Chapter Six: The Healthy Sexuality Model

Before the Fall: Preventing Pastoral Sexual Abuse
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In Part One we have attempted to understand the sexuality "offending moment," the point at which the unhealthy dynamics of an offender, victim, and the environment converge. In Part Two we will outline ways in which we might begin preventing such moments. In Part One, we talked about the fact that other forms of abuse by a potential sexual offender may precede the sexually offending moment. In Part two our attention will focus on **assessing and developing candidates for ministry in healthy ways**. To do this we must begin by understanding what we mean by healthy sexuality. The opposite approach in assessing a person's capacity for destructive sexuality is to assess their capacity for healthy sexuality. **The screening of candidates for ministry demands that we have a model of what we mean by healthy sexuality.** Our experience in various theological schools and ecclesiastical forums has demonstrated a rather pronounced need for this model. In this chapter we will present a model of healthy sexuality that can be used as a guide to help us in this assessment.

We believe that a model of healthy sexuality should be more broadly defined than genital sexuality. It should include wider dimensions of a person's experience than purely biological ones. **We also believe that a person's ability to experience healthy sexuality depends on their ability to be close to God, to themselves, and to others.** The word intimacy best describes the state of being close. A person can be intimate intellectually, emotionally, spiritually, and/or physically. People can be intimate in one of these areas and not the others. When we broaden the definition in this way, we include the possibility that healthy sexuality may not even involve genital sexuality.

We need to distinguish the difference between the state of intimacy and the capacity to be intimate in healthy ways. The state of intimacy can occur in healthy and unhealthy ways. **For example, physical intimacy can occur without emotional, intellectual, or spiritual intimacy being a part of the relationship**. From our moral perspective we believe that this is not healthy. The **capacity to be intimate** includes abilities such as trust, honesty, vulnerability, self-disclosure, response to the other's self-disclosure, courage to take risks, awareness of the needs of the self and of the other, and communication skills.

A healthy person will be able to make healthy choices about which kinds of intimacy are appropriate in a given relationship. They will know and accept the boundaries between the kinds of intimacy. An unhealthy person cannot make these healthy choices because they allow their needs in one area to be confused with their needs in another. For example, a person with needs for emotional intimacy may confuse those with needs for physical intimacy. As we have discussed, many who sexually offend are equating sex with love and nurture. Others confuse sex with power and control.

Evaluating and preparing people for ministry, among other things, means that we help them evaluate their capacity for appropriate holistic intimacy. We believe that if a candidate has this capacity, there will be much less likelihood that he or she will sexually offend. This, of course, does not preclude other factors, such as environmental ones, from overcoming even the healthiest of people.
With potential students in the admissions process, there are **a few obvious factors** that we can pick up through background checks and psychometric evaluation. However, the greater

percentage of these students have not as yet acted in ways that cause evaluative or psychometric alarm.

A model of healthy sexuality should allow us to do **two things**: **First**, it should help us identify the capacity for healthy sexuality. **Second**, it should give us a direction about developing and forming that capacity even in people who in early assessment demonstrate many deficiencies for it. We are not as much interested in screening out as we are in the process of building and forming. In this chapter we would like **outline and explain such a model**. In the rest of Part Two, we would like to offer ways of **implementing the model**.

We also believe that a model of healthy sexuality should not define morality but should fit well with one's own theological and moral interpretations. We propose then that such a model should include the following five interrelated dimensions. These are (1) personal, (2) relational, (3) behavioral, (4) physical, and (5) spiritual *(see Figure 3).*

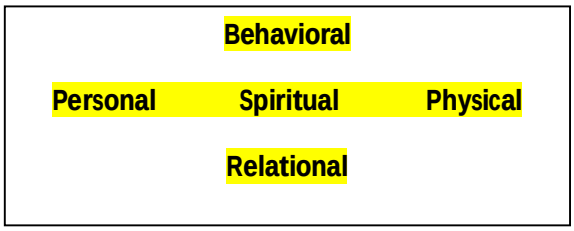

Fig.3: Healthy Sexuality

Following is an explanation of the key questions and elements of each of these dimensions.

1. Personal Dimension

The central questions of this dimension are, "**Who am I as a sexual person**? What are the messages and identities that I have been given? What impairments did I suffer developmentally that prevent me from being intimate? The answers to these questions depend on a variety of factors, including:

- ***Sexual Identity.*** By this we mean whether or not a person considers himself or herself as male or female. In addition, does he or she experience himself or herself as attractive?

- ***Sexual Orientation.*** What does person consider his or her sexual preference for a sexual partner to be?

- ***Sexual Role Assignment.*** What messages, cultural and otherwise, has a person received about his or her role as a male or female?

- ***Sexual Trauma.*** What sexual or other traumas has a person experienced that will affect his or her perception of self as a sexual being and his or her ability to function as a sexual partner?

- ***Developmental History.*** How has a person completed the developmental states appropriate to their age? How does this affect the person's ability to attach and bond in healthy ways?

When we discover dysfunction in any of these areas it is an obvious danger. Such dysfunction may or may not reflect serious psychological pathology as might be diagnosed on Axis II of DSM-IV. Remember that the results of the Irons/Laaser study of twenty-five offenders revealed almost no serious Axis II personality disorders. Such dysfunction, however, does reflect a serious vulnerability to the influence of other dysfunctional factors.

One of the most obvious dysfunctions would be that of unresolved sexual trauma. The shame, anger, and fear of this condition predisposes a person to be vulnerable to unhealthy sexual expression. Sexual trauma experienced at crucial developmental relationships. For example, a man traumatized

in early development may have anger at the gender of the parent or guardian who neglected to protect him from the trauma. How will this anger be played out?

Such questions cause us to wonder about appropriateness for ministry of sexual-trauma victims. Is a sexual trauma victim who has not involved themselves in a healing process ready to enter ministry and be vulnerable to the projection of previous injuries onto others who are under his or her care?

2. The Relational Dimension

The basic question of this dimension is: "**Who am I in relation to others**?"

We believe that relationships are experienced at three levels:

a) ***Primary Relations.*** This is a relationship with a significant or committed other such as a mate, spouse, or partner. This may or may not include genital/sexual expression. For example, an engaged couple are "significant" and "committed" to each other but may choose, because of theological convictions, not to engage in genital sexual expression until marriage.

b) ***Secondary Relations.*** These may be enduring and committed relationships and can include touch or physical contact (e.g., hugs), emotional vulnerability, and communication, but not genital sex. Friends, colleagues, primary and extended family members, church members, and members of any other meaningful communities (fraternal organizations, clubs, athletic