heavily reliant upon group processes. This intensive approach to treatment does something that one-to-one counseling cannot do: it creates a culture of recovery where a group of people gather under the direction of professionals to help each other recover and grow as human beings. For a priest, the advisability of this approach is hard to question. Priests are public professionals: what they do and how they act is at the center of their lives in the public forum. Being committed to one’s personal health and well-being and acquiring stable self-care skills assists in their ministry and improves the chances of ministry lasting throughout their lives. Improving interpersonal contacts and skills not only aids recovery from compulsive behavior, depression, or other forms of affective distress, it also enables a man to learn new skills to care for himself in a mature manner; these skills can be integrated into his ministerial practice to great effect. Thus, the corrective emotional experience that occurs in therapy provides essential tools for living as well as the possibility of enhanced ministry.

Behavioral programming of this sort is somewhat out of fashion these days. Hospital-based programs, which traditionally offered this type of treatment, have essentially been defunded by insurance carriers, who have opted for a biomedical model of mental illness along with short-term behavioral interventions. Intensive behavioral treatment is costly. The remaining programs available are almost all based on client fees, which restricts their use to a small stratum of society or to those organizations willing to invest in their people. This is unfortunate. But the Church has for the most part seen its way to keep investing in such programs because she understands that the health and effectiveness of individual priests helps sustain the health, reputation, and mission of the Church more generally. And in this, Church leadership has demonstrated an enlightened position.

Research continues to show that the pastor is a primary factor influencing a parish. He often sets the religious and social tone for the parish, and it is he who is responsible for managing the various conflicts that can impede parish life. A healthy priest is indispensable to a healthy parish.

And, of course, there is this: When a man who has lain prostrate before the altar of God and made a solemn oath to a bishop who is vested with the fullness of the priesthood and an assembly of believers; when the celebration of this event is the culmination of years of education; when this act elevates his standing among his friends and family; when his entire life thenceforth is defined by this ceremony—when that man engages in immoral, illicit, or evil behavior, or when he is joyless, angry, or chronically unhappy, something is seriously amiss.

Chapter One:

Recognizing and identifying problems

What are the most common problems among clergy? The answer to this basic question is that priests are susceptible to the same kind of maladies to which lay people are prone. As a bishops' national psychological study of priests concluded, "Priests are ordinary men." However, they experience these problems in a milieu that has higher expectations not only for good behavior but for a positive life. A priest is supposed to be an exemplar of Christian values. As an *Alter Cristus*, his behavior is to be uniformly above reproach. An unhappy priest is often seen as a violation of who a priest is and what he is expected to be. Sometimes this can be a disappointment to people. While

most lay people understand that priests are simply humans and may experience distress under certain circumstances—the death of a parent, for instance—any prolonged period of sadness or depression may be looked upon askance, at least by some.

A related consideration is that a priest lives his life in a fishbowl of sorts: whatever he does is scrutinized. When he steps even a little out of character, out of his role, eyebrows are raised, questions are asked. Things that are often tolerated in other people are seldom dismissed when a priest does them. Drink too much at a party? Happens to many people. A little too familiar with the attractive widow? Perhaps understandable in a bachelor. But if a priest engages in these kinds of things, rumors can start, letters can be written.

What is a priest to do then, if he finds that his flock is inattentive or unsympathetic to his distress? What many priests do, short of seeking help when they need it, is what appears to be the next best thing: they pretend to be happy. They submerge their unhappiness or their conflict or their troublesome behavior and put on a happy face to the people they serve. Many parishioners expect this. While this is a satisfactory strategy in the short term, it can be lethal over the longer term.

The truth is that what is behind the happy face matters. We humans are generally not able to simply deny our misery and forge ahead as if our feelings don't matter. That is, we cannot do this without consequences. Once the split between one's external self-presentation and one's internal experience occurs, it tends to widen and crystallize into a habit, inviting all manner of troublesome or even dangerous things to develop. It is this split that enables a person to begin compartmentalizing his life, and this often involves a sense entitlement: giving oneself permission to exempt oneself from the vows and values that have been publicly embraced. This lays the groundwork for acting in ways priests should not act.

This is not something to criticize so much as it is something to understand. Few people live in this kind of fishbowl, where their every action is seen and often commented upon. And few people appreciate the stress this engenders. A case can be made that nurturing a public persona is part of the occupational requirement of people in ministry. After all, it is the job of the priest to be there for others, and his personal problems naturally recede into the background as he focuses on the needs of those he

serves. So the ability to adopt an approach to people that is clearly focused on their needs and not one's own is in fact a strength. But as with any personality strength, going too far can transform it into a vulnerability. Instead of being a way to minister to others, overemphasizing the public persona can be a way to hide out. And it is the hiding out that can lead to trouble.

We humans are curious creatures, and we are sometimes prone to believing things that are neither true nor likely. One of those things is that we can mask the reality of our lives from others indefinitely. We might believe that, just because I tell no one that I don't sleep at night or that my weight is going up or down, they won't notice. And that might be true for a while. But the effects of sleep deprivation or the increase or decrease in weight are things that have an impact on how we relate to others, especially how we minister to them. People who do not sleep well tend to have shorter fuses, get irritable, become socially distant, and in general operate with less efficiency than the well-rested. People who lose weight start looking gaunt, and their clothes begin to hang on them in noticeable ways. And people who gain weight, of course, need to buy bigger clothes.

In addition to these obvious signs, parishioners pay attention to their priests. They notice when things change, when they gain or lose weight, when their moods start to shift. The bond between a priest and his parishioner is multifaceted: it is at once guide, friend, confidante, caretaker, administrator. We notice things about people close to us, people we care about. And Catholics care about their priests.

This is especially true when a priest is down or unavailable or drinking too much or absent too much. Most priests desperately want and need to be helpful, and threats to that ability—depression, excess anxiety, intemperate behavior—easily become things to hide rather than face directly. This is the beginning of trouble.

Consider depression. The word originally derived from the depression or dampening down of affect or of feeling. It was used to identify someone who seemed to have lost the zest for living that is palpable in normal, healthy, emotionally vibrant and alive persons. Depressed people don't feel much of anything, and what they do feel tends to feel bad. This can engender an unending gloom that William Styron insightfully labeled 'darkness visible' in his book of the same name.

Depression poses a complicated picture to a priest or committed religious. Is not the Gospel the 'Good News'? Is it not incumbent upon him to be happy, to joyfully await

the resurrection? So depression, which for a long time was associated with weakness, is easily associated with shame. And that kind of shame—the kind that leads one to deny his experience--readily becomes toxic. It does so when it limits the ability of the priest to tell the truth to himself about himself, when it leads him to minimize his condition rather than address it, when he relinquishes his hold on himself so as to continue ministering as best as he can. It is usually a fruitless enterprise. Shame is especially toxic when it leads him to seek out proscribed means of comfort: sexual relationships, mood-altering substances, abandonment of duty.

So what does one look for with people who are depressed? The symptoms are lack of interest, sadness, trouble sleeping, changes in appetite or weight, social withdrawal, anger or irritability, sadness, low energy, and difficulty concentrating. Thoughts of suicide or a wish for death are common. Often depression has a gradual onset, so that the signs and symptoms are not noticeable at first. They may seep into the life of a person and not be noticed until the syndrome is full-blown. Also, these things are generally not easy to spot among people who live alone, as many priests do these days. So it is often the case that someone must inquire. How are you sleeping? Are you depressed? Has your weight changed? Etc., etc. Asking is good.

What is more available is the effect depression has on the rest of a man's life. This can take many forms: a priest may seem to have lost his vitality, his performance at liturgy may have become more mechanical, his sermons perfunctory or perhaps poorly prepared. He can be irritable and easily frustrated. He is less available than he used to be. All of these are indications of trouble, and depression is a common culprit.

But it is also the case that depression can get entangled with other problems. This happens in a number of ways. What might be seen by others may look very much like the opposite of depression: often a priest will try to compensate for a deteriorating mood by feigning happiness, by trying to prove to others (and to himself) that he is okay. He may try ratcheting up his enthusiasm, which may seem a bit hollow upon examination but can usually get him through a parish staff meeting.

But the other, more damaging and perhaps more common problem is not the depression itself but the efforts of the priest to treat it without medical or psychological help. Drinking is, for some reason, attractive to depressives. This is counter-intuitive because alcohol is a depressant drug, but the initial lift it provides is apparently a

compelling reason to imbibe. But depression also lurks behind many of the behavioral problems often seen in priests in trouble: it fuels anger, it promotes distance and alienation, it fosters hostility, and it exacerbates social withdrawal. And it can lead to involvement in pathological relationships. More on this later.

There are different forms of depression, of course. Bipolar Disorder has gotten a lot of attention in recent years, and it seems to have become a common diagnosis. The two 'poles' referred to in the name of the diagnosis refer to low mood (depression) on the one hand and elevated mood (mania) on the others. A person afflicted with Bipolar Disorder swings from periods of low mood to periods of euphoria. Sometimes this occurs over a period of days or months. Sometimes, however, there is something called 'rapid cycling' where a person's mood can shift up and down much more quickly. So while the signs of depression might be seen, what might be more troublesome is an uptick in frenetic activity: excessive shopping, excessive socializing, an increase in dangerous activities (drug use, cruising, and the like). These activities make diagnosis challenging because depression often results from drug use or illicit behavior without the underlying condition. But mania can engender behaviors that can draw the attention and the ire of parishioners very quickly.

There is a younger sibling of Bipolar Disorder called Cyclothymia, which is essentially the same type of illness with less intense periods of depression and mania. There is also a chronic form of depression that gets a little better and then a little worse but never completely goes away. The technical name for this is Dysthymic Disorder or Dysthymia.

These are what therapists call 'affective disorders'—depression and the like. They are common among the clergy. But they are not the sole issue. Here are some other common ones, along with some reflections on each:

Anxiety can show up in lots of ways. Many of the activities in which priests are engaged generate anxiety: presiding at liturgy, counseling distressed couples, running a large parish, preparing talks. Priests are there for the celebrations of life—births, marriages—but they are also there—and there more often—for the stresses and tensions of life: the deaths, the marital discord, the anguish people have in their lives. All of these things can trigger anxiety in the minister. In fact, the management of anxiety is a central skill in order to function successfully as a priest and to sustain adequate

functioning over time. But sometimes, even with our best efforts, symptoms of anxiety occur, and they can do so in peculiar ways. A not uncommon manifestation of anxiety among priests is phobia presiding at liturgy. This is particularly sad because presiding at liturgy is a defining act of priesthood, and most priests place Eucharist as a central value in their life overall and in their spirituality in particular. Other forms of anxiety are commonly seen as well: social phobia, where a person becomes increasingly shy and withdrawn; generalized anxiety, where a man gives himself over to constant and debilitating worry; and post-traumatic stress disorder, which can follow upon a traumatic event either recent or from a long time before. Also, inadequate management of anxiety can readily contribute to . . .

Compulsive behavior: Compulsive disorders are essentially anxiety disorders that have developed into stable patterns of repetitive behavior. A case can be made that American society at large is vulnerable to this in this era. Compulsively pursuing some task, activity, or drug easily becomes an enduring attempt to manage anxiety or emotional distress over the longer term. Such behaviors are typically rooted in an effort to manage anxiety by engaging in a behavior that provides some relief. This is certainly true in the case of alcoholism. There is no doubt that alcohol provides some relief from anxiety in the short term. It slows a person down, induces euphoria, and calms jangled nerves. But in those so disposed—that is, those who have a predisposition to alcoholism—this common tonic can easily be abused. Then, what begins as a pleasurable relief turns into an uncontrollable pattern of drinking that prevents a man from doing his job, carrying on his relationships, or building a suitable life for himself. Paradoxically, full blown alcoholism also makes anxiety worse, a development that is generally dealt with by drinking more in a downward spiral of illness.

