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Recommendations and An Enquiry About Alcoholism Among Catholic Clergy

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The Bishops' Committee on Priestly Life and Ministry

Recommendations and An Enquiry About Alcoholism Among Catholic Clergy

The
Bishops' Committee
on
Priestly Life
and
Ministry

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PART I

RECOMMENDATIONS BASED ON THE STUDY: AN ENQUIRY ABOUT ALCOHOLISM AMONG CATHOLIC CLERGY

Alcoholism or chemical dependency is one of the most serious health and social problems facing our society today. It is a disorder which has devastating effects in the spiritual, physical, psychological and social life of the human person. Alcoholism is a serious disorder which limits the person's abilities to experience life's fullness and impedes the opportunities of personal growth. It is a destroyer of family life, of human relationships, of community life, and of personal vocations. Because of its threatening influence to the dignity of the person and the fabric of society, it must necessarily be a major concern to all of us in the compassionate and healing ministry of the Church.

We know that alcoholism or chemical dependency affects people of all ages, walks of life, and professions. In the most recent research sponsored by the NCCB Priestly Life and Ministry Committee, it is suggested that alcoholism is a problem among priests as it is among the general population. It indicates that in many cases insufficient attention has been paid to carefully developed programs, techniques, and policy procedures in relation to alcoholism or chemical dependency among priests. The data shows too that clergy alcoholism is proportionately present in the smallest, as well as the largest dioceses and religious orders. It points out that the personal admission of alcoholism by the priest is particularly difficult. The difficulty stems from the fact that the very symptom of this illness is denial, and possibly because of the often unjust moral overtones associated with the sickness in the past.

While proportions and numbers are significant to perceiving the influence of alcoholism or chemical dependency among priests, our primary concerns are the dignity and goodness of the priest as person, and the effects of his alcoholism on the people whom he is called to serve. Love for our brother is our motive in reaching out with support, assistance and encouragement to priests who are ill because of alcoholism or chemical dependency. The priest as a person has a right to adequate health care, a right to live the ideals of his priesthood and ministry, a right to our understanding, compassion and love. Although there is no cure for alcoholism, we know that there are means of treating the disease. And what excuse can we claim if we do not help a brother priest who is sick from this disease? Fear of hurting him? Fear of making the person angry? Fear of confrontation? Our personal dis-

comfort from such fears is a very small price to pay as a first step in alleviating a brother priest from a dreadful, destructive disease.

Our motive is also a sense of justice toward those people whom the priest is called to serve. These people have a right to the fullest possible experience and expression of the Church's ministry. We recognize that the ministry of the priest is integrally related to and dependent upon the personal growth of the priest. The priest is able to proclaim the Word of God only to the extent that he is free as a person to assimilate that Word in his heart and life. He is able to lead in worship and prayer to the degree that he is free to accept himself and to know his people. He is able to serve the Christian community by involving himself in their life and culture to the point that he is free to be open and vulnerable to their experience of life. The priest can minister for justice to the degree that he is free to respect his personal dignity and the human rights of others. To the extent that alcoholism or chemical dependency enslaves the life of the priest, his personal growth in Christ is limited and his ministry of service to people is impeded.

As bishops we recognize our pastoral ministry in terms of ministering to our brother priests and in terms of serving the people whom we are called to lead. In this spirit of service and love, the following practical principles of rehabilitation in regard to alcoholic priests are proposed for implementation:

1. Alcoholism is a grave disorder which requires the rehabilitation of the whole person: physically, psychologically, spiritually and socially. Its care should definitely include the services of people with expertise in these fields.

2. The bishop must place the weight of his authority behind the alcohol and drug rehabilitation program. The crucial lesson learned in work organizations—in industry, the military and elsewhere—is that top management must be known to be firm and serious about insisting that the alcoholic be cared for.

3. Merely promulgating the program and policy of the National Clergy Conference on Alcoholism, with a covering letter from the Ordinary, is practically useless. It may even be threatening unless there is an operational structure to implement the direction.

4. While respecting his role as Shepherd and concerned Father, the bishop should not attempt to handle the problem case himself. Only in extreme cases may he be called upon to assert his authority. The task of confronting and ministering to the alcoholic priest is best done by a health board or committee, which has the bishop's full trust, and to which he delegates authority.

5. This subsidiary board must have the full approval of the Priests' Council and the cooperation of the Personnel Committee of the diocese. Such integration is essential so that a tone and spirit of loving, fraternal care is evidenced.

6. In fact, this health board cannot function effectively unless it has the full trust and confidence of the clergy of the diocese, especially among the priests who are close friends of the alcoholic priest and who might tend to "cover up" for him.

7. The health board should always have some recovering alcoholics among its membership. These need not be priests unless the latter are competent for the responsibilities. The board should also include a medical person, preferably a recovering alcoholic.

8. The subsidiary authority should not be vested in one person—an Auxiliary, Chancellor, Vicar for Priests—no matter how competent that person is. This is an area where consultation and collegiality are essential to produce positive results.

9. The growing number of successfully recovering alcoholic priests should be utilized in the diocese. These are men who have lived the pascal mystery through their experience of the illness and subsequent recovery process. They are many times men whose personal lives have been enriched and their ministry enhanced through the process. Some of these men are both apostolic and experienced in recognizing fellow alcoholics and doing what is necessary to serve them.

