Impaired Clergy: Applications of Ethical Principles

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Impaired clergy present problems for themselves, for those whom they serve, and for the profession itself. An ethical decision-making model is described to assist professionals in clarifying ethical issues and deciding on an appropriate course of action.

The problem of impaired clergy has been the focus of attention in recent years (e.g., Bissell & Haberman, 1984). Although there are little or no data regarding the number of impaired clergy, it is clear that no profession is exempt from the problems of impairment. For example, the prevalence of impaired physicians has been estimated to be at least as high as in the population at large; those physicians also are 30 to 100 times more likely to become addicted to narcotics (Angres & Busch, 1989). McNees & Godwin (1990) found that 19% of pharmacists and 41% of pharmacy students had used a controlled substance without a prescription order. According to a Gallup poll, the clergy reported alcohol as being a problem in their immediate families nearly as often as it has been found for the general public (Bissell & Haberman, 1984).

Members of the clergy experience increasing stresses, such as more demands on their time with fewer resources (both monetary and volunteer labor) available. As congregation members experience the stress of economic hardship, they may have less money and time to give to their place of worship, and yet those people may have greater need for the clergy's support during difficult times. The clergy may feel increasingly isolated as they take on the function of being the strength for others, and they may not seek help to work through the stresses of their own life. These stresses may make the clergy vulnerable to impairment.

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Although impairment is most often thought of in terms of drug and alcohol abuse, the problem is broader. In its "sick doctor statute," the American Medical Association (AMA) defined impairment as "the inability to practice medicine with reasonable skill and safety due to physical or mental disabilities including deterioration through the aging process or loss of motor skill or abuse of drugs or alcohol" (AMA Council on Mental Health, 1973). Walzer (1990) added that "Notable distraction or dysfunction secondary to unremitting situational crisis, such as marital or financial stress, also would qualify where professional skills, conduct, or responsibilities are compromised" (p. 131). In a similar vein, Laliotis and Grayson (1985) defined impairment as "interference in professional functioning due to chemical dependency, mental illness, or personal conflict" (p.85). Kutz (1986) indicated that there is a "diminishment from a previously higher functioning" (p. 220). In this article, a broad view encompassing the foregoing definitions is used.

The concept of personal conflict as an issue of impairment may be particularly significant for the clergy, because there is general presumption that members of the clergy are somehow immune to personal conflict and impaired judgment. Because they are assumed to be experts in what is moral and ethical, the general public (and the clergy themselves) may expect them to practice higher standards of personal and professional behavior. Fortune (1991) pointed out that

> Our profession, unlike many others, brings us in an ongoing way into some of the most intimate, sacred and fragile dimensions of others' lives. Paradoxically, it is because of these intimate connections that we, as ministers, face the risk of engaging in inappropriate or unethical behavior with those persons whom we serve. (p. 17)

For example, in a poll of readership among the clergy, 24% of the respondents admitted to having sexual experiences outside of marriage ("How Common," 1988).

Impaired clergy present a serious and complex problem for the religious organization in general, the congregation, and its individual members. The potential for malpractice and poor judgment on the part of impaired clergy poses serious risks for the organization and its members. Decision making regarding impaired clergy is complicated because different and seemingly contradictory ethical actions may be indicated. Also, there are risks for the impaired clergy's denomination as well as for the profession. The religious organization may lose income, suffer from adverse public relations, and experience mismanagement of resources, increased liability, and losses resulting from litigation.

There are many difficult and complex ethical dilemmas for a colleague or a counselor of the clergy who is seeking to assist an impaired clergyperson. Dilemmas include the duty to warn clients (those who use the impaired clergyperson's service) versus the obligation to maintain the impaired clergyperson's confidentiality; the impaired clergyperson's voluntary treatment versus coerced treatment or even refusal of treatment; and informed

consent on the part of the consuming public, that is, those who may become clients of the clergyperson.

As mentioned, the issues are complex. How can a colleague think through such dilemmas to ensure that he or she is assisting impaired clergy in an ethical manner? A review of the literature reveals little information to assist a colleague, a congregation, or a church official to make ethical decisions concerning impaired clergy. Mines, Anderson, and Von Stroh (1991) presented a general discussion of ethical principles that can be used in considering ethical decision making with impaired professionals. The remainder of this article applies these principles specifically to the clergy by presenting a framework of multiple levels of justification for thinking through ethical dilemmas. There is a description of the "tiers of justification" in ethical decision making (Beauchamp & Childress, 1989, p. 16; Kitchener, 1984), a description of five ethical principles, and an application of these principles to a specific ethical dilemma.