Compulsivity shows up in many other areas. A common one is **sex addiction**, where some type of sexual behavior becomes the focus and preoccupation of a person's life. Internet pornography is an increasingly common symptom of this. This often starts with a seemingly innocent impulse to see what is 'out there' on the Web; but it can start to plow into a person's private time and take a larger and larger share of time, energy, and sometimes money. It is often accompanied by a pattern of compulsive masturbation. It can lead to sexual acting out with others, a dangerous prospect. **Drug abuse**, while not widely seen among members of the clergy, does occur. But the more common addictions are the so-called 'process addictions': addictive behavior that does

not involve a substance. Common in this category are **spending, gambling, hoarding, exercise,** and overinvolvement in hobbies such as **geneology, stamp collecting,** or collecting religious objects or books: these activities are benign in moderation but destructive when addictive. The word 'destructive' is intended to reflect the havoc these things can wreak on an otherwise sensible and devoted life.

A common compulsive activity to which priests are especially susceptible is **workaholism:** Hard work is both an American and a Catholic virtue. We laud the diligent student, productive worker, and selfless pastor. But devotion to work, which is a good thing, has a dark side. When work begins to take over one's life, other needs go unmet: needs for emotional connection to others, for recreation and diversion, for rest, for prayer and contemplation. It is not uncommon for priests to work throughout the day and evening, and it is a testimony to their dedication that they do so. But humans are not maintenance-free organisms. We need time to refresh ourselves, to be off the clock, to have down time. Without this, we become depleted and pave the way for some of the problems mentioned earlier. When emotional needs are thwarted, they have a way of protesting by showing up in ways we do not intend: we get irritable, we start fantasizing about escape, we are vulnerable to acting out. And because we work so hard, we deserve some reward or indulgence. Or so the process often leads men to believe.

Sexual Difficulties cover a lot of ground in the maladies of priests. Of course, priests are celibate, and, while this is sometimes derided in our culture, it is not, contrary to much media commentary, an impossible or unnatural state to sustain. It is a value that the Church has held for centuries and which, if anything, is perhaps more critical at this time in human history than at any other, given the rampant use of sexual stimuli to sell everything from toothpaste to expensive cars. But celibacy, like marriage or any other state in life, brings its unique challenges. Celibacy does not condemn a man to perpetual loneliness, although the ability to be alone is central to success in living it. For the celibate, having and relying upon a support network of like-minded people is critical. Without support and routine interpersonal contact, most people wither. This is as true for priests as it is for anyone, and a lack of attention in this area often leads to sexual trouble. That trouble can take a variety of forms. Masturbation is one behavior many think is innocent. While no one thinks that an occasional moral lapse of this sort is pathological, it is true that it reflects a violation of the moral position of the priest or

religious. As such it violates integrity, a key factor in mental health. Masturbation can become compulsive, as a man begins to look for solace in this solitary way on a regular basis. With the advent of the Internet, sexual interest can be stoked in a way that readily leads to what is now widely understood as sexual addiction or sexual compulsivity, as noted above. There is no doubt that the entire sex industry has as its principal pursuit drawing attention to itself. And in this quest it provides sexual imagery and content of a dizzying range. Almost any sexual impulse can find an online home.

Sexual Difficulties II: Another area of sexual difficulties common among priests in trouble—and the one that gets the lion’s share of attention—is physical involvement with other people. And in this area there is a wide range. On one end of the spectrum, there are men who act in ways which reflect sexual immaturity, such as a priest who touches a women’s thigh when counseling her or who stares at attractive women inappropriately. At the other end of the spectrum are predatory sex offenders, the types that have gotten such press in recent years. In between is a range of behaviors. First, the solitary approaches: men who engage in sex acts in an anonymous fashion: they cruise parks or rest stops looking for nameless sex partners for simple sexual excitement and release. Or they expose themselves to others. These men most often come to the attention of their religious superiors when they are seen, recognized, or arrested in pursuit of what appears to be a solitary and joyless sexual experience. This type of revelation occasions scandal if it becomes widely known and reflects poorly on the man and the Church. Secondly, there are men who attempt to carry on a physically intimate relationship with another person. Sometimes these are with partners they have met in some non-Church setting; sometimes the partners may not even be Catholic. But for the most part, people tend to get involved with people they know, and most priests know their parishioners, especially their employees or volunteers. So the likelihood is not small that a priest will get involved with a penitent, someone he is counseling, someone he works with, or someone in the parish. Sometimes the other person is married, which adds another layer of complication; often the person is vulnerable because of his/her own depression, anguish, loss, or loneliness.

This ‘double life’ scenario is corrosive to the mental health of priests: it eats away at the core value set to which Catholic priests have committed their lives. It often occasions anxiety as efforts to maintain secrecy are ongoing; it at times is both triggered by and exacerbates depression. A related issue, however, is that of boundaries. In any pastoral

situation, whether counseling or providing spiritual direction or greeting parishioners after Mass, it is always the responsibility of the priest to maintain appropriate boundaries. In the eyes of the court system and the general public, he is the trained professional; it is he who is charged with the care of the flock; he alone can erect and maintain the appropriate distance that allows him to attend to his people without taking advantage of them. The violation of boundaries adds yet another layer of complication to the already debilitating involvement: it can make the priest and the Church vulnerable to legal action. This is not salutary for anyone's mood. Sexual difficulties of this type are a subset of a broader category of problems grouped under. . .

Interpersonal difficulties: Some priests are shy; some are unremitting extroverts; and most fall in between. On the shy end of the spectrum, the principal problems are isolation and loneliness resulting from an inability or unwillingness to expose oneself to unnecessary social interaction. Shy people who are in the public eye, as priests are, often experience anxiety. Successful ones develop specific strategies for dealing with their social anxiety: they memorize their sermons, or at least write them out; they give thought to their agenda before even informal meetings; they stay task-oriented during formal ones. But shy people are often at a loss as to how to construct relationships. They may lack basic social skills, such as greeting others without being greeted first. Again, the current low number of priests makes this more problematic than it was forty years ago, when priests commonly lived together and formed social groups without much trouble. Extroverts, on the other hand, tend not to have difficulty meeting people. The problems they run into involve overextending themselves in too many relationships. This is not such a common problem for priests, as engagement in a wide social network is a healthy thing for a celibate, particularly for one who lives alone. But extroverts can exhaust themselves and lose sight of their needs. They can have lots of relationships but too many superficial ones. Particularly for successful extroverts, a sense of entitlement can develop, and the belief that the rules may not apply to them can insert itself into their mind set. So it is not unusual for a successful extrovert to justify to himself the keeping of a sexual partner, or the spending of money frivolously, or the indulgence of a lavish lifestyle.

There are other serious interpersonal difficulties that are commonly reported. A frequent one is anger. One of the subtests on the venerable Minnesota Multiphasic Personality Inventory (MMPI) that signals trouble for clergy is Overcontrolled Hostility.

Anger is a complicated matter for a priest. Is it not one of the Seven Deadly Sins? Is not wrath the province of God alone? But priests, being human, get angry, as Jesus did. If he is depressed, he may get irritable; if he is anxious, he may get hypercritical. If his anger is chronic and largely out of his awareness, he may act out. The inappropriate expression of anger is one of the most common ways priests in trouble come to the attention of their superiors. Perhaps they are explosive; perhaps they are scolding people from the pulpit; perhaps they are alienating the parish staff. A chronic exhibition of anger usually points to an underlying problem. Sometimes it is a matter of skill, a man may just not have a clue what to do with feelings of anger. It may be that his family did not model this well, and/or it may be that he learned early in life to submerge such feelings. More often, a lack of skill combines with a painful degree of personal passivity with respect to emotional functioning overall. Often heightened anger is a signal of depression. It can also signal a vocational crisis. Whatever the attendant aspects, increased anger is something that warrants close attention, as it is destructive to the work of the Church in addition to being injurious to the relational life of a priest.

Other Problems: To paraphrase a famous observation by Tolstoy: normal families tend to be all the same; dysfunctional ones find endless ways to get into a mess. So too, there are many ways for other things to go wrong. Some of those we have encountered in treatment include stealing parish funds, overspending, hoarding, social isolation, self-sabotaging behavior (failing at expected tasks, e.g., school), rampant irresponsibility, unwillingness to work diligently. In short, any malady that can afflict a human being can afflict a priest as well. And a priest who is not living the life of a responsible, mature, committed celibate is a burden and a danger for the Church.

Human problems are seldom textbook-clear. The multiple issues that can arise arrange themselves in unique ways for every individual who has them. There is seldom "one problem". There are usually multiple problems appearing simultaneously. Teasing them apart is the task of the mental health professional. But dealing with them on the front line is the task of the bishop or major superior.

Chapter Two:

Now What? Intervening when problems are reported

Problems usually come to the attention of a religious superior because people complain. While few people in authority enjoy this aspect of leadership, a little reflection suggests that those people who complain early when trouble is spotted are doing the priest and the Church a service. Problems that are ignored tend to get worse.

Much of what I am about to say about intervening is already familiar to those with administrative or oversight responsibility. I include it here for completeness and for those new to such roles who might not be so practiced in dealing with the situations described here.

So what does a superior do upon hearing of a complaint? It is useful to distinguish between anonymous complaints and signed or acknowledged ones. Anonymous complaints are generally not helpful, and beyond indicating to the priest that some have been received and inquiring if there is substance to the allegations, little can be done. The exception to this, of course, is if there is an actionable allegation. For instance, if a complaint states that a specific person or a specific group of people are being abused in specific ways, that is something to attend to, no matter that the complaint was received anonymously. If a victim was named, that is actionable. Generally, however, anonymous complaints tend to be vague and non-actionable.

Claimed complaints, on the other hand, are serious business. The context we often encounter is this: Catholics revere, respect, and love their priests; we also respect authority. If someone writes or calls a religious superior, it is usually because there is a situation that is sufficiently serious to compel a parishioner to overcome his or her apprehension about going over the head of the priest and approaching someone he or she may not know personally. Priests often complain that “a small group of dissatisfied parishioners” complain about him but most of the people love him. That is most likely the case, but if a priest is engaging in behavior that a group of parishioners are complaining about and that group of people has the fortitude to take it to a higher level, the superior has everything to gain and nothing to lose by listening, by taking their complaints seriously, and by taking whatever action is appropriate. It is also true that the “small group” most often includes the people who are closest to the priest: parish

staff members, volunteers, and those actively involved in parochial life. They deserve a hearing.

The first step in any response protocol is listening. It is important that everything the complainants say is understood as specifically as possible. It is not sufficient to hear that some parishioners are unhappy. It is important to know what they are unhappy about, what the specific problems are, how long they have been going on, and what they have done prior to complaining to the superior to address the issue. For instance, if a man is absent from the parish, it is important to know exactly what this means. Is he simply not attending to specific requests? Is he geographically absent or is he holed up in the rectory? Has he been unavailable on a consistent basis? How long has this been going on? Specifics in regard to the nature of the problem are helpful for all concerned and make dealing with the problem much easier.

There are, of course, certain aspects of this process that are key. As in dealing with all humans, care and respect are paramount. Empathy does not hurt. Objectivity and a sense of neutrality also matter. The tasks in the initial stages of an inquiry have as their goal the development of an understanding of the problem from an objective perspective.

A note about priority before an example: The priorities in an inquiry into misconduct or other concerns are the safety and well-being of the Church and of her people. All of her people, including the priest. To that end, other factors, such as the sensitivities of the people involved or the political weight of confronting particular individuals, take second place. What this means is that, if someone is in danger or is being abused, or if there is danger that someone will be harmed, preemptive action may need to occur. This is consistent with regard to sexual abuse of minors with the Dallas Charter: no abuse is tolerated, and any credible allegation is sufficient to remove someone from ministry and place him on leave. Strong medicine, but well-advised.

An example: Fr. Smith's performance in the parish has fallen off. His presiding, which used to be at least moderately engaging, now seems rote and more than a little lifeless. His sermons are short, which is often welcome in parishes, but they lack focus and seem to be lifted from some other source. He attends monthly staff meetings at his middle-class suburban parish, but he often seems distracted and barely pays attention. The accountant complains that she cannot locate him for routine questions and decisions.

He is gone from the parish more than usual. This has been going on for some months. Parish staff started getting hints from parishioners inquiring into his well-being, and they have begun talking among themselves about whether or not Fr. Smith was OK. Everyone knew Fr. Smith's mother died earlier in the year, and everyone wanted to cut him some slack. But it is going on ten months, and he does not seem to be snapping out of his grief. Everyone is getting a little edgy.