Bishops' Committee on Priestly Life and Ministry
Bishop Raymond J. Gallagher, Chairman
November, 1977

PART II

AN ENQUIRY ABOUT ALCOHOLISM AMONG CATHOLIC CLERGY

BY

THE BISHOPS' COMMITTEE ON PRIESTLY LIFE AND MINISTRY

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of New Orleans

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Introduction

Under a covering letter from Archbishop Hunthausen, a brief questionnaire was distributed in March, 1976, by the Subcommittee on Priestly Affirmation and Support of the Bishops' Committee on Priestly Life and Ministry to all the dioceses and religious orders of men in the United States. After a second wave of questionnaires was mailed out, the total of respondents was 138 dioceses (with 27,815 priests) and 110 religious congregations (with 22,958 members).

Out of the 165 dioceses listed in the 1975 Official Catholic Directory, twenty-seven (16.4%) did not respond to the questionnaire. In the thirty-five largest dioceses of 300 or more priests, ten did not respond. Among the seventy medium-size dioceses of 100 to 300 priests, nine did not answer. In the sixty smallest dioceses with less than 100 priests, eight did not respond.

We need not stop to speculate why these 27 dioceses failed to comply with the request for information about clergy alcoholism, even after a second request was sent to them. The "absentees" from this report represent about one-fifth of the diocesan priests of the United States and they are fairly well distributed over the whole country. On the positive side, however, the actual rate of return—83.6% of all dioceses—is remarkably high for a mailed questionnaire. A similar enquiry, sent to Ordinaries and Major Superiors in 1971 by Joseph McNamara, was ignored by the great majority of them. In the present instance, our best calculation is that this enquiry covers 78.1% of American diocesan clergy.

There is much less clarity about the representativeness of our sample of religious orders of priests. The *Official Catholic Directory* of

1975 lists 101 religious orders of priests, but many of these are subdivided into separate provinces, monasteries or abbeys. It was to these separate addresses that the enquiry was sent. As a matter of fact, the 110 responses we received from them are not proportionately similar to the rate of return from the dioceses. A further complication arises from the fact that many of these religious congregations include brothers and non-priest clerics among their membership. Thus, the data received from them apply to their total membership of 22,958 men, and are not limited to ordained priests.

Although we cannot provide precise statistics on the proportion of priests among the members of these responding religious congregations, we may safely assume that the great majority of them are priests. Among the 110 religious communities under study, the twenty-nine largest have 14,745 members, the thirty-two of medium size contain 5,479, and the forty-nine smallest have 2,734 members.

Opinions and Estimates

In the covering memorandum sent out with this enquiry on March 15, 1976, Archbishop Hunthausen mentioned the "alarming situation concerning alcoholism among our American clergy." Do the respondents to this survey think of alcoholism as an alarming problem among the men of God with whom they are associated? Hardly any of them (1.6%) consider it a severe problem, while half of them (49.6%) feel that it is minimal, or even non-existent, in their diocese or religious community. Bishops and Provincials answering the questionnaire were somewhat more likely than others to suggest that alcoholism is a minimal problem.

There is a significant difference of opinion by size of diocese. In the smallest dioceses two-thirds think it is minimal, as compared to only one-fifth in the largest dioceses. The difference of estimate is found also in the religious communities, with 61% of the smallest, as compared to 14% of the largest, saying it is a minimal problem. (In a separate survey now being conducted of 685 clergy who have gone through treatment for alcoholism, one-fifth (19%) believe it is a severe problem, while only one-eighth (12%) consider it minimal.) [1]

The second opinion we asked centered on the current trend in clergy alcoholism. It is commonly asserted that America is a "drinking culture," that the consumption of alcoholic beverages is on the increase, and that there is a steady rise in the incidence of alcoholism. The general assumption seems to be that the priests simply reflect the drinking patterns of the society around them. We asked for an opinion about this trend among the clergy in the dioceses and religious orders and found that one-tenth (9.8%) of the respondents opine that alcoholism is in-

creasing, while about one-quarter (26.4%) of them have the opposite opinion. The majority, however, think that the trend is continuing the same as before.

One may say that the "optimistic" opinion is that which thinks the problem is decreasing, and we find this view somewhat more often in the religious orders (31.2%) than in the dioceses (22.6%). An interesting contrast emerges, however, according to size of diocese and religious community. The smallest dioceses are more likely (21.2%) than the largest dioceses (12%) to say that alcoholism is decreasing. The opposite opinion emerges among the religious orders, with the smallest less likely (23%) than the largest (44.8%) to report that the problem is decreasing.

Again, the recovering alcoholic clergy we are surveying have a different and more negative opinion. Three out of ten (31%) believe that clergy alcoholism is on the increase and only 12% say that it is declining.[2] This divergence of opinions and estimates raises the question whether we should accept the judgments of the alcoholic respondents or those of the non-alcoholics. In both cases it is a minority which thinks that alcoholism is severe and that it is increasing among the clergy, but this negative minority is larger among the recovering alcoholics than it is among those who answered the enquiry of this sub-committee.