The first tier is moral intuition, which includes gathering of facts and ordinary moral senses. Sometimes this level of reasoning may be sufficient, necessary, or both. Instances that require immediate action do not offer the luxury of time and reflection. But as Kitchener (1984) pointed out, sometimes our "moral intuition is not enough" (p. 44). For example, a given situation may be too emotional or complex for people involved to make a simple decision. When such a situation occurs, it is necessary to use a more reflective thinking process.

The second tier is the critical-evaluative level of reasoning. At this level people can "evaluate or justify our ordinary moral judgments" (Kitchener, 1984, p. 45). This level is hierarchical and includes (a) rules, professional codes, or the law; and (b) ethical principles.

Professional codes, such as the *Code of Ethics* of the American Association of Pastoral Counselors (AAPC, 1991), and state laws provide the initial direction for a person to evaluate moral intuitions. Sometimes ethical codes may conflict with the law. For example, on a basic level, the codes may require confidentiality, whereas the law on child abuse requires that confidentiality be broken even when there may not be imminent danger. It is impossible for professional or legal codes to be able to account for every unique situation.

When discrepancies occur between professional codes and the law, there is need for a "higher level of level of norms called principles" (Kitchener, 1984, p. 46). These ethical principles provide a framework for a colleague to understand ethical situations. This level of justification involves the application of the principles discussed in the following paragraphs (Beauchamp & Childress, 1989; Kitchener, 1984).

Autonomy has been understood to include both freedom of action (i.e., freedom to do what one wants in life as long as it does not interfere with similar freedoms of others) and freedom of choice (i.e., freedom to make one's own judgments) (Kitchener, 1984). Restrictions on the autonomy of impaired

clergy include (a) no harm to one's self or depriving others of autonomy and (b) competency on the part of impaired clergy, which assumes the ability to make competent and rational decisions. The most difficult ethical decisions come when an impaired clergyperson is neither totally competent nor incompetent.

Nonmaleficence has been defined as "above all do no harm" (Kitchener, 1984, p. 47). Harm has been defined as "injury to something in which a person has a genuine stake. Those things in which one has a genuine stake are both permanent (one's health and security) and temporary (a piece of property that one plans to sell)" (Rich, 1984, p. 123). *Webster's New World Dictionary* (1988), in its definition, includes mental or emotional hurt or damage. Generally, as the risk and magnitude of potential harm by or to the impaired clergyperson increases, ethical prohibitions and limits on treatment increase. Ethicists argue (Beauchamp & Childress, 1979; Kitchener, 1984) that when all things are equal the best possible action is to do no harm. Sometimes, however, it is easier to document the harm versus the potential good (Kitchener, 1984).

Fidelity is considered to be "faithfulness, promise keeping, loyalty" (Kitchener, 1984, p. 51). Issues of fidelity can arise when an impaired member of the clergy enters a voluntary relationship having obligations and boundaries (with, for example, a parishioner or as a client of a treatment provider). Informed consent explicitly establishes the nature of the therapeutic relationship and the requirements of both parties that sustain it. In treatment, fidelity makes the impaired clergyperson a joint participant in the process rather than someone who is fixed, cured, managed, or processed (Kitchener, 1984). There is also the issue of public trust. The clergy are often more integrated into the fabric of their clients' lives than are most other professionals. For this reason, violation of the principle of fidelity by a member of the clergy is especially grievous.

Beneficence has been defined as contributing to health and welfare, or doing good for others (Kitchener, 1984). A balance of beneficence with autonomy leads to ethical concerns regarding paternalism. Paternalism presumes that a colleague or treatment provider has knowledge of what is good for impaired clergy and undertakes to regulate that person's behavior according to what the treatment provider believes is good.

Justice in the broadest sense means fairness (Kitchener, 1984). Issues of justice arise over (a) conflicts of interest involving limited goods and services and (b) limited human benevolence. Justice is based on the assumption of equal treatment for all. If people are not to be treated as equal, an argument must establish a rationale for differences in treatment.