Because Fr. Smith has been at the parish for almost four years, everyone wanted to respect his position and not push too hard. But then one day, he did not show up for the first Sunday liturgy. No word. Calls were made to the rectory, but no one answered.

At a later Mass, Fr. Smith did show up, but he did not say anything. When the parish secretary asked him after Mass what happened earlier, he looked at her askance, as if he did not understand the question. He mumbled something barely audible and walked off, leaving the secretary standing alone with even more concern.

The secretary, feeling that she pushed as hard as she could, went home. And then the telephone grid in the parish lit up as people started talking about poor Fr. Smith and what could possibly be wrong. The secretary learns that several other people have questioned him about odd behaviors, but he was similarly dismissive. The level of concern was palpable. A group of parishioners decided to meet at one of their homes to talk about the situation in more detail.

When they met, they decided that the concern would best be expressed to the bishop, since Fr. Smith was not responding to questions about his behavior. The parishioners who attended the meeting decided to compose a letter to the bishop and sign it with all their names. They did so and mailed it the next morning.

This example is not so unusual. There is no scandal here: no drunken rages, no revelations of sexual misconduct, no impropriety as such. Just concern for a priest as a human being who is clearly in distress; but a human being who is at the center of parish life and who is essential to the life of the parish.

It is clear that the response of the bishop would best be inviting, sympathetic, attentive, and reassuring. The bishop himself could invite all signatories to a meeting at the chancery to hear their concerns, or he could delegate someone to do so. He could take detailed notes, or have someone take detailed notes, repeat what he hears aloud to

make sure he understands it properly, and assure the people that their concerns would be respected and followed up on. He would thank them and arrange a time by which he would get back to them with some information about a possible course of action. The parishioners feel heard, relieved, and hopeful for the first time in months. They leave and have coffee to talk about what a great guy the bishop is.

Once they leave, the bishop's task is to determine what is going on. Dioceses differ in their approach to procedures to do this: some dioceses are large and the task gets delegated to a Vicar or a Dean or an auxiliary bishop. Most dioceses are small, however, and the role of the bishop is central in dealing with the situation.

Step #1: Gathering information. The first step in dealing with a situation like this is to gather as much information as possible. One can start with the personnel file to see if any indication of trouble had appeared earlier. Have there been previous complaints? Has there been a history of mood disturbance? Is there any record that the priest is on medication? If the bishop is aware of other priests who he knows to be close to the man in question, it might be a good idea to check with them and see if they have any concerns. This is a sensitive area, as treating the priest with respect is important. But in small dioceses there are few secrets, and news generally becomes known informally.

Step #2: After information is gleaned from whatever sources are available, the next step is to invite the priest in or to arrange to meet with him at his residence. Some of this depends upon the personality of the bishop: some prefer to have the priest come to them; some are more hands-on and want to observe the priest in his natural habitat. Neither is to be preferred: it is important that the bishop be as comfortable as possible as he approaches delicate issues with the priest in question.

The best approach to these meetings is (a) to be cordial and welcoming; (b) to be as direct as possible—e.g., “Fr. Smith, some of your parishioners wrote me a letter expressing their concern for you, and I met with them last week. These are their concerns. . .”--(c) to invite Fr. Smith's response—“What is your reaction to this?”—(d) and to listen as attentively as possible.

Now: religious superiors are not mental health workers. They are not trained to diagnose, identify, or treat emotional disturbances. But they are trained to listen attentively and to care for the human being in front of them, and this is the task. It is also important, as the person responsible for the care of the priest, to make a decision

about what to do next. What action to take, of course, depends to some extent upon what the priest says. The options are varied: He may minimize anybody's concern and dismiss them out of hand—"Some people are just touchy". He may hang his head and start to cry. Most men will listen and say what they know: "I haven't been myself since my mother died" or "I've been depressed for months and I can't seem to snap out of it." These are hopeful signs.

Sometimes, the bishop gets more than he bargains for or expects. The bond between a bishop and his priest is an intense one. Bishops are often what we psychologists call 'transference objects'; as such, they are often treated the way priests treat their parents. As one can imagine, this can range from the loving and deferential to the resentful, hostile, and antagonistic. It is small consolation to the bishop that this reaction is seldom personal; it can feel very personal in the moment. However, there is often the possibility that a man will acknowledge more than just low mood and a lack of pastoral zeal: maybe he has been drinking too much; maybe he has developed an inappropriate relationship; maybe he has been cruising and acting out sexually. While priests generally hide these things, as most people do, in a moment of candor they may share them. The bishop should receive any such information as matter-of-factly as possible, assuring the priest that he will support him in any way he can.

But whether the issue is simply low mood or not, the bishop must be prepared to make a decision as to what's next. The urgency of taking action depends upon the seriousness of the situation. If a priest is ready to abandon his ministry, action should be taken as quickly as possible. If he expresses ideas of suicide or if he is overdrinking or if he engaged in potentially scandalous or illegal behavior, action needs to be taken immediately.

In the latter cases—criminal or abusive behavior of any sort—a priest may have to be placed on administrative leave. This is now routine practice in most jurisdictions, and it is a wise one, even though it is painful for the priest involved and often for his parishioners.

Most religious jurisdictions also have in place review boards to consult regarding instances of sexual misconduct and other procedures for dealing with potentially litigious situations. It is, of course, incumbent upon the Ordinary to follow these policies carefully and in as rapid a manner as a situation allows.

But most priests do not engage in sexual misconduct, do not abuse minors or others, and are often simply suffering. In this situation, the relationship between the bishop/provincial and the priest is central to initiating a healing process. This is where a superior can wisely use his role as the 'transference object' to move a healing process along.

To sum up some of the major points about dealing with problems among clergy: It is almost always a good policy to proceed with "cautious haste" — that is, respond as soon as possible to complaints or symptoms but do so in a way which is thoughtful, reflective, solicitous of all voices, and informed by appropriate consultation. The safety and well-being of the Church overall is a priority when dealing with any difficulties encountered in the life of a priest. He is not simply a man who is suffering: he is the representative of the Church in the local parish, and his actions reverberate through the lives of many people. Respect for the individual is at the core of Catholic teaching, and that respect applies to everyone: the priest, his parishioners, his co-workers, his family, and those with whom he is involved.

It is almost never a good idea, on the other hand, to let things slide. Sometimes this is the first reaction of superiors when the problems seem not quite so serious. For instance, when a man is drinking "a little too much." Or when he was reported to be a "little too friendly" with young women. It is a natural tendency of people in trouble to minimize their difficulties and to posture competence to those to whom they are responsible. In any situation where there is concern, close attention needs to be paid to whatever collaborative sources may be present to make a final determination regarding disposition.

Chapter Three:

Assessment

As with most situations where there are a lot of questions and some ambiguity — people disagree in their impressions, fact is sometimes hard to separate from hearsay, interpretation or distortion are rampant — a thorough assessment of the situation is ordinarily both welcome and useful. It is welcome because it provides a path to understanding in an objective way the various issues at play in the life of a particular priest. It is useful because it can point to a direction for resolution of difficulty. But the type of assessment is important.

By 'assessment', I am referring to the kinds of comprehensive evaluations performed at places such as the St. Louis Consultation Center, St. Luke's Institute, or Southdown. That is, a priest or religious man or woman is scheduled for at least a four or five day stay, during which time they undergo a battery of psychological tests, complete lengthy questionnaires about their history, and discuss their behavior, personal and professional history, and spirituality. Information is ordinarily solicited from the referring superior. The client is interviewed by a team of mental health professionals, ordinarily including a person who explores their spiritual life. The process culminates in a feedback conference during which the results of the assessment are shared and recommendations are made on the basis of the findings.

It is important to recognize what an assessment of this sort is and is not. For instance, it is not the same thing as an investigation. The examiners are not in a position to check sources or gather information beyond what they received from the superior and from their own work with the person being evaluated. Investigations are important in any situation where there is scandal, where there are accusations of misconduct, and where there is disagreement about what actually transpired. For instance, if a priest is reported to be carrying on a sexual relationship with his housekeeper, interviews with the housekeeper and with people who have some exposure to the situation is clearly warranted. Even if the investigation is ultimately inconclusive, it provides important information about what is being perceived in the parish or other ministerial situation.

It goes without saying that sharing any such information with the evaluating team is a very, very important part of the process. Experience and psychological testing are potent things, but information regarding the nature of the problem, its history, and how it came to light are also key factors in any objective assessment.

There are, of course, situations where this kind of comprehensive approach to assessment may not be necessary. If someone is simply depressed and there are no complicating factors, he may profitably be referred to a psychiatrist for medication and a mental health professional for psychotherapy. Periodic follow-up—that is, touching base with the man every few months—would be valuable both to provide support and to check to see if he is cooperating with the treatment and if it is working.

But most situations are more complicated by the time they reach the desk of the bishop or provincial. If there is scandal involved or some sort of behavioral problem, such as

drinking or illicit sexual activity, an assessment can provide several useful functions, such as. . .

1. enable the superior to hear problems identified in an objective, prioritized way, so he can make decisions accordingly;
2. reveal issues that were not originally recognized by the bishop or acknowledged by the priest;
3. provide detailed documentation of the difficulties, should this be necessary in the future for whatever reason, including legal complications, further deterioration of behavior, or demands by the laity that “something should have been done”;
4. serve as a basis for any subsequent treatment.

These kinds of situations—where problems are reported and an evaluation is considered—are usually stressful for all concerned. Most of us humans do not like to look into the face of trouble head-on if we can avoid it. But one of the weighty responsibilities of leadership is to do just that when the situation demands it. And an evaluation procedure provides a structure for doing it in an objective, professional, non-personal way.

Approaching the possibility of an assessment:

In dealing with people whose behavior has been reported or who are experiencing significant personal and/or professional difficulty, it is important to keep in mind some basic principles. Most religious superiors I have known do these things instinctively, but they are so important that they warrant being spelled out in some detail.

1. Because conflict typically engenders strong feelings—parishioners are angry, a priest may be angry or frightened or ashamed or all of these, the superior himself may be disappointed or worried—it is incumbent upon the bishop or provincial to maintain calm and stick to the facts of a situation. A situation that is causing scandal or potentially could cause scandal is something he cannot ignore. In this situation, he is the person whose job it is to maintain clarity and perspective, even if—or especially if—others may allow themselves to get carried away with their fears and emotions. It is not that he has to ignore his own emotional reactions, but he must use them judiciously and sometimes instrumentally to highlight the seriousness of the situation. So he can say, for

example, after reviewing a troublesome situation, that he is disappointed or concerned or even shocked; but he must communicate these things in a calm tone and not give into an impulse to berate the man in question or excoriate him publically. If at all possible, he should build on whatever relationship he has with the priest so that subsequent action feels collaborative for both of them.

2. It is also important to recognize that the decision on what to do next is his to make, even if the priest does not like it. This is a task of leadership. Some religious superiors, perhaps especially those in religious life, tend to be excessively collaborative in situations that call for more decisive action. If a man is using or abusing someone sexually, it needs to be stopped. And the diocese or province needs some reasonable ground for believing that subsequent similar behavior will not re-occur. More is required than a man simply saying, “Well, I promise I won’t do that anymore.” We have known for a long time that, without intervention, the best predictor of future behavior is past behavior. Even if the person has sincere intentions to follow through, the likelihood of his being able to do so without understanding the many issues that led to the behavior in the first place and modifying his behavior accordingly is small. So it is up to the bishop or provincial to make the best decision on the basis of all information available to him, no matter what the personal position of the priest is.

3. In making the decision, it is critical to have the well-being of the Church overall as well as the priest in question in mind. An important question to ask oneself is, “What will happen if I do nothing?” Sometimes the answer may reveal that doing nothing is the best thing for the man in question and the people. If a person is anxious or depressed but is still functioning adequately, it may be a satisfactory decision to let him live with those things a little longer with some kind of assistance. It is unlikely to be injurious to him or to the larger Church. If, however, his behavior is causing scandal; if he is not keeping up with his responsibilities; if he is engaging in self-injurious acts—even indirect ones, such as cruising for sexual contact or abusing drugs or alcohol—allowing him to continue without intervention hurts him and causes harm to the People of God. Most superiors recognize that those consequences are unacceptable.