Facts and Figures

We are on safer ground when we leave the area of estimates and opinions and inquire about actual numbers of men who are known to be alcoholics in the dioceses and religious orders. We asked about the numbers who have actually been sent to alcohol treatment centers, and the answers provide what is unquestionably the most accurate information of the whole survey. Since arrangements have to be made, assignments shuffled, and bills paid, we have to assume that the bishops and chancery officers, as well as the provincial headquarters of religious communities, have the facts at hand and put them into the questionnaires.

Some of the respondents, however, refused to divulge the information requested. Five dioceses with a total of 3,509 priests, and one religious order with a total of 1,008 members, did not provide the statistics on their men who had been at alcohol treatment facilities. It seems important, however, to rely on the assumption that the respondents from 133 dioceses and from 109 religious communities have provided a fairly accurate account of the men who have undergone therapy for alcoholism. We did not ask whether, or how many, alcoholic priests have sought sobriety in the fellowship of Alcoholics Anonymous, nor are we in a position of knowledge to estimate this number.

Aside from the reliability of these statistics, there is also the remarkable fact that the rate, or proportion, is the same for diocesan priests as for religious order members. Out of the 24,306 priests in the reporting dioceses, 704 (or 2.89%) have gone to alcohol treatment centers. Among the 21,950 members in the reporting religious communities, there are 632 (or 2.88%) who have experienced in-patient therapy for alcoholism.

TABLE 1

DIOCESAN CLERGY SENT TO ALCOHOL TREATMENT CENTERS BY SIZE OF DIOCESE

	Small	Medium	Large	Totals
Dioceses reporting	51	60	22	133
Priests in dioceses	3,215	10,194	10,897	24,306
Sent for treatment	114	292	298	704
Percentage	3.54%	2.86%	2.73%	2.89%

TABLE 2

MEMBERS OF RELIGIOUS ORDERS SENT TO ALCOHOL TREATMENT CENTERS BY SIZE OF COMMUNITY

	Small	Medium	Large	Totals
Communities reporting	49	32	28	109
Members in communities	2,734	5,479	13,737	21,950
Sent for treatment	70	156	406	632
Percentage	2.56%	2.85%	2.95%	2.88%

It seems important to recognize at this point that opinions are not in agreement with facts when we consider the size of the diocese or religious community. The prevailing notion as we saw above, is that there is proportionately much less alcoholism in the smaller places than in the larger. Opinions about the prevalence and trend of clergy alcoholism differ sharply according to the size of the diocese or religious order. When we look at the actual statistics in the above tables we become aware that size is not an important factor. The proportions of men who are sent for treatment are approximately the same.

The Success of Treatment

The restoration of the clergy alcoholic to sobriety and a normal pattern of life and ministry is the central objective of any program or policy on alcoholism. Here again, we are dealing with facts rather than opinions and appraisals, and the facts of this survey are remarkably similar to the data we obtained in the self-reports from 685 recovering alcoholic clergymen. These men had undergone therapy for alcoholism and from their responses we find that almost three-quarters (73%) are maintaining sobriety, while one-fifth (19%) are still struggling with the problem, and the remaining minority (8%) are still drinking.

We have seen that among the 133 dioceses reporting to this enquiry there were 704 priests who had been to treatment facilities, and that in the 109 reporting religious communities there were 632 members sent to therapy centers. The rates of success in terms of maintaining sobriety are respectively 70% for the dioceses and 74% for the religious communities.

The general similarity of the statistics on recovering alcoholics between dioceses and religious orders, and between the respondents to this committee's enquiry and the recovering priests who reported about themselves, tends to undergird the reliability of the information we have at hand. Oddly enough, the only notable difference is in the proportion (32.8%) of men in the small religious communities who are still struggling with the problem of drink. We do not know whether this is a factor of size of community, or whether some other explanation is needed.

TABLE 3

RESULTS OF TREATMENT FOR ALCOHOLISM BY SIZE OF DIOCESE

	Small	Medium	Large	Totals
Priests sent for treatment	114	292	298	704
Maintaining sobriety	73.5%	68.1%	71.8%	70.5%
Occasional lapses	17.7	24.0	18.8	20.8
Still drinking	8.8	7.9	9.4	8.7

TABLE 4

RESULTS OF TREATMENT FOR ALCOHOLISM BY SIZE OF RELIGIOUS COMMUNITY

	Small	Medium	Large	Totals
Members sent to treatment	70	156	406	632
Maintaining sobriety	64.3%	76.9%	74.9%	74.2%
Occasional lapses	32.8	15.4	16.3	17.9
Still drinking	2.9	7.7	8.8	7.9

One of the pertinent questions on rehabilitation is whether it is better to send the alcoholic priest to a facility exclusively for the clergy or to one that is open for all alcoholics. Among the 124 dioceses answering this question, about two-thirds (64.5%) expressed a preference for exclusive clergy facilities. Among the 93 religious communities giving an answer, the preference was slightly lower (57%).