The remainder of this article examines the ethical principles and levels of justification when applied to a specific ethical dilemma. In this way, the aforementioned tiers are illustrated. The ethical principles are applied both to an impaired member of the clergy and to a colleague considering intervention

with that person. It is the intention of this article to demonstrate the difficulty and complexity of the issues and to emphasize the need for thorough evaluation of the ethical principles in decision making.

Suppose there is a situation in which a male clergyperson is sexually involved with a parishioner he is counseling for spiritual guidance, not knowing that the parishioner, a woman, is a survivor of sexual abuse and has a multiple personality disorder. As the affair continues, her psychological condition deteriorates substantially and she becomes suicidal. Suppose furthermore that the clergyperson claims the parishioner initiated the sexual contact and that she was a "willing participant." In fact, he claims that the parishioner, even in her present despair, says she "still loves" the clergyperson. How can the ethical principles be used to critically evaluate this situation?

Autonomy allows for freedom of choice and implies that the impaired member of the clergy can choose to do what he or she wants as long as it does not interfere with the rights of others. Restrictions on autonomy include not harming others (such as counseling clients or parishioners) and being able to make competent, rational decisions. Factors such as sexual addiction, personal or marital problems, overwhelming loneliness, stress, or sociopathy may affect the clergy's ability to make competent rational decisions. The autonomy and competence of the woman in this situation is also at issue. She is not likely to be capable of making competent, rational decisions, given her suicidal ideation and multiple personality disorder. A colleague contemplating intervention must consider restricting the clergyperson's autonomy, basing such consideration on the need to protect the clergyperson's clients. Is the harm being done sufficient to warrant restricting his autonomy? What is the risk of more serious harm to the woman? What will best help her and protect the public trust? What kind of intervention will assist the clergyperson in rehabilitation rather than have the clergyperson (and other members of the clergy in similar circumstances) keep his or her problem a secret and not seek help.

Beneficence requires a balance of the clergyperson's autonomy with what is good for the woman he is counseling. Having sexual relations with her may be his autonomous decision, but in the context of his counseling relationship with her, it is causing her harm. There is also the question of her ability to make an autonomous decision. Her psychological condition can cloud her ability to make an informed choice. She is looking to her clergyperson as an expert in helping her with serious personal problems and she is trusting him to act with beneficence. In reality, he probably does not have any training or experience in treating or even recognizing her multiple personality disorder, or that she is a survivor of sexual abuse (Young, 1989). A trained therapist would readily recognize her seductive behavior as a potential symptom of childhood sexual abuse.

One might also ask about the more subtle psychological problems that the clergy would be likely to encounter in giving spiritual guidance to clients in

general. It is important for the clergy who do counseling to be able to recognize situations that overstep the limits of their competence and to refer these individuals to qualified, trained professionals (Young, 1989). Beneficence on the part of a colleague making an intervention may involve confronting the person with how he is misusing his role and going beyond his limits of competence in treating this woman's psychological problems. In addition, it is the responsibility of the denomination to educate and monitor its clergy in practicing within the limits of competence. In that way, situations such as the one related can be avoided.

In this example, the clergyperson has multiple dual role relationships with the woman; he is pastor, counselor, and sexual partner. These dual role relationships run the continuum from benign (pastor) to abusive (sexual partner). Dual roles become inappropriate and abusive when (a) there is an incompatibility of what is expected in each role, with increased potential for misunderstanding and harm; (b) differing obligations in each role result in a loss of objectivity and potential for divided loyalties; and (c) because of the difference in power and prestige between the clergyperson and the person counseled, there are the problems of exploitation and a client's inability to remain objective about what is in her or his own best interest (Kitchener, 1988).

Unequal power in relationships can create potential abuse or exploitation because the person in the less powerful position may not have the resources or autonomy to make an informed choice regarding an intimate relationship with the more powerful person. In counseling, the client can be exploited or abused emotionally, sexually, financially, or physically as a result of the power and prestige differential. In the situation examined thus far, it is obvious that what may have originally been defined as a "love relationship" by the participants is actually an abusive relationship because of the power and prestige differential as well as the vulnerability of the client. The psychological dynamics of the client by definition create a vulnerability that the clergyperson has an ethical obligation to protect. It is ultimately the clergyperson's responsibility (not the client's) to maintain objectivity and protect the client rather than to meet his own needs through a dual relationship. The principle of nonmaleficence, doing no harm, is now being violated by the clergyperson. His inappropriate and abusive sexual relationship with her is incompatible with the counseling relationship and, as a result of this serious violation of the professional role, her condition is deteriorating. Therapeutic intervention with this clergyperson and his client-lover is crucial and may minimize the potential for further harm by getting each of them appropriate treatment to begin to address the harm that has been done already.