4. Respect and care are the two virtues that apply most directly in many of these situations. Even if a person has done something outlandish—gambled away hundreds of thousands of dollars, engaged in public drunkenness, flaunted his commitments with apparent abandon—it is important that the religious superior treat the person with

respect and concern. This is sometimes hard to do. The natural reaction—"You did WHAT?"—can be hard to suppress. But again, leadership requires that a leader maintain calm, clarity, and clear-eyed purpose. And to demonstrate or signal a lack of respect for the man in question is to betray that task. Having other, private venues to express whatever contrary feelings a bishop or superior has is often very useful for him personally and is something to be cultivated.

Even with the most even-tempered, thorough approach, however, there are complications with an assessment that are sometimes difficult to manage. A priest may refuse to undergo an assessment. Canon law gives them the right to do this: priests cannot be forced to have an assessment; nor can they be forced to engage in follow-up treatment. This is an important safeguard woven into the fabric of Church law that is designed to protect the priest. It is also true, however, that while a man can refuse an assessment, prudence dictates that such a refusal be considered in light of information and risk. Just as the priest has a right to refuse, so does the Ordinary or provincial have the right to assign him or not. And if a man is engaging in behavior that is risky for him or others; if it is suspicious, even if there is no conclusive evidence, such as in cases of child abuse; if it poses a threat to him personally or to others, as in the case of alcoholism; if it is scandalous, as when someone is involved in a romantic relationship; if it is criminal, as in cases of theft or extortion; or if his effectiveness as a minister is seriously compromised, as in the case of chronic anger or poor interpersonal relationship skills, legitimate questions can be raised regarding the wisdom of keeping a man in an assignment.

So pressure can be brought to bear. And, realistically, a man can still refuse to proceed with an assessment. That is his right. But as discussed earlier, the safety of the Church and the wellbeing of the People of God are paramount in these decisions and if either of those are threatened, the loss of a single priest's service may be a price that must occasionally be paid.

Fortunately, it has been my experience that most men are cooperative with a request for an assessment, and most have little difficulty sharing the results of the assessment with a major superior. This has been the case even though new information surfaces. It appears that most priests are healthy enough to recognize a day of reckoning when it is upon them.

The assessment procedure ordinarily culminates in a feedback conference with the evaluating team, the client, and the superior. This is usually done in person, although some superiors, because of their crowded schedules, have understandably opted to participate in the feedback session by telephone conference. This is satisfactory in some situations, but in general it is not to be preferred. There are several reasons for this. One is that anxiety on the part of the client is usually high, and, even though he may fear the responses of his superior, he also finds a measure of support in that relationship and in his physical presence. Secondly, voice-only communication limits the ability of the superior to get a feel for what the team members are saying: they understand the content, but sometimes do not get adequate information about the seriousness or relative weight of the many things that are discussed. So if at all possible, being physically present at the conference is important.

Another aspect of the conference is what to do with the information that is shared. We routinely recommend that assessment documents, which are sent both to the superior and to the client, be destroyed after use and not be made part of a permanent record. This prevents them from being used inappropriately later on, after a superior has left office and after whatever disposition has been completed. These are very personal documents, containing highly personal and often very sensitive information. It is, in general, not wise to keep them in a file where anyone can have access to them. Some superiors return them to the evaluating institution after reviewing them; this is perfectly acceptable.

Sometimes, there are legal issues pending that prevent the superior from destroying the assessment documents. But the same concept applies: that is, when the diocese or province is finished with them—after the legal situation has been adjudicated, for instance—it is wise for them not to be kept. Of course, it is important to seek legal counsel about this, as lawyers are in a better position to judge the wisdom of destroying records or not. It is important to know that civil law generally requires that mental health records be kept by the treating agency for a number of years. In Missouri, where the St. Louis Consultation Center is located, it is five years. But legal advice through the American Psychological Association recommends keeping them indefinitely.

While the detailed reports may be destroyed, it is advisable that some information be kept on file at the diocesan or provincial level. This would include a summary of the difficulties—alcoholism, for instance, or sexual misconduct—and a statement about the

disposition of the matter. Was the person treated for this? Where did the treatment take place? What was the outcome? There is a balance to be struck between the privacy of the individual and the needs of the institutional Church. No one wants the Church to be accused of destroying records or somehow hiding significant information about clerical malfeasance. But on the other hand, no one would wish the details of a person's history to be on display for all to see. As with all people, priests have a right to their good name and reputation. The Church has the right and the responsibility to defend itself, to demonstrate that it took appropriate action when complaints were made. This needs to be documented. But in most cases it seems sufficient to document this as outlined above with the knowledge that additional information resides with the treating agency if it is needed.

A related issue is clarifying issues around confidentiality. It should be made clear in preliminary discussions between the client and the superior how information will be handled. The evaluating agency can assist by answering questions about this. If there are areas of confusion or uncertainty, these can be discussed at the feedback conference. It is vitally important that no one be surprised about the uses to which the information will be put, who has access to it, and for how long. Clarifying these issues will help everyone involved.

There is some room for negotiation of these elements. As far as the evaluators are concerned, it is our job to shed light on situations that are often murky or poorly understood. We routinely send assessment documents both to the superior and to the client, except in those situations where a client may be so disturbed that sending the documents would not be helpful to him or could even be injurious. Those situations are rare.

The Assessment Proper

Up till now, we have been discussing preliminary issues pertaining to the assessment. We now turn our attention to the actual process of assessment. From the superior's point of view, after making the referral and sending the man along to the evaluating agency, the next moment of participation is the feedback conference, where the superior meets with the client and the team members to hear the results. In most cases, the procedure involved in a feedback session is straightforward. The client and his superior are welcomed into a room with several mental health professionals. The chair of the

conference begins by stating the purpose of the assessment (“We are here to shed light on some things that have been going on; we are not here to judge or criticize or shame you.”) If there are challenging things that need to be addressed, he may point this out. (“Some of what you are about to hear, while not new to you, may be difficult to hear.”) It is the purpose of the feedback conference to lay out difficulties as clearly and objectively as possible. It is not the purpose to criticize or judge or shame someone. People generally do not volunteer to be depressed, anxious, or suicidal; they generally do not choose in a conscious, self-possessed way to be alcoholic or to exhibit other compulsive behaviors. These are afflictions to be identified and treated as such. They give reason for compassionate understanding.

After the introductions and preliminary remarks, the evaluating team members share their reports from their particular perspectives. In our model, the evaluation addresses three key domains: the psychological/emotional, the psychosocial, and the spiritual. We only include medical testing with our clients when it is indicated; generally it is not.

The purpose of the psychological assessment is to provide an overall description of how the person functions on a psychological and emotional level with an eye toward pointing out areas of vulnerability. It has an important additional purpose of providing an objective idea of where a person stands on a spectrum. Now, there is some art to this. Many of the psychological issues noted among priests—excessive intellectualization, for instance, or emotional avoidance—are seen among many segments of the population, especially among professional groups. But the seriousness of psychological problems is really measured by the extent to which they impact a person’s behavior, particularly when they impede proper vocational or social functioning. It is one thing for a person to be overly intellectualized or even repressed; it is quite another when that set of defenses leads him to depression or to illicit involvement with someone else. So the psychological evaluation describes a client’s psychological make-up in the context of the actual difficulties of his life, pointing out how his vulnerabilities feed into problematic behavior. As a noted early pioneer of psychological testing once observed—and this is a paraphrase-- “No matter how sophisticated, a psychological test cannot do its own thinking.” The data must be interpreted in light of what we know about the person being evaluated. This point can hardly be overemphasized. It is one of the reasons context and corroborative information is so important.

While the psychological test results provide an overall outline of the issues involved, the psychosocial history fills in the human details of the person's life experience. As much as some people do not like to recognize it, we are all impacted by our personal and family histories. Our histories do not cause us to have the problems we have, but they provide the context for understanding how deviant beliefs, attitudes, or behaviors developed. Even people who come from solid families find that their thoughts and beliefs are populated by early impressions of caregivers, by important family events and practices, and by early relational patterns. Many priests are practiced at putting the best face on their early experience—they may actually believe that they came from solid families when they did not. But a closer examination can uncover a more objective view. Many responsible people tend to minimize the impact of early events on their own development and see this as the very definition of personal responsibility. But it can lead to a sense of false maturity. Genuine emotional maturity involves facing the issues of one's life, taking ownership of them, and exercising judgment with respect to one's actual vulnerabilities. All of these things require a firm and realistic understanding of how we developed.

The psychosocial history is often the most poignant component of the assessment process. It is not data-driven but narrative-driven; that is, it is a story of how a person developed. For humans, much of that is out of our control when we are young. It is an essential narrative if a person is to understand his life on more than a superficial level.

The third element of the assessment is spirituality. This is also a narrative of how a client developed spiritually. The spiritual assessment has several key functions. It describes the development of a person's spirituality and points out how this did or did not help the client deal with real-world problems. A person's spirituality is often a barometer of how well he is doing. It is significant that a priest can sink into depression and either abandon his spiritual life or limit it to perfunctory sacramental functioning. Or he can continue to conduct his daily spiritual regimen of prayer and devotions in a completely compartmentalized way, as if these did not inform or impact the life he actually leads. A key function of the spirituality assessment is to bridge the language of emotion and psychology on the one hand with the language of spirituality, faith, and prayer on the other. Priests are not mental health professionals; they are devoted to their own spiritual welfare and that of others. As such, they need to be able to describe their own development in spiritual terms rather than psychological ones, even though

these two languages are often ways of approaching many of the same experiences. Having a well-grounded spirituality is critical in the life of a priest.

In this regard, the fact that agencies who do this work are avowedly Catholic in their orientation is very important. We take as a given the doctrine, practices, and beliefs of the Catholic Church. We do not see these as separate or of no relevance in the behavioral and psychological life of a priest: they are central to it. To exempt priests or religious from the values of the Church is to undermine their integrity and the integrity of the assessment process. And integrity, as has been discussed, is essential to healthy psychological and mental functioning.

Following the presentations of the professionals, we inquire into the reactions of the client. How did he feel about what he heard? Are there things he does not understand? Does he need more clarification? Responses are also solicited from the superior. We encourage discussion of the material to ensure that all present understand the same thing.

Following this discussion period, the staff makes a recommendation or a set of recommendations to address the issues raised in the assessment. This can be participation in a treatment program of some type or outpatient psychotherapy. Occasionally no formal recommendations are needed; however, that is rare once a problem has gotten the attention of a religious superior.

While generally clients agree with the assessment—we are, after all, feeding back to the client information he provided us--the scales do not always simply fall from the client's eyes. Sometimes it is genuinely difficult for a man to understand his behavior in a new light. What meets the criteria for alcoholism, for instance, may seem to him to be a manageable habit. He might justify a sexual boundary violation as a "consensual relationship" even if it is with a parishioner and even if it violates the values he publicly espouses. He might see a long history of such relationships not as the behavior of a sexual predator but as someone who has an occasional weakness. There are endless justifications for illicit behavior. If there weren't, there would be a lot less of it.

The point here is that feedback conferences are naturally serious business. We are talking about a person's life with its strengths and weaknesses, its often shameful underside, and its failures, vulnerabilities, and challenges. This is not always pleasant for people who are under the gun because of complaints made about their behavior.

Even though most people appreciate the candor and care with which this process is done, few people would sign up for it without compelling reasons.

But evaluations of this sort are only conducted for compelling reasons. If there were not serious concern, the parties would have dealt with whatever problem they had in a less dramatic way. Evaluations are usually significant events in the lives of clients, and they should be.

Regarding disposition, there are some important distinctions to be made. At times, treatment—by which we mean intensive, focused, multi-month treatment at a facility structured specifically to provide it—is urgently recommended. These cases include the following:

1. If a person is seriously depressed and/or exhibits suicidal tendencies;
2. If a person's continuing in ministry risks scandal or additional harm;
3. If there is an identifiable pattern of compulsive behavior (drinking, gambling, sexual behavior, spending) that is out of control;
4. If the person is involved in scandalous behavior that has recently come to light which compromises his ability to function in ministry;
5. If there is any danger that further exposure to a vulnerable group (children, female counselees, and the like) would risk acting out.

There is another group of people who are referred to intensive treatment programs. While these referrals lack the urgency associated with the cases listed above, they require the kind of resources found in intensive programs to make headway. This category includes people who exhibit longstanding patterns of behavior that they are unlikely to change in the absence of serious intervention. Anonymous sexual behavior, for instance, or an ingrained habit of Internet pornography. This is particularly true if they also have longstanding habits or defenses that support the problem behavior—e.g., emotional avoidance, isolation, excessive intellectualization. Similarly, people who suffer from chronic depression and/or people who have been seen in individual psychotherapy for a long time with little result. Also, people who experience serious and/or complicated anxiety, such as those who suffer from acute symptoms of Post-

Traumatic Stress Disorder or who have developed an anxiety reaction to engaging in routine clerical responsibilities, such as presiding at liturgy.

In this group are also those people who have underdeveloped social skills and who have little idea how to build a social network that would help sustain them in ministry. Such persons are often depressed and/or anxious, but, more damagingly, they are often interpersonally isolated. This both exacerbates depression and works against its resolution. Finally, people who have significant issues involving anger are appropriate for intensive treatment experiences. If anger has gotten to the point of complaints piling up, it most likely reflects an ingrained pattern that requires considerable energy to re-orient.

A third group consists of people for whom treatment is neither urgent nor specifically indicated but who would benefit greatly by it. To some extent this is a matter of degree. There are generally few resources in the United States which combine the best of behavioral interventions—group work, skills training, reexamination of belief systems, psychoeducational training—outside costly hospital or residential settings. Even for people whose difficulties are subclinical—that is, their problems do not rise to the level of a diagnosable condition—a well-coordinated, intensive program would enhance their skills and help them lead a happier and more rewarding life and ministry. This is greatly to be desired for those serving the People of God.

A recent development where this kind of care is often warranted is in cases of foreign priests serving in the United States, especially those from the developing world. These men are filling more and more parish assignments in the United States, especially in rural dioceses. Often these men are devoted priests, but they have little direction or training in the cultural mores where they are asked to serve. Twenty-first century America is quite a different place from the traditional cultures from which many of these people hail: Africa or Asia or South America. Often priests from these other places are unaware of what is appropriate behavior in American culture and end up acting in ways which are offensive. Sometimes their behavior violates appropriate boundaries. They often derive less esteem in their position as priest in the US than they did in their home countries. They are often befuddled by demands that they cook for themselves or take care of their personal needs with little or no outside assistance. They may feel pressure from their families to provide money. In addition, they are often mystified by the relative equality of the sexes in current American culture: in fact, they

may find themselves answerable to or even supervised by women, which they may have trouble coping with. Issues of grief are common in this group if they are to let go of their home cultures and try to embrace contemporary American culture. They must learn new skills and work through their often stiff internal resistance. These are tasks for which group work, skill training, and a spiritually informed learning environment are especially helpful.

Those are cases that are appropriate for intensive behavioral programming. And while this is the most common referral made, it is not the only one.

Sometimes, a referral is made for simple outpatient therapy, perhaps a medical consult, and involvement in spiritual direction. These are cases where none of the above criteria apply and which can benefit by individual remediation of uncomplicated depression, low-level anxiety, or modest skill development. It can also help a relatively healthy person get back on track if he has fallen behind in his commitment to his vocation. These are worthy goals and reasonable means.

A common occurrence in the evaluation procedure is to encounter someone who has been in therapy for some time, even years prior to the assessment. Either the person has not improved significantly or some situation has developed which required intervention from his superior. One can legitimately inquire: How did this happen? How can a person be seen in individual psychotherapy for months or years and still have the kinds of problems that would get him into trouble? There are several reasons for this, some of which relate to the psychotherapeutic environment itself and some of which relate to its limitations. The typical psychotherapeutic environment consists of two people meeting one-to-one once a week. Ordinarily the sole source of information for the therapist is his client, who may consciously or unconsciously withhold significant information. This is often how alcoholism goes undiagnosed or acting out is not confronted. Clients simply omit the more troublesome aspects of their behavior as they focus on their mood or sense of well-being. The therapist can only be expected to deal with what he knows, and if there is a consistent withholding of information, even when a therapist may inquire, there is little he can do. He will start taking action and planning intervention on the basis of what he knows.

But there is another issue that often presents itself in this circumstance. The practice of psychotherapy was shaped by secular forces--Freud early on, and later academic

psychologists and psychiatrists. Religion has traditionally gotten short shrift in these developments: many therapists were trained not to comment on it; some were actively antagonistic towards it. There has been a suspicion or a negative bias associated with religion in psychotherapeutic circles until recent years. As the importance of spirituality is gaining more recognition in research, in practice, and in the lives of clients, it is gradually gaining more respect for the potent force that it is. But many established therapists do not share this burgeoning awareness. They may be ambivalent or even hostile toward religion in general and derisive of Catholic values regarding sexuality in particular. As a result, they may be inclined to view sexual behavior as acceptable, whether it be a solitary habit of masturbation or an actual sexual involvement with another person. As we have seen, this violation of personal and professional integrity comes at a profound price. But the tension that arises in such a therapeutic situation is that the client essentially acts out in a way which violates his integrity, and regular contact with the therapist works to make that tension bearable. Neither is likely to question or confront the basic conflict which precipitates the anxiety in the first place. And nothing, then, is likely to change.

For all these reasons, a comprehensive evaluation at a facility which is inherently respectful of Catholic moral teaching is a desirable way to proceed when faced with the kinds of difficulties encountered by priests and religious men and women.

A final word on collaboration. The main centers that perform these evaluations do so in a collaborative manner: that is, they present the data to the client and to his or her superior. Reports are typically sent to both. Some protest that this approach is patronizing or that it somehow limits the freedom of the client. But there are compelling reasons for doing these assessments in a collaborative way.

One is that the priest or religious does not live in a vacuum where he is accountable to himself alone. As a minister in the Church, a priest is accountable to his bishop and/or to his religious superior. His behavior reflects on that superior and on the Church in general, and, as such, is measured by a higher standard than someone who is single and living and working alone. Secondly, it is the diocese that is supporting the evaluation: they are paying for it. That in itself warrants a place at the table. Thirdly, the bond between a priest and his bishop—or between a religious and his major superior—is unlike other bonds. Just as priesthood is more than a job, the relationship between a priest and his bishop should be one of trust, openness, and confidence. Secrecy and

dissimulation do not serve that relationship properly. How a priest behaves—especially if he is engaging in behavior that is potentially scandalous—is a matter of grave concern to his religious superior and to the Church overall. Communication about otherwise personal matters takes place in that context: out of respect for the importance of a priest maintaining the values he, the bishop, and the Church espouse. Anything short of that is a form of duplicity. While there may be occasions where disingenuousness is indicated because of the quirk of a religious superior—if he is unable to maintain confidentiality, or if he has his own nefarious motives—the norm and the ideal should be one of transparency.

Finally, there is the matter of disposition: What happens after recommendations are made and discussions and clarifications ended? In situations where urgency is involved, as in those cases described above regarding safety for the individual, the People of God, or the Church, timing may be critical. That is, it may be important that the person avail himself of treatment at the earliest possible opportunity. In cases where the behavior is longstanding but does not pose an immediate threat, a more reflective approach to the alternatives may be advisable. We typically invite people in this category to “. . .think about it, talk about it, pray about it. . .” before they make a final decision. If the assessment process is serious business, the decision for treatment is all the more so. It warrants time, reflection, and honest discussion. It must be said that, for most people who come to the evaluation and walk away with a recommendation for treatment, such reflection generally yields a positive result. Optimally, the client and his superior see eye to eye and mutually agree that treatment is the best alternative for the man, the Ordinary or superior, and the Church.

There may be, however, some cases where the client is resistant to the notion of treatment. Perhaps he is afraid. This is certainly understandable; treatment is delicate, highly personal, and sensitive work. It requires a commitment of time and attention. Or he may simply not believe that his problems are so serious as they are presented to him. There is a natural resistance to change among us humans.

So I will not dwell on those people who recognize their need for help and consent to treatment. That kind of openness is not uncommon and is to be applauded for the maturity it reflects.

The challenge comes when people hear what is said and may even agree with it but insist that they can or will handle it another way. Or they might insist on a 'second opinion'. Or they might drag their feet. For dealing with such people, there are some important things to keep in mind.

The first, of course, relates to safety. If a person does not engage treatment, can he be returned to ministry without injurious effects to himself or others? Can he return without continued risk of scandal? If there is any possibility that the answer to these questions is no, then a serious and sober conversation needs to take place about the reality of the situation. Most religious superiors are entirely capable of these conversations, although they are often personally difficult. If strong encouragement does not have its intended effect, consequences of refusing treatment may need to be stated clearly. Sending a man back to ministry knowing that his behavior is dangerous is unwise policy.

Some people believe that treatment will be ineffective unless a person comes to a decision to participate in it willingly. Curiously, this is not the case for intensive treatment programs. It does not matter if a person is skeptical or resistant or even angry when he shows up for treatment. In fact, from a clinical perspective, those individuals who are able to share whatever reservations or aversive feelings they have to the process early on typically do better in treatment. We clinicians worry more about those people who are enthusiastic on the front end and dismiss their fears or reservations. It is our experience that sidestepping the natural reservations and apprehensions one has only allows those resistances to go underground and show up at a later time. It is to be hoped that the later time is still while a person is in treatment, as is usually the case. It is useful to be reminded that many priests are practiced at impression management—it is an occupational hazard—and are able to create the impression of cooperation no matter how resistant they are feeling internally.

The other issue not to be overlooked is the power inherent in the authority a religious superior possesses. While Church law proscribes ordering someone into treatment against his will, the support and encouragement of the bishop or major superior is often decisive in a person's decision to participate or not. A priest may agree, even if reluctantly, if he understands that his religious superior believes it is in his best interest and the best interest of the Church for him to engage a treatment process. This ability to build on the relationship between superior and priest is a valuable one.

Chapter Four:

Intensive Treatment Programs

It has become routine over the last thirty years in the United States to send priests to treatment programs specifically designed for them. There are several major institutions in the United States that provide these services. Most of these are residential. The Saint Louis Consultation Center is an outpatient program that provides a similar service for those who can function safely on an outpatient basis.

While the specific approaches to treatment vary somewhat by institution or agency, they typically share a number of components. They are holistic, in that they attempt to treat the 'whole person', his psychological, physical, spiritual and emotional aspects. They are typically group-oriented and have multiple group experiences woven into their weekly schedules. Most use a Twelve Step approach to addiction, co-dependency, or what is known as Adult Children of Alcoholics work. Most include spiritual direction and actively work to integrate Catholic spirituality into their treatment protocols. Most are collaborative and share information with religious superiors routinely. Most are six to eight months in duration. Most have a structured aftercare or continuing care components.

I am going to describe the components of the St. Louis Consultation Center program, because I am most familiar with it and because it includes all of these elements. This model has worked effectively with priests and religious women for almost twenty years, so it has solid track record.

Once a person has been evaluated—and a comprehensive evaluation is required for admission into the Intensive Treatment Program (ITP)—and all parties consent to treatment, an admission into the ITP is scheduled. This can occur any week of the year. If a person was evaluated at a different facility, that evaluation will be reviewed prior to acceptance for admission. Since the SLCC program is outpatient, housing needs to be arranged for the client prior to arrival. This is readily done either at Mercy Center, a retreat and conference center operated by the Sisters of Mercy of the Americas where our offices are located, or at a local religious house. If a person so chooses, he may also rent an apartment during the course of his stay here. This flexibility regarding housing

signals an important advantage of an outpatient model: that is, it allows the agency to treat the client as the adult he is. Also, it avoids some of the negative effects of institutional living.

The first formal step for admission is an orientation session. The client meets with the administrative staff to sign several forms: a Consent to Treatment Form, a Release of Information Form, and an Assignment of Benefits Form. These attest to the fact that a person is choosing to participate in treatment; that he gives the staff permission to share information with his religious superior or someone whom that superior designates; and that, if insurance monies are forthcoming, they will be paid directly to the agency.

The client then meets with the Clinical Director, who conducts the orientation session. This session ordinarily begins with the Director asking the client about the assessment process. He inquires if the client has read the assessment report. He also encourages him to set up a separate time to discuss this if he has any questions or if he wants to discuss it in more detail.

The Director then explains each component of the program and discusses policies relative to the client's stay. This includes the flow of information, and hence the relevance of the Release of Information. It is explained to the client that the policy of the Consultation Center is to work collaboratively with religious superiors and that a release is required for us to do so. In fact, the form is similar to the one signed for an assessment.

The policies regarding information are important. While we work collaboratively with superiors, we are also sensitive to the fact that the client will be sharing very personal information. We work to strike a balance between sensitivity to that information on the one hand and, on the other, providing enough information to the referring superior to assure him that we are addressing the issues that brought the person to treatment. In other words, we want to reassure the superior that he is getting what he is paying for.

The reporting procedure is explained in some detail. This includes an initial letter to the superior saying the person has begun treatment and explaining who he is seeing and what to expect. This is basically a form letter. The next routine report is an Interim Report prepared after the first three months of treatment. The client sees that report prior to its being sent out. If he has objections or concerns or corrections, these can be addressed. What this means in practice is that he is able to express whatever questions

or concerns he may have openly. We have a responsibility to articulate the truth to the superior in as understandable way as possible. But these things do not occur in a vacuum, and often the client provides useful clarification. The conversation about the final product is important.

The only other routine report is a discharge report, which is a lengthy description of what transpired in treatment. This follows the discharge conference, where that information is discussed. The discharge report also outlines recommendations for ongoing care and serves as a pivot to the Aftercare Program. This will be discussed in some detail later.

There are other policies regarding information: We have a policy of transparent communication with superiors, and we try hard to keep out of secret communication. This is not always possible. But since our approach is to treat our clients like the adults they are, if there is an issue or a conflict, we encourage all parties to address it as openly as possible between or among themselves. We see our role as facilitating that process. But in general, if there is a conversation between the clinical staff and the superior, the client will know about it. Transparency of this sort is often helpful to the treatment process and fosters trust, respect, and collaboration.

Religious jurisdictions vary in how much information they want. Some want frequent contact, some do not. We are small enough and nimble enough to accommodate a range of contact protocols.

Other important aspects of treatment are addressed during the orientation session. One is that we work on a staff model. The client is seen by a number of different professionals. As an agency, we share information among ourselves, and it is important that the client know that. This includes the spiritual director, who in our model is a fully participating member of the treatment team. Formal staff meetings are held monthly. In the next scheduled appointment with the client's individual therapist, the therapist shares with the client the observations and recommendations made at the staffing. Again, this underscores the collaborative nature of treatment we strive for and keeps the client up to date about how we see his progress.

It is also explained to the client that our expectations include his not acting out in any way during treatment or violating any of his religious commitments. If he has difficulty with alcohol, even if is not full-blown alcohol dependence, we require that he abstain

from all alcohol use during the program. Similarly, in cases of other addictions, such as sexual compulsivity or gambling, abstinence is a requirement of treatment. One of the things that differentiates our program from residential ones is that our clients need to be able to abstain. If they have one lapse, they are placed on probation. If there is a second incident, they are referred to a more restrictive environment.

We also ask that priests not hear the confessions of other program participants, as this limits the process of transparency in the program and complicates the flow of information.

The group process is also explained, although group psychotherapy is more profitably experienced than described. No matter how clearly the concept of feedback is presented, for example, it appears that it is something that can only be learned by doing. But we explain the structure of group, highlighting that respect and candor are the governing values of the process of building an emotionally safe interpersonal environment.

After the orientation session, the client is armed with a basic understanding of the process and a schedule of weekly activities along with a list of appointment times. Ordinarily, the first scheduled activity is group psychotherapy. This is a daunting prospect for most clients, although it also underscores the interpersonal nature of the program overall.

There is a core program in which everyone participates. This includes group psychotherapy three times per week (Monday, Wednesday, and Friday), individual psychotherapy once or twice per week, spiritual direction weekly, and participation in a five-hour psychoeducational training workshop, which is held on Saturdays. Everyone in the program participates in these activities. In addition, individuals may be referred to an Addictions Group (Tuesday) if there is a question of addictive or codependent behavior and/or a Sexual Health Group (Thursday) if there is any issue of a sexual nature that was identified in the original assessment. So a person may be participating in group psychotherapy sessions three to five times per week, a regimen that is sufficiently intense as to enable most people to make good progress on longstanding issues.

Following the orientation session, the client's primary contact with the clinical team is his individual psychotherapist. This is ordinarily a doctoral-level psychologist who sees

the client once or twice a week. It is this relationship that helps ground the client in an attentive, one-to-one relationship which serves a number of functions. It enables a personal relationship within which a person can talk about things that he may be hesitant to address at first in a group setting. It is also a unique support system for the client. A personal therapist is able to track closely the client's mood, his goals, and his apprehensions and resistances to the treatment process. These are all essential elements of the treatment process. In this setting, the client can also explore how he understands things in his personal, idiosyncratic way. This is the type of work at which individual therapy excels. The individual therapist also serves as to 'go-to' person if a crisis arises.

But the clinical heart of the program is group process. Group experiences provide advantages that individual psychotherapy cannot. Whereas individual work is largely based on verbal delineations of ideas, beliefs, and behavior, group process provides a window into the actual behavior of the client, not just what he thinks but how he behaves. It is a laboratory in which the client can practice new skills and observe others doing the same. But perhaps most importantly, we have found that people do in group what they do in life. So if a person is emotionally avoidant or superficial or manipulative or touchy, these features will show up in his interaction in the group process, *whether he intends them or not*. Once they are identified, they can be dealt with much more directly and realistically than simply talking about them.

Because of the complexity of the group process, all of our groups are conducted by two therapists: a male and a female. This has the added advantage of bringing alternative, sex-based perspectives to individual problems, something which is often lacking in religious communities of same sex members. It also allows a client to see if he or she responds differently to males and females. It enables him to track his responses and to identify the extent to which his reactions are conditioned by earlier relationships, such as with his parents. This is a common experience in life that often goes unidentified and can contribute to a host of interpersonal complications. These are the types of things that can be worked out profitably in group.

Also in this setting, beliefs that are operative but often invisible to the client can be illuminated. Alternative beliefs can be explored. The consequences of maladaptive behavior can be seen not just in theory but in practice, and new paths toward greater maturity can be forged *in vivo*.

Finally, it is group which fosters the culture of recovery that is characteristic of intensive treatment. This is a potent construct which provides support, inspiration, and direction to men who need all of these things to help them change behavior, belief systems, and goals. And it is the culture of recovery that makes intensive programming so useful and so much more potent than individual therapy alone.

The structure of group work is straightforward. At the beginning of group, each member checks in, that is, he states what he is feeling, what is of greatest moment in his life at that particular time, and sometimes expresses a desire to 'work', or to talk about something that is important to him. The check-in period is usually brief. Following it, individual group members volunteer to address an issue (to 'work'). At that point, the work is structured by the therapists. They ask questions, provide direction and structure for the work if needed, and apply behavioral techniques as indicated. This may include exploring beliefs, reconsidering attitudes, increasing one's awareness of his behavior, role-playing, checking out perceptions, soliciting feedback, experimenting with a new skill, sharing particularly sensitive information, and the like.

After a person's work with the therapists is completed, the group is invited to give feedback, that is, to share with the person who worked how they felt about his or her work. Feedback is an unparalleled opportunity for clients to be candid with each other in a respectful way. This is in itself a new skill for many of our clients. In addition, people come to treatment for many reasons, some of which are not always easy to listen to. If a person has been abusive or has acted out in a way which violated his vows or has hurt someone, it is helpful if challenging to hear how others feel about that. This is critical in the development of empathy, a feature which is often lacking in those who abuse others. But the fact that even negative feedback is shared in a supportive and respectful environment goes a long way to helping a person see his behavior in a new light. It also sets up a new norm of what meaningful relationships entail. Having people in our lives who are prepared to share difficult feedback is critical to optimal functioning. Many people use their spouses for this, but that option is not available for celibates, so the formation of honest, respectful, yet supportive relationships is key to making a success of the celibate life.

Once feedback is given, the person who worked responds by sharing his thoughts and feelings. Once that is done, another group member volunteers to work. This continues until group ends.

If there is a new person joining the group, he introduces himself to the group at the beginning and shares the main reason he is in treatment. The group then falls into its regular routine. The new client is aware that there is no pressure to respond in the early sessions. This allows him to see how group operates.

Another critical component of the treatment process is the series of psychoeducational training workshops that are conducted weekly. Whereas the group therapy sessions are small—five to eight members, these sessions include the entire client population. They meet on Saturday for five hours to address information and skills that can be taught directly. Some of this information is not new to our clients, but the fact that it is presented in the context of a culture of recovery means that it is more likely to be inculcated into their lives in a meaningful way. It is no longer just information that might pass them by; it is presented in such a way as to be relevant to their particular life story. This is especially important in key areas, such as boundaries. Almost all priests these days have been through some kind of training about appropriate professional boundaries. That does not, however, prevent individual priests from crossing them. But when the information is presented in light of their infraction of the norms and in a setting where they are working to understand their own behavior in a new light, it takes on a different perspective.

The Saturday workshops are not just didactic lectures. They are as experiential as possible, enabling our clients to apply information to their lives in an immediate and reality-based way. This increases the likelihood that the training experience will become part of their behavioral repertoire.

The Addictions Group has a different structure and focus from the intensive groups. It is geared specifically toward learning and working the twelve steps and entails homework and preparation. In this group, clients typically complete the first three steps of the Twelve Steps in their particular area of addiction, so an alcoholic follows Alcoholics Anonymous, a sexaholic follows Sexaholics Anonymous, and so on. Also in this group, triggers to relapse are identified, and the quality and nature of the clients' involvement in ongoing twelve steps groups is assessed.

The Sexual Health Group has sexuality as its major focus, and this covers a wide area. People are referred to this group if they have been engaging in inappropriate sexual behavior, if they have been the victim of sexual abuse of some sort, or if sexuality is not

well-integrated into their lives. This last category is a common one, as it is possible for a person, even if he has not crossed any personal or professional boundaries, to have a sharply underdeveloped notion of how sexuality impacts his life. Sexuality is not something that can be ignored: if there are unresolved issues—around attraction profiles, orientation, intimacy needs—they may show up in ways that are not healthy. For instance, a man may get overly involved with a parishioner short of actually having an affair and may be blind to his own neediness or to the impact of his behavior on others, such as the woman's spouse. Or a person may think that solitary sexual behavior on the Internet is not a problem because no one sees it, when we know that just the opposite is true: it is problematic specifically because it is secret and typically associated with shame and interpersonal isolation. That shame is often rooted in an association with sexuality, a feature that leads to a lack of integration of sexuality in the mature life of a person.

As indicated above in the section on problem identification, sexual difficulties cover a wide range, and the Sexual Health Group is specifically designed to keep the focus on sexual development. In that group, any issue that is related to sexuality may surface, such as the family context of sexual education and maturation, but the emphasis and focus is on how those things impact a person's current appreciation of himself as a sexual being with a commitment to sexual abstinence.

The last critical component of treatment is spiritual direction. Each person is assigned a spiritual director and is seen weekly and as needed by that person. Spiritual direction has several distinct but related functions in a treatment context. The primary purpose is to revivify the spiritual lives of those persons for whom it has lapsed. The abandonment of one's spirituality is ordinarily not a deliberate process, but it is a common concomitant of emotional and behavioral distress. If a person becomes depressed, spiritual sensitivity is one of the first things to depart. If a person has violated his integrity by involving himself in an inappropriate relationship, he may quite unconsciously distance himself from those spiritual practices, such as spiritual direction or regular reflection, which would help him confront the untenable situation he is choosing. Or if a person is workaholic, he might attempt to maintain a prayer life, but that may become increasingly hard to sustain. A life of prayer requires time, patience, and attention. Activity or busyness is a seduction, especially for people involved in parochial ministry, where the demands are often endless and where it is easy with the

best of intentions to throw oneself into work with little regard for the consequences. So reconstructing or rebuilding a spiritual life is a primary task of spiritual direction in the treatment process.

Another major task, however, is to assist the client in understanding what he is going through from a spiritual perspective and translating the things he is learning in treatment into the language of spirituality. We do not attempt to turn our clients into amateur psychologists or therapists. We are treating them for specific conditions. But the language of treatment is notoriously jargon-ridden, as much as we strive to keep our language simple and applicable to day-to-day life. It is the task of the spiritual director to help the client understand and verbalize his growthful experiences in the language to which he has committed his life, that is, the language of spirituality and religion. Key Christian ideas, such as reverence, compassion, respect, struggle, sinfulness, morality, making amends, forgiveness, fasting, and redemption all have a place in this important domain.

It is always good to see a client discharged from the program with an improved state of mind and new skills. It is more reassuring, however, if that client is equipped with the language and spiritual understanding to deepen his progress and to pursue a life of greater spiritual sensitivity for himself and for those with whom he interacts on a routine basis. And this depends on proper spiritual direction.

There is, of course, a natural rhythm to the various group and individual processes in which clients participate. So a person may address an issue in Addictions group and follow it up in the intensive group or in individual sessions. Individual sessions often present material that is profitably pursued in group. The key to the success of this is the level of staff communication, which is high. Since the staff communicates regularly and alerts each other to significant developments, the overall protocol creates an environment which can accommodate various levels of progress in treatment and respond to the client in a unified and professional way. The cohesiveness of the staff is a lynchpin of solid service delivery.

Chapter Five:

Treatment from the Inside: What it's like for the client

So far, we have been dealing with the components of treatment and what is involved in a practical way. But one could profitably ask: What is treatment actually like for the person going through it? What is it that we require of our clients as we help them address the various issues from which they suffer? The answer to these questions is probably different for each person who undergoes a treatment process, but there are some common aspects of the process that apply to the vast majority of our clients. As such, they deserve attention.

Before we explore those elements, however, I would like to emphasize some things that may be so obvious as to be easily overlooked. First of all, treatment of the type we are discussing here is one of the most difficult things that a human being can do. The primary reason it is so daunting is that it requires by its nature that a person identify and examine closely the assumptions under which he has been living his life. This is no small task. We humans cherish our beliefs about ourselves and about the world almost as much as we cherish our lives—principally because we often conflate the two and behave as if one is the other. This being the case, a threat to one's beliefs can feel as if it is a threat to one's life. If one doubts the veracity of this, I recommend speaking to someone who has successfully completed a treatment process.

Secondly, the potency of treatment lies in its distinctly interpersonal nature. What this means for the client is that his life is examined not in the relative obscurity of a single clinician's office, but amidst a group of people who are similarly engaged. So while it is a highly personal endeavor, it is one that is pursued in full view of a group of other human beings. For most of us, this would be mortifying. It often is.

It is for these reasons that those who undergo treatment deserve great respect. They are pioneers in their own lives and have taken a risk that most humans avoid. They have faced shame, embarrassment, challenge, and questioning about the most personal aspects of their lives. This is not for the faint of heart. And it is not to be undertaken without considerable interpersonal support.

As with many aspects of human experience, the source of embarrassment and the source of healing are found in the same activity, which, in this instance, is the

construction of a therapeutic community. Personal disclosure is at the heart of this process: once attained, it breaks down and replaces shame with a healthy transparency rooted in the reality of a person's life.

I have used the phrase 'culture of recovery', referring in a general way to an important aspect of intensive programming. But what is that culture based on? What does it require? These are important questions.

The requirements of a culture of recovery include candor, personal integrity, emotional transparency, and personal responsibility. **Candor** may seem like a low-bar expectation for those involved in Christian ministry. After all, there is a commandment about this and a longstanding tradition of holding fast to the truth. Alas, that does not always translate into complete transparency on the part of priests who seek help. People misrepresent the truth for various reasons and in varying degrees. Disagreeing about the impact of a particular substance, such as alcohol, does not necessarily imply that a person is lying. He may be in denial; he may not understand just how thoroughly alcohol has impacted his life; or he may be correct in saying that it is or was a passing problem. But if that conversation is taking place, it is a safe bet that the person is being as candid as possible. All the more so if a conflict is involved. Heated, candid conversations are no less useful because of the passion they engender. It is the honesty that matters.

Many people understate the extent of their difficulties when they are first sent for assessment. This is true for problematic alcohol use, sexual behavior, a wide range of compulsive behavior, and potentially any behavior that leads to an assessment. This is not so unusual—it usually signals impaired understanding—and is not in itself problematic, especially if a person is able to reverse his position and lay claim to the truth as treatment unfolds, as most people are.

But there is a virulent type of misrepresentation that can make progress in treatment impossible. There is an old adage in AA circles that states that the ability to tell the truth is an essential requirement of recovery. And there is truth to this: If a person continually fudges the facts, misrepresents himself, or if he more or less constantly masks the truth about his experience, his behavior, or his thoughts and feelings, there is little that can be done with normal behavioral techniques to help him deal realistically with his life. If he is able to identify a pattern of such misrepresentation and, with appropriate structure,

hold himself accountable to telling the truth, then there is a possibility for progress. If not, no amount of talking in the world will make much difference. These are generally sad, misguided people who often believe they are exempt from the rules of normal social intercourse.

Integrity refers to the extent to which a person is who he claims to be. This also might seem so simple as to be hardly worth mentioning, but in the life of a priest being who you say you are is a high standard. As an *Alter Cristus*, a priest embodies Christian values. His behavior is held to a higher standard than that of most people. It may be functionally impossible for anyone to live up to that standard one hundred percent in practice, and it is certainly not fair to the priest to expect perfection; but people do. In part, this reflects the esteem in which priests in our culture are held and the importance they have in the lives of their parishioners. Integrity is an essential element of any mature adult's mental health, but for the priest it requires more personal sacrifice and steady attention.

The fact that a priest is celibate is not a side issue in this regard. Most people work out their personal happiness and tune their moral sense in the context of a committed intimate relationship, whether sanctioned by the state in marriage or not, whether they are heterosexual or not, and whether they actually live with the other person or not. Being celibate closes the door to this common human experience. Because of the unavailability of an intimate partner, it is up to the celibate to identify what sustains him: what combination of interpersonal contact, prayer, solitude, leisure, and work leads him to feel secure, useful, and emotionally connected to others. The precise formulations are no doubt different for each person, but a priest or a committed celibate cannot ignore this basic life task and expect to be happy or well-adjusted.

If a priest fails to find this balance, he may often turn to some other proscribed relationship and may do so in secret in the naïve belief that this is a way of 'meeting his needs'. An illicit sexual relationship may indeed fulfill some basic needs for connectedness on the part of a priest, but that fulfillment comes at a cost of his integrity and a surrender of his mental health and well-being.

This is something that is often not well understood outside Church circles. Secular therapists are often more tolerant of illicit liaisons for a variety of reasons, as discussed earlier. A priest may seek therapy because of depression but fail to even bring up an

illicit affair. If he does, he may find the therapist more supportive of the relationship and neglectful of the surrender of personal integrity that can trigger a depressive episode in those so disposed. This is one of the reasons individual outpatient psychotherapy in isolation often does not get to the heart of the matter.

There are many other, less dramatic ways to surrender one's integrity as a priest. One can become overly involved in amassing goods or take up questionable habits such as gambling. He can start spending an inordinate amount of time watching TV or surfing the Internet or golfing. He can become sharp and critical with others and neglect his duties. He can abandon his spiritual life. But to the extent that a person relinquishes his personal integrity, the chances of his making a success of the clerical life diminish.

Emotional transparency is another requirement of treatment. This too is a component of healthy mature functioning, but it is often complicated for a priest, especially for one who struggles with depression or anxiety, illnesses which impact a person's ability to regulate his emotional life normally.

In the United States religious ministry has become increasingly professionalized. This may be an ambivalent prospect from a strictly religious point of view, but the reality is that priests are increasingly seen and treated as professionals engaged in the tasks of ministry: presiding, preaching, counseling, administration, fund-raising, and providing guidance to those charged to their care. As such, they are increasingly liable for claims of malfeasance or even malpractice when their behavior injures someone. This sad fact is at the heart of the disastrous monetary rewards handed out by juries in the last two decades. The point here is that seminary formation and continuing education underscore the professionalized nature of ministry. And, as with many of the professions, the emphasis on professionalism leans heavily in the direction of intellectual development, awareness, and understanding, sometimes to the detriment of emotional development.

Other factors conspire to make dealing straightforwardly with one's feelings a tricky business. Being seen as a person who is in control of himself is a feature of serving others, so priests learn—as psychologists, psychiatrists, lawyers, and physicians learn—to put their personal reactions aside as they focus on the person in front of them. In addition, an emphasis on moral development can at times leave little room for idiosyncratic emotional reactions. Many priests abhor conflict and learn to assume a

passive and/or avoidant role when conflict looms. There is often an overemphasis on the sensitivities of others. Sometimes priests and the religiously inclined may idealize suffering and feel that depression is simply something that must be borne. All of these tendencies can distract a priest from taking his own feelings seriously and finding appropriate outlets for their expression.

Anger poses a special problem. It is one of the Deadly Sins. It is proscribed in Scripture. It belongs to God alone. There are numerous religious reasons to sidestep the anger that every person on the planet feels. In treatment, one of the routine tasks is to assist our clients in facing feelings of anger that have accumulated over the years of avoiding it and equipping them with new skills to work with anger in a more mature, self-possessed way. The rubric of treatment is that anger does not equate to violence or resentment or force: it is simply a strong feeling which, if neglected, will very likely have harmful effects on a person's psychological well-being, possibly his physical well-being, and usually on his interpersonal relationships. In fact, the avoidance of anger is what is more likely to lead to violence or to resentment rather than dealing with such feelings directly. It is an essential skill.

But skill is required to deal with all emotions. Grief is another major emotional experience which is often challenging for a priest, who ordinarily helps others deal with it on a routine basis. Emotional cues, such as fear, loneliness, longing, and desire are things to which all humans could profitably attend. They indicate an area of life that needs attention. Our feelings tell us what a situation means to us in a rapid and unmistakable way; learning to listen to them requires practice and attention.

Finally, **personal responsibility** is at the heart of treatment. All clinical efforts are geared toward helping the client identify his vulnerabilities and take action to limit the negative impact of them on his life. It is ultimately up to him to bring his life into compliance with what is expected of him as a priest and minister of the gospel. It is for this reason that clients are encouraged to identify troublesome patterns of behavior, to explore their origins, and to acquire improved skills. The purpose of examining patterns of behavior from the past, such as in the family of origin, is not to blame one's parents or to remain encased in a victim position but rather to understand how one's behavior developed and to use that understanding to develop mature alternatives in the present. Many people try to force themselves to do better in the present--to stop drinking or to refrain from compulsive use of Internet pornography--but in the absence of close

attention, appropriate clinical support, and genuine understanding, most of those efforts turn out to be futile and often make the problem worse.

Taking personal responsibility for one's life and well-being is a requirement for all mature adults. Unfortunately, the problem with people who end up in treatment is that the ways they have attempted this are in themselves dysfunctional: by drinking, by illicit sexual behavior, or by other proscribed actions. At base, those behaviors often reflect determined but misguided efforts to relieve anxiety, prepare to face one's obligations, or to otherwise sustain a status quo. Unfortunately, they tend not to serve any of those legitimate goals over time. Undoing those efforts does not mean undoing their intent: those are still legitimate goals. It does mean acquiring new, more adaptive ways of achieving one's goals.

The hows of this work is what constitutes most of the literature of psychotherapy. Without detailing those, suffice it to say for our purposes that evidence is increasing that a sustained effort to rework cognitions, acquire improved skills for dealing with emotions, and taking greater possession of our emotional and physical lives is life-changing both internally and externally. In fact, recent research indicates that the staples of self-awareness—i.e., exploring emotions, examining avoidances, identifying recurrent patterns, discussing past experiences, focusing on relationships, and examining the client/therapist relationship—not only provide equal or better improvement than drugs alone for a wide variety of conditions but actually lead to continuing improvement once treatment has ended.

Now, these are sensitive and sometimes delicate tasks. What is it like for a client embarking upon this work? First, it is almost universally anxiety-producing. Someone who is not anxious at the prospect of revealing the most intimate secrets of his life to others is either deranged or hopelessly narcissistic. We encourage people to talk about their anxiety or to see what behavior (outbursts, for example) it might engender. Secondly, this work can hardly be pursued without considerable interpersonal support. This is yet another reason why group work is so important. And finally, the intermediate target behavior is to assist the client in learning the skill of stating a personal issue, asking for help, and learning to resolve it. If a person can do this, he has the skill to deal with many of the challenges life will continue to throw his way. He will, as the old saying goes, learn to fish.

Disclosure is difficult, and deeper disclosure is even more difficult. That is the day-to-day reality of the lives of our clients, who would often be doing almost anything but the therapeutic work they are in the program to do. This is more than understandable. Early in the research on psychotherapy, it was noted that an essential feature of effective treatment was that the therapeutic experience be different from what the person experiences in the rest of his life. That is certainly the case in an intensive treatment program.

Treatment is not a one-way street, although the onus is ultimately on the client, as noted above. Just as it is incumbent upon the client to bring his material to various therapeutic venues, it is incumbent upon the clinical team to maintain an atmosphere where that can realistically be done. In practice, this means that the mental health professionals must maintain an atmosphere of respect, safety, and honesty. Clients can under no circumstances be berated, mocked, or belittled by their therapists. Moralizing or shaming a client is similarly unacceptable. Their feelings must be attended to in the most compassionate ways. And, if asked a question, a therapist is obligated to respond honestly unless there is a specific and compelling reason to withhold information, in which case he or she needs to state that reason calmly and directly.

No matter how stringently therapists maintain these standards, however, some exceptionally sensitive clients will find reason to not feel safe, to feel belittled, or to feel shamed or criticized. It is essential in these circumstances that the therapist assist the client in understanding the roots of his vulnerabilities in another experience. This is often difficult with more disturbed clients, but it is critical to the recovery process that the therapist serve as the truth-teller, the one who hears the client's fear and also understands that a person may be feeling criticized even though no one is criticizing him in the present. It is the therapist who must find a way to make this clear to the client. This kind of phenomenon is not uncommon among those who have been abused as children.

All of these processes take time. While short-term psychotherapy has had a popular run, especially at the behest of insurers who saw in it a more profitable approach, common sense and clinical experience both suggest that changing life-long patterns of behavior is not a quick-fix enterprise. It takes sustained attention with the client at the heart of the process. Even when intensive treatment has been completed, ongoing work

is indicated to ensure that gains made in the process are not swept away in the flow of normal living.

When Intensive Treatment ends, it is followed by two years of Aftercare. This process of transitioning out of treatment and back into ordinary life is a critical one. It is, in fact, the goal of treatment: to return a man to life with improved skills, improved mood, and with greater enthusiasm. The structure of Aftercare is straightforward: a discharge conference, a recovery plan, a reentry workshop, where a staff member meets with the client and significant people in his environment to facilitate reentry, and four return workshops at our facility. All of these activities involve not only the client, but his superiors and others involved in his care as well. Growth is a collaborative effort.

Our Aftercare program—and similar ones at other facilities—lasts for two years. It is our experience that after six months of treatment and two years of sustained follow-up, the changes effected by the treatment process are well-entrenched and the person is free to continue his life with little or no therapeutic involvement. That is, after all, the goal of treatment.

Chapter Six:

Miscellaneous considerations

What can treatment accomplish?

The treatment process as described here is hard work, and it can be helpful in a wide range of human difficulties. Emotional or behavioral disturbances, mood disorders, 'normal' human challenges, vocational issues, interpersonal issues, and the like. There are, however, some human impairments and debilities which are not amenable to improvement using these methods.

There are three broad categories of dysfunction that do not benefit from treatment. These include organic disturbances, psychotic illnesses, and a subgroup of severe personality disturbances.

Organic disturbances include individuals who suffer from brain dysfunction of various sorts: those who have suffered head injury with enduring effects, some stroke victims, those who suffer from Alzheimer's disease or other dementing processes. These people deserve and require attention, but they are generally not amenable to interventions that

are behavioral and/or emotionally focused in the way those services are provided at treatment centers such as ours.

Similarly, if a person suffers from psychotic illness, such as schizophrenia, severe bipolar disorder, or other illnesses where one's grasp of reality is compromised, talk therapy alone is not usually beneficial. In certain cases—if the psychotic symptoms are well-controlled with medication—supportive interpersonal therapy may be of use. However, it is inadvisable to mix populations of normal, neurotic clients with those who suffer from psychotic illness. It frightens the normal group and holds unrealistic promise to the psychotic one. As such, it is detrimental to both.

The third group is harder to identify. There is a subgroup of personality disorders whose patterns of behavior are so deeply engrained and who are so well-defended that efforts to impact their behavior or even their understanding are ineffective. This is most commonly the case for some antisocial personality disorders and narcissistic and borderline personality disorders. The difference is a matter of degree: some of these personality types can be successfully treated, but more impaired ones cannot. Unfortunately, the only reliable way to distinguish the treatable from the untreatable is to attempt treatment and to ascertain in the early stages of the process whether continuing intervention will have an effect. Among this deteriorated group are found those who are incapable of honesty or those who cling desperately to a version of reality which is theirs alone. Also in this category are those people who are so terrified of change that they settle for the status quo no matter what. These are people who gradually find themselves grinding to a halt over the course of their lives, becoming less and less effective over time. Such persons tend not to learn from experience and usually end up marginalized in their communities.

But for those who are amenable to treatment—and this includes the vast majority of priests and religious men and women who need help—treatment of this sort offers an alternative to simply suffering or causing the Church endless irritation and/or scandal. It not only offers relief from depression, anxiety, or other forms of felt distress, but it serves as a transitional point from a maladaptive way of dealing with the world to a healthier, more adaptive one. It enables a person to take greater responsibility for his life, to build a viable support network, and to face the future with a sense of hope and optimism. This is beneficial for the individual and for the Church overall.

Emotional and behavioral disorders tend to sap the vitality out of a person. This is one of the signals that something is wrong: one loses access to the passion of life. Even those behaviors which people at some point in their life find stimulating, such as drinking or sexual behavior, can lead to a corrosive pattern of daily intoxication or monotonous repetition which is neither stimulating nor healthy. It may not even be enjoyable. Yet we humans are creatures of habit, and, unless deliberate action is taken to counter some of our destructive ways, they tend to persist, often for years. This type of work—admitting the loss of vitality, locating the sources, and providing oneself with alternatives—is uniquely a dynamic, human, and psychoeducational task. Pills can't do it, a workshop can't do it, reading a book can't do it. It requires the type of focus, candor, and courage that is only available with human engagement, as has been described earlier in this book. And it typically requires the assistance of knowledgeable, compassionate professionals.

This is not always the case. There are many people who recognize that they drink too much and stop or cut down. There are many people who give up a life of sexual profligacy when they recognize the sterility in it. One doesn't hear much from these people because they do not seek help or end up as statistics. But humans are capable of change, even if the statistics argue otherwise.

Consider, for example, the statistics on weight loss. It has been shown that about eighty percent of people who lose weight gain it back within one year. Two thirds of them gain more. Does this mean that weight loss is hopeless? Hardly. A full twenty percent of people who lose weight sustain it, and a full third do not gain more than they weighed at the beginning. These peoples' experience counts. They do not reflect a small number. While we do not understand all of the factors that contribute to this situation, we have some good and workable ideas: committing oneself to an ongoing program, providing oneself with appropriate support, examining the thoughts, behaviors, feelings, or experiences that contribute to overeating in the first place, paying close attention to food intake. Choosing to make weight management an ongoing priority in one's life. All of these are powerful tools. Alternatively, science devotes considerable research to weight reduction, much of which seems premised on the belief that it is a disease, an inexorable force that is outside the control of the one person who has the final say over what he puts in his mouth. This is not the story for people who successfully lose weight.

It is germane that many positive aspects of life—higher education, artistic accomplishment, asceticism, are not attained by most people. In fact, they derive their respect partly because of this. So the fact that a significant minority of people who undertake to challenge their maladaptive habits succeed is consistent with what we know of most humans and validates what we believe as Christians. It offers hope to individuals, if not always to those engaged in public policy.

The therapeutic perspective:

Therapists and mental health workers are sometimes seen as overemphasizing the weaknesses of human life rather than celebrating its strengths and joys. And to some extent, this may be true. The sad fact is that we err more often by underestimating pathology than by overestimating it. This vulnerability of ours is rooted in a respect for a person's reputation and what we believe to be a healthy respect for the limits of our discipline. If one is to make a judgment about a person, respect requires more than 'gut feeling' or 'instinct': it requires evidence.

Even so, we are often privy to the side of a man's life that others do not see. And what we search for are patterns of behavior. So what might casually be seen as an occasional drink too many may in fact reflect a more serious problem with alcohol when all the facts are known and considered. Similarly with sexual behavior. It is unusual for a person to have a single episode of sexual misconduct, although many claim this. Experience has taught us to scan for patterns beyond what our clients allow others to believe about them. This sometimes surprises superiors.

There was a time when therapists touted 'neutrality' as the preferred perspective. Subsequent research has revealed that neutrality is an elusive commodity. We do not treat our clients from a neutral stance. We ally with the healthy parts of them, and we deliberately espouse Catholic Christian values. We believe that this is the path of maturity for our clients, as they are all believers.

Thoughts on medication:

Psychotropic medications—those substances used to combat depression, anxiety, psychosis, and the like—have gotten a great deal of press. And standard clinical practice is to refer for a medication consult anyone who might possibly benefit from them. This is a wise practice and one which is followed at all major treating institutions.

Medication alone, however, is ordinarily an adjunct to the kind of behavioral treatment conducted for priests and religious. No one would wish to withhold relief from someone who suffers from debilitating depression or anxiety. But nor would it be wise to believe that medication alone is sufficient to impact the array of concerns we have been describing in this book.

Mood stabilizers used to treat Bipolar disorder are particularly important in the management of this enigmatic disorder. These medications make a more decisive difference in the lives of those who suffer from this serious malady. They smooth out the highs and lows of experience. This is clearly helpful.

With regard to medications which relieve anxiety (the 'anxiolytics', such as valium Librium and related substances), it is the case that they are often helpful in the short term. Longer term use, however, raises some concern, not the least of which is dependence upon the substance and related problems withdrawing from use. These need to be carefully monitored.

Final Thoughts

Treatment, like life, is about balance. Overemphasize one aspect or one small part of one's experience—sex or alcohol, for instance, or shopping or relationships or exercise—and the whole gestalt of our life shifts in a perilous direction. There are many ways to make a mess, as Gregory Bateson once observed, and only a few for things to be right.

There are many paths to recovery. For those entrusted to our care, we have selected what we believe are the most useful tools for a person to identify the real difficulties in his life, acquire the skills to address these, and commit oneself to an ongoing program of growth. This is, in our view, the most sensible, the most realistic, and the most evidence-based approach to health and well-being.

We know that professional assistance helps many people. It is arduous work, but it is fulfilling work as well. One of my favorite responsibilities is chairing the discharge conferences for men who are completing the program. It is in these meetings when a measure of perspective is attained, where the superior, the staff, and the client behold the progress that months of work have wrought, where everyone looks up from the

messy process of treatment and points to the results. Most often, it is a humbling and powerful experience.

It is for this that we are engaged in this work. It is for the transformation of the individual and the reverberation of that transformation in the broader Church and the even broader society. It is part of what John Paul II called for in the Church in his call to holiness.

"The aim of all Christian education, moreover, is to train the believer in an adult faith that can make him a "new creation", capable of bearing witness in his surroundings to the Christian hope that inspires him."

— Pope Benedict XVI (The Sacrament of Charity: Sacramentum Caritatis)