When we asked opinions on this matter of preference we asked also the reason why the respondent opted for his particular choice. While there was a variety of reasons provided, the main one seems to be based on past experience. In other words, the stated preference generally lies with the type of facility that proved successful in rehabilitating the alcoholic clergyman. Nevertheless, the arguments are sometimes vehemently expressed on both sides of this question. Proponents of "mixed" treatment centers tend to say that "it's the man, not the priest, who has the illness of alcoholism. Priesthood does not set him apart in any other sickness. Association with other alcoholics makes priests realize that they are not priests with a problem, but sick men, no matter what their profession or occupation."

The majority of respondents who express a preference for exclusively clergy treatment centers, tend to argue that "it's easier to get a priest to go there. The therapists are familiar with clerical life and know the special circumstances and areas of stress in a priest's life. Alcoholic priests appreciate the privacy, anonymity, companionship, mutual support, restoration of dignity and renovation of spiritual strength and religious practices."

In our current survey of recovering alcoholic clergy we find that the preference is manifested in a kind of loyalty to whichever treatment center that gave them sobriety. There are some (22%) who had been in one or more treatment centers other than the one from which they finally "graduated," which is the one they recommend. In an attempt to reach a more objective appraisal we made a comparison of results of

therapy at the two types of centers. We have 543 responses (80.2%) from those who went for treatment to exclusively clergy places (Guest House, Paracletes and Southdown). The remaining 134 (19.8%) were at other centers (Chit Chat, Hazelden and Lutheran General, with fifteen men scattered at Alina Lodge, De Paul and Valley Hope).

TABLE 5

COMPARATIVE RESULTS FROM TWO TYPES OF TREATMENT CENTERS FOR ALCOHOLISM

	Sober	Trying	Drinking	Totals
Exclusively for clergy	73.7%	18.2	8.1	(543)
Open for all	70.9%	23.1	6.0	(134)
Both types	73.1%	19.2	7.7	(677)

These crude comparative statistics say nothing about the quality of sobriety enjoyed by the recovering alcoholic, or about the many other advantages or disadvantages he may have experienced in the process of therapy. While the statistics on success and failure are relatively similar for both kinds of treatment centers, there are other aspects of rehabilitation we omit from consideration here.

Those Who Need Therapy

Whether or not the alcoholic priest goes through the rehabilitation process in the company of other priests, the more practical matter is to get him into some kind of treatment in the first place. In our survey of recovering alcoholic priests about two-thirds (64%) believe that clergy have more difficulty than other people in admitting they are alcoholics, and that they put up greater resistance to going for treatment. Only one out of five (21%) claims that he went voluntarily, that no pressure was put on him to go for treatment.

Included in the enquiry mailed out by this sub-committee was the question: "What estimate (or accurate count) do you have of the number of priests in your diocese (or religious community) who have this problem and **should** go for treatment?" In this survey we were not asking about clergy drinking patterns, whether priests in general have a high, moderate, or low consumption of alcoholic beverages. We assumed that the people who undertook to answer the questionnaire knew who the "problem drinkers" are in the diocese or religious community. We saw no need to provide a technical definition of alcoholism (about which even the experts quarrel) but we appreciate that in some instances it may have been difficult to distinguish between genuine alcoholics and con-

sistently heavy drinkers. We are enquiring here only about those recognized alcoholics who are in need of treatment for their addiction.

TABLE 6

CLERGY IN NEED OF ALCOHOL TREATMENT BY SIZE OF DIOCESE

	Small	Medium	Large	Totals
Dioceses reporting	50	57	21	128
Priests in dioceses	3,136	9,584	9,768	22,488
Priests needing treatment	77	181	230	488
Percentage	2.45%	1.89%	2.35%	2.17%

It should be noted that among the 138 dioceses that sent back the questionnaire there were ten (containing 5,327 priests) that failed to divulge information about their priests who need therapy for alcoholism. It is probable that these ten respondents simply did not have the requested information. One may also surmise that in these dioceses alcoholism is still considered a form of moral turpitude and that its revelation would admit a blot on the reputation of the diocese.

TABLE 7

RELIGIOUS IN NEED OF ALCOHOL TREATMENT
BY SIZE OF COMMUNITY

	Small	Medium	Large	Totals
Communities reporting	48	30	27	105
Number of members	2,683	5,113	13,122	20,917
Men needing treatment	51	124	220	395
Percentage	1.90%	2.42%	1.67%	1.89%

There were also five religious congregations (containing 2,041 members) from which we received no information about the numbers of men who are in need of alcohol treatment. The comparative statistics show a close resemblance between the dioceses and the religious communities in the proportions of men who should be in therapy. There is also a fairly clear indication that the occurence of alcohol addiction does not differ significantly by size of diocese or religious community.

One may argue, though cautiously, that the similarity of these proportions indicates not only that the rate of alcoholism does not differ

much among the diocesan priests as compared to members of religious congregations, and that it is present regardless of size of diocese and community, but also that there are acceptable general criteria for identifying alcoholic persons. In other words, we may believe that the respondents to this survey knew what they were talking about when they reported both the numbers of men who had been sent to treatment and the numbers of men who still need treatment.

Rate of Clergy Alcoholism

At this point when we discuss the prevalence of clergy alcoholism in the United States we are no longer relying on the opinions and guesses of observers and commentators. Here we have numerical data. For the first time we have at hand sufficient statistical reports from dioceses and religious congregations that allow us to say with some confidence that the rate of Catholic clergy alcoholism is approximately five percent. The alcoholics identified in this enquiry are both those who have undergone treatment and those who are still in need of treatment. When these statistics are combined, we find that the incidence of alcoholism is 5.07% for diocesan priests and 4.77% for members of religious congregations.

While there are many and diverse opinions about the rate of Catholic clergy alcoholism, there is a paucity of statistical data on the subject. The probe questionnaire sent out in June, 1975, by the National Federation of Priests' Councils, and answered by senate or council presidents in forty-five dioceses, reported that about six percent of diocesan priests are alcoholics.[3]

This estimate by the NFPC representatives seems reasonably accurate in the light of extended and careful research done in the military by Dr. Marc Schuckit. He reported that the actual rate of alcoholism in the U.S. Armed Forces "is probably in excess of five percent," but he adds that "these figures are probably slightly higher in the service than in the general male population." In commenting on his separate study of Navy and Marine Corps officers he remarked that "the Chaplain Corps had a slight but significantly elevated rate of alcoholism when compared with other categories." [4]

A questionnaire was sent out in 1971 by Joseph McNamara for the National Clergy Council on Alcoholism to all the Ordinaries and Major Superiors of the United States. Only three out of ten (29.7%) bothered to return the questionnaire, but the great majority of these (81.6%) felt that alcoholism was not a major problem among the men under their jurisdiction. The point of interest here, however, is that the incidence of alcoholism was estimated to be 4.1% (which the author of the report footnoted as being of "questionable validity").[5]

The survey of 5,475 American priests done for the bishops by the National Opinion Research Center in 1969 provides no information about clergy alcoholism, but it did find that 2.1% reported that they take three or more drinks every day. If these men are not alcoholics, many of them are probably "on the way" to addiction. There are also 7.2% who said they take two drinks a day.[6] In their book, *Problem Drinking Among American Men,* Cahalan and Room write about the "heavy intake" of alcohol and use as a criterion what they call "the relatively low quantity of five or more drinks on an occasion." They found that six percent of American men, 21 to 59 years of age, do this at least four days a week.[7]

A survey of drinking patterns in a sample of American Catholic clergy conducted in 1974 showed that 16% are "heavy drinkers," as compared to 33% of Catholic lay men and 21% of male American adults. "The comparisons reveal also a much higher proportion of abstainers among the Catholic clergy (39%) than among Catholic laymen (9%) and American males in general (23%), a finding that should give pause to those who make generalized estimates about drinking practices (and alcoholism) among the clergy." [8]

Programs for Rehabilitation

Since 1970 the National Clergy Council on Alcoholism has made strenuous efforts to circulate among dioceses and religious orders its program and policy on rehabilitation. In the present survey we asked whether this NCCA program had been instituted and we found that only one out of six (16%) answered in the affirmative. About three out of ten (28%) respondents said they have no need for such a program, and we know from other sources of information that in some dioceses the program has been circulated among the priests with a covering letter from the bishop but it has not yet been put into operation.

The techniques for recognizing alcoholism and for bringing the alcoholic person into the process of therapy are now widely known among people who are experienced in the field of alcoholism. The ability to intervene, however, and to pursue the steps needed for successful rehabilitation, is much more technical than most people seem to realize. When we asked in this survey who "handles" the case of the alcoholic priest we found that in the majority of instances it is done by the bishop himself (55.6%) or by the religious superior (73.3%).

These responses indicate that there is relatively infrequent use made of a duly constituted health board to handle the problem of alcoholism. It appears also that the talent and experience of recovering alcoholic priests are not being sufficiently utilized. In the several dioceses and religious orders that have instituted a program of alcohol

rehabilitation there exists a formalized structure of operation that depends on the bishop or provincial only for his ultimate authority. The actual program is carried out at the intermediary level of persons delegated for this work, but with the strong and ultimate support of higher authority.

Some alcoholic priests are able to regain their sobriety by joining the fellowship of Alcoholics Anonymous, and we have no research data about them. Some alcoholic clergy are hospitalized for two or three weeks while others stay at a treatment facility for three or four months. All types of hospitalization are costly, and professional therapy for the sickness of alcoholism is likewise expensive. One bishop, whose alcoholic priests are maintaining sobriety, remarked that "it would be cheap at twice the cost." Another bishop, however, in a financially straitened diocese complained that the alcoholic priest himself should assume at least some of the financial burden of rehabilitation. In some States, and in those treatment facilities that are accredited, a proportion of the cost is paid by insurance plans like Blue Cross and Blue Shield.

In this survey we asked also about the average financial cost of sending a priest to an alcohol treatment center, but the responses varied so greatly that it is difficult to arrive at an accurate average cost. Much depends on the type of facility and the length of treatment. Some alcoholic priests are able to cope with their illness in a shorter period of time than others. Some may undergo primary treatment and then spend some weeks at a half-way house, during which period they are gainfully employed and contribute to their own upkeep. Perhaps a fairly reliable estimate of the monthly cost of treatment at the present time would be approximately $1,260. The diocesan priest continues to receive his monthly salary while in treatment, as he would if he were hospitalized for any other illness, but there is also the expense of supplying a replacement for his assigned position during his absence.

One of the strongest recommendations made by counselors and therapists in the field of alcoholism is that the recovering alcoholic should become involved in the fellowship of Alcoholics Anonymous after leaving the treatment center. The responses to this survey show that relatively few (3.4%) of them attend A.A. groups exclusively for the clergy, and also that diocesan priests are more faithful to A.A. meetings than are the members of religious orders. The self-report of recovering alcoholic priests reveals that one-third of them seldom or never attend an A.A. meeting.

Aside from regular participation in the fellowship of Alcoholics Anonymous, a factor of gaining sobriety is the promise of a definite assignment on return from treatment. Professionals in the field of alcoholism advise that the recovering alcoholic be returned to the same

position—if he wants it—or to one of equivalent status. Eight out of ten respondents to this enquiry say that most of their recovering alcoholics are returned to the same type of work they had done before going to treatment. This is based on the expectation that the same arrangement would be made if the individual had been absent for hospitalization for any other type of illness.

Generalizations and Reflections

At this point many questions remain unanswered. There are, of course, many other aspects of clergy alcoholism that could profitably be investigated. In this respect, the findings presented here do not pretend to be exhaustive of this perplexing and mysterious illness. It should be clear that we did not attempt to study the alcoholic priests themselves, but only to obtain information and opinions about them from reliable spokesmen in the dioceses and religious communities.

1. This survey reveals that there are more alcoholic priests who have been sent to treatment facilities than there are alcoholic priests who are still in need of therapy for their illness. In general, this seems to suggest that bishops and religious superiors are fairly well aware of the problem of clergy alcoholism and are conscientiously trying to do something about it.

2. Nevertheless, it appears that much more use could be made of the time-tested and pragmatic materials distributed by the National Clergy Council on Alcoholism. In many instances there is evidence that insufficient attention has been paid to the carefully worked-out program, techniques, and policy procedures that are available on request from the NCCA.

3. The survey finding that the "handling" of the alcoholic case is taken over by the bishop or religious superior himself suggests an under-utilization of the increasing number of recovering alcoholic priests who are competent and experienced resource people in the larger dioceses and religious communities. Wherever they are given recognition, delegation and semi-official status they prove to be invaluable aids to Church authorities in confrontation and intervention with fellow alcoholic clergy.

4. While every alcoholic priest is seriously ill and in need of help, the severity, or extent of the alcohol problem among American Catholic clergy tends to be minimized by the respondents to this survey. About half of them label the problem "minimal," and only one out of ten considers it "severe." Similarly only about one-tenth of them think it is an increasing problem among the clergy. These are obviously subjective opinions but it is important to know them and to test them against the facts.

5. While there is a variety and range of speculation about the prevalence of clergy alcoholism, the most significant factual finding of this survey is that the incidence of alcoholism, serious enough to require in-patient therapy, is approximately five percent among the American Catholic clergy. This is a much lower rate than the one-in-ten statistic that is most frequently cited whenever the problem of clergy alcoholism is discussed.

6. Another finding that seems significant in the face of conventional speculation is that clergy alcoholism is not just a big-city problem. The data from this survey indicate that it is proportionately present in the smallest, as well as the largest, dioceses and religious orders.

7. Alcoholism is a progressive disease in the sense that the individual alcoholic will be at one stage or another of his sickness. We have no way of knowing how many priest alcoholics simply decided to stop drinking, or how many of them regained sobriety through the program of Alcoholics Anonymous without having been hospitalized at all. Perhaps the most encouraging fact emerging from this survey is that almost three-quarters of these men are maintaining sobriety after having gone through treatment.

8. Any chronic illness may be subject to relapse, and this is the case with about one-fifth of the priests who have had treatment for alcoholism. Not everyone succeeds in gaining permanent sobriety the first time in treatment, and there are repeaters, as well as some instances in which the illness is not arrested at all. Unless there is permanent brain damage, professionals in the field of alcohol therapy are reluctant to admit that there are any "hopeless" cases.

9. There is a vehement minority sentiment that alcoholic clergy should go for treatment to places where they will mingle with non-priest patients, but the majority of respondents argue in favor of the exclusively clergy facility, and actually send their sick priests there. Some, however, point out that the treatment center of choice should be the one that best meets the needs of the individual alcoholic.

10. Like all extended hospitalization, in-patient treatment for the disease of alcoholism is expensive, but the economic argument is logically made that it is less costly to rehabilitate a priest than it is to train a new one. Some few bishops and religious superiors balk at the expense, but the majority indicate that the restoration of the alcoholic priest to sobriety and a fruitful ministry should be above financial considerations.

11. The respondents to this enquiry appear to recognize that no one is ever completely cured of alcoholism, and that after-care for the maintenance of sobriety calls for regular participation in the fellowship

of Alcoholics Anonymous. While it is commonly asserted that the clergy, like other professional people, are reluctant to join A.A., only about one out of seven respondents (14%) reports that the recovered alcoholic priests do not attend these group meetings.

12. The importance of proper placement for the recovering alcoholic priest is widely recognized in the responses to this survey. In the great majority of cases the priest is returned to the same assignment, or given an appointment of equivalent status to the one he had before going off for treatment. All evidence points to the abandonment of the outmoded concept of using punitive measures for either the active alcoholic or the recovering alcoholic.

Footnotes

[1] This Study is the result of mailed questionnaires answered by clergy who had graduated from six different treatment centers. It was funded in 1976 by the Jesuit Conference on Theological Reflection and the Department of Sociology of Loyola University of the South. The final report, titled *Ardent Spirits Subdued: The Healing of Clergy Alcoholics*, is being prepared for publication.

[2] *Ibid.*

[3] *Probe Questionnaire on Alcoholism in the Clergy*, conducted by the National Federation of Priests' Councils Ministry and Priestly Life Committee, June 1975.

[4] See Marc Shuckit, "Alcohol Problems in the United States Armed Forces," *Military Chaplains' Review* (Winter, 1977), pp. 9-19.

[5] See Joseph McNamara, "Challenge to NCCA Members," pp. 107-111, and also Appendix L, pp. 143-145. *The Blue Book*, Vol. XXIV, 1972.

[6] This question was asked as Item 78 of the Main Questionnaire. The data tapes of NORC Study 5029 are available to social scientists for the kind of secondary analysis from which the above information was derived.

[7] See Don Cahalan and Robin Room, *Problem Drinking Among American Men*, (New Haven, College and University Press, 1974), p. 18. See also Appendix B, "The Drinking Problems Scores," pp. 240-245.

[8] See *The Guest House Experience 1956-1974*, (Privately distributed by Guest House, Lake Orion, Michigan, 1974), p. 33; also Table 11.1 on p. 34.

APPENDIX A

Statistical Tables

These Tables present the statistics separately for the dioceses and the religious communities. The numbers in parentheses represent those who actually answered each question and they vary because in some instances the respondents failed to supply the answer. (Note that in Table 9 the figures in parentheses represent the number of men who had been in treatment centers.)

TABLE 1

ESTIMATES OF THE PREVALENCE OF CLERGY ALCOHOLISM IN DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (138)	Religious (110)	Both (248)
Severe	2.2%	0.9%	1.6%
Moderate	44.9	53.6	48.8
Minimal	52.9	45.5	49.6

TABLE 2

OPINIONS OF THE TREND OF CLERGY ALCOHOLISM IN DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (137)	Religious (109)	Both (246)
Increasing	12.4%	6.4%	9.8%
Staying the same	65.0	62.4	63.8
Decreasing	22.6	31.2	26.4

TABLE 3

SOURCES OF INFORMATION TO AUTHORITIES ABOUT CLERGY ALCOHOLICS IN DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (124)	Religious (103)	Both (227)
Fellow clergymen	30.6%	86.4%	55.9%
Priests and laity	37.1	9.7	24.7
Lay people	21.8	1.9	12.8
Others	10.5	2.0	6.6

TABLE 4

THOSE WHO HANDLE THE ALCOHOLIC CASE IN DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (135)	Religious (105)	Both (240)
Bishop or Superior	55.6%	73.3%	63.3%
Personnel Committee	19.2	6.7	13.7
Health Committee	6.7	11.4	8.8
Designated Person	8.9	5.7	7.5
Others	9.6	2.9	6.7

TABLE 5

DISTRIBUTION OF DIOCESES AND RELIGIOUS CONGREGATIONS THAT HAVE INSTITUTED THE PROGRAM AND POLICY OF THE NATIONAL CLERGY COUNCIL ON ALCOHOLISM

	Diocesan (137)	Religious (109)	Both (246)
Yes, in operation	13.9%	19.3%	16.3%
No, but underway	13.9	9.2	11.8
No	72.2	71.5	71.9

TABLE 6

RESPONSES TO QUESTION WHETHER DIOCESES AND RELIGIOUS CONGREGATIONS WISH TO RECEIVE COPY OF NCCA PROGRAM AND POLICY

	Diocesan (136)	Religious (109)	Both (245)
Yes	61.8%	51.4%	57.1%
No, have our own program	12.5	17.4	14.7
No need of it	25.7	31.2	28.2

TABLE 7

PREFERENCE FOR TYPE OF ALCOHOL TREATMENT CENTER BY DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (124)	Religious (93)	Both (217)
Exclusive for clergy	64.5%	57.0%	61.3%
For both lay and clergy	24.2	23.7	24.0
Either or both	11.3	19.3	14.7

TABLE 8

DISTRIBUTION OF TREATMENT FACILITIES TO WHICH ALCOHOLIC CLERGY WERE SENT BY DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (126)	Religious (84)	Both (210)
Guest House	66.7%	66.7%	66.7%
Paracletes	28.6	27.4	28.1
Southdown	12.7	28.6	19.0
Hazelden	15.9	15.5	15.7
Chit Chat	4.8	13.1	8.1
Schick-Schadle	6.3	6.0	6.2
Local Alcohol Units	56.3	48.8	53.3
Other Centers	30.2	13.1	23.3

TABLE 9

NUMBERS OF ALCOHOLIC PRIESTS IN DIOCESAN AND RELIGIOUS CONGREGATIONS WHO HAVE BEEN IN TREATMENT CENTERS, WITH PERCENTAGES ON RESULTS OF TREATMENT

	Diocesan (704)	Religious (632)	Both (1,336)
Maintaining sobriety	70.5%	74.2%	72.3%
Occasional lapses	20.8	17.9	19.4
Still drinking	8.7	7.9	8.3
Total clergy	(24,306)	(21,950)	(46,256)
No answer for	(3,509)	(1,008)	(4,517)

TABLE 10

DISTRIBUTION OF RESPONSES TO QUESTION ON WHO PAYS THE COST OF TREATMENT FOR ALCOHOLIC CLERGY IN DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (130)	Religious (95)	Both (225)
Diocese or community	71.5%	92.6%	80.4%
Insurance	15.4	7.4	12.0
Diocese and priest	13.1	0	7.6

TABLE 11

ATTENDANCE AT A.A. GROUPS BY RECOVERED ALCOHOLIC PRIESTS IN DIOCESES AND RELIGIOUS CONGREGATIONS

	Diocesan (126)	Religious (80)	Both (206)
Clergy A.A. groups	4.7%	1.2%	3.4%
Lay and clergy	80.2	60.0	72.3
Both kinds	9.5	11.3	10.2
Neither	5.6	27.5	14.1

TABLE 12

EXTENT TO WHICH THE RECOVERED ALCOHOLIC PRIESTS IN DIOCESES AND RELIGIOUS CONGREGATIONS RETURN TO THE SAME TYPE OF WORK THEY HAD PREVIOUSLY DONE

	Diocesan (128)	Religious (84)	Both (212)
Most of them	82.0%	78.6%	80.7%
Some of them	11.7	15.5	13.2
None	6.3	5.9	6.1

APPENDIX B

The Questionnaire

ENQUIRY ABOUT ALCOHOLISM AMONG THE CATHOLIC CLERGY

BY

THE SUBCOMMITTEE ON PRIESTLY AFFIRMATION AND SUPPORT

OF

THE BISHOPS' COMMITTEE ON PRIESTLY LIFE AND MINISTRY

March-April, 1976

1. From your experience and observation would you say that in your diocese (religious community) the problem of clergy alcoholism is:

   1. ☐ severe 2. ☐ moderate 3. ☐ minimal

2. In looking at clergy alcoholism as a "trend," would you say that in your diocese (religious community) it is:

   1. ☐ increasing 2. ☐ staying the same 3. ☐ decreasing

3. What estimate (or accurate count) do you have of the number of priests in your diocese (religious community) who have this problem and **should** go for treatment?

   Number: ________________

4. How do you "discover" those priests who are said to be drinking excessively, or are considered alcoholics, i.e., do fellow priests report them, does the word come from physicians, from the laity?

5. Who handles the problem case, i.e., who figures out what to do about the alcoholic priest?

   1. ☐ Bishop himself (religious superior)
   2. ☐ Clergyman designated for this
   3. ☐ Clergy personnel committee
   4. ☐ Clergy health and welfare committee
   5. ☐ Some other arrangement, which is: __________________

6. The National Clergy Conference on Alcoholism (Episcopal Moderator: Most Reverend Andrew J. McDonald) distributes a Policy and

Program on Alcoholism. Have you instituted this Policy and Program in your diocese (religious community)?

1. ☐ Yes, in operation 2. ☐ No, but it is underway 3. ☐ No

Enquiry About Alcoholism Among the Catholic Clergy, March-April, 1976

7. If the NCCA Policy and Program is not in effect in your diocese (religious community), would you like to receive a copy of it?

   1. ☐ Yes 2. ☐ No, have our own program 3. ☐ No need of it

8. How many of your priests have actually gone to a treatment center for alcoholism (do not include those who are deceased):

   Number: ----------------

9. To which treatment centers have they gone?

   ----

10. As far as you know, what proportion of your clergy who have had treatment for alcoholism are now:

    1. ( ) Maintaining sobriety
    2. ( ) Trying, but with some lapses
    3. ( ) Still drinking

11. In you opinion, is it better to send the alcoholic clergy to:

    1. ☐ A treatment center exclusively for priests
    2. ☐ A center that treats all types of alcoholics

12. What is the main reason for your response to the above question?

    ----

13. What is the average financial cost of sending a priest to an alcoholic treatment center:

    Dollars: ----------------------

14. Who pays this cost?

    1. ☐ The priest himself

    2. ☐ The diocese (religious community)

    3. ☐ Other: ___________________________

15. In general, does the recovered alcoholic priest return to the same type of work he had previously done?

    1. ☐ Yes, most of them   2. ☐ Some of them   3. ☐ No

16. After treatment do these men participate in A.A. groups?

    1. ☐ Exclusively for priests   2. ☐ Other types of groups

17. Please provide the names of one or two priests in your diocese (religious community) who are actively engaged in the apostolate to alcoholics:

    ________________________   ________________________

18. Please provide the name and address of the person responding to this enquiry:

    Name ____

    Address ____

    Diocese: ____
    (religious community)

We would appreciate any comments that may be helpful in furthering the rehabilitation of alcoholic clergy.

N.B. Should you have your own policy and program would you kindly send a copy with this questionnaire to:

1312 Massachusetts Ave., N.W.
Room 501
Washington, D. C. 20005