Fidelity (faithfulness, promise keeping) issues are involved because the woman in this case has entered into a voluntary counseling relationship with her clergyperson. The counseling relationship is an implied contract involving ethical obligations and boundaries (Kitchener, 1984). The dual relation-

ship, by introducing a sexual relationship into the counseling setting, disregards the recognized boundaries of the counselor relationship and violates the implied contract, as well as ethical and possibly legal codes of conduct.

The principle of justice requires equal treatment for all parties, unless there is a compelling reason for inequity. In this case, the clergyperson has treated this woman differently from the way he probably would treat another person in a counseling relationship. Regarding intervention with this clergyperson, justice requires that his problems be acknowledged and that he be provided with appropriate rehabilitative treatment in the same way that other impaired clergypersons would be, unless there is reasonable cause to do otherwise.

Colleagues with knowledge of any impaired clergy have an ethical obligation to those clergypersons, to individuals who have been harmed, to congregations, and to the denomination to act. Colleagues must use the same ethical principles to guide their actions. The clergyperson's confidentiality must be respected unless there is sufficient cause to violate it, such as the individual's refusal to change combined with the potential for further harm. Each denomination may have specific rules or laws regarding conduct of its clergy. These rules or laws may enhance or impede the identification of an impaired clergyperson because of the perceived costs to the impaired clergy. Sometimes these rules, if they are punitive, may be at cross purposes with psychological interventions regarding rehabilitation.

Each denomination has additional questions to consider. What standards of training and practice will be required, especially in the area of counseling, and how will those requirements and counselor expertise be monitored? Many members of the clergy practice alone, with great autonomy and little supervision. How will the denomination ensure ethical practice within the limits of competence? How does the denomination monitor the practice of identified impaired clergy? The denomination has an ethical obligation to the clergy as well as to individuals and groups who have been harmed or may be harmed in the future by impaired clergy. There can be a delicate balance between the clergyperson's confidentiality and the duty to warn those who may be harmed. Does the denomination assist the clergy with rehabilitation and help individuals and the congregation through the crisis? Is the clergyperson punished by dismissal, without treatment for the problem? Or does the denomination shuffle "problem" clergy to another congregation, hoping the problem will just go away? The aforementioned actions do not provide an ethical solution for the clergy or the congregations involved, and in recent years many denominations have paid a high price for "protecting" clergy while not appropriately caring for those who have been victimized. In reality, when individuals feel that their victimization is acknowledged and appropriately dealt with, litigation may be averted.

There are better and worse ways to manage impaired clergy. Although disciplinary action, legal action, or both may be appropriate and necessary, the denominations should consider developing processes that encourage

rehabilitation and not just punishment. The punishment-dismissal model often results in the impaired clergy keeping their problems secret. As with many problems, they just get worse before they get better unless there is an intervention. Many organizations and businesses are recognizing the importance of assisting their valuable employees to recover rather than ignoring problems or summarily dismissing the employee. Society and the denominations have invested considerable resources in training the clergy, and it behooves the denominations and the counselors to consider how the impaired clergy can be helped rather than dismissed summarily.

Ideally, the impaired clergy would seek treatment voluntarily, but realistically, this may not happen. The denomination may also make treatment mandatory depending on the employment agreement, and may impose other requirements, such as restrictions of practice and practice oversight, as a safeguard. If the clergyperson does not comply with such requirements, then it becomes an issue of job performance, and the person may be dismissed. In this way, the denomination can work toward rehabilitating the offender while also protecting the public.

Employee Assistance Programs (EAPs) and Peer Assistance models can be economical resources to keep such employees on the job. These types of programs provide sources of assessment, referral, case management, and treatment monitoring. From a case management viewpoint, the impaired clergyperson may be treated at the appropriate level along the continuum of care (e.g., the continuum includes outpatient as the least restrictive option, to intensive outpatient, to partial or day treatment, to inpatient as the most restrictive option). EAP or peer programs protect the impaired clergyperson, as well as the denomination. The positive side of rehabilitation is that professionals who are employed and have undergone the process enjoy a good success rate. The examples set by role models within specific religions include combining confrontation and compassion. Such examples may well serve the clergy and those who counsel them.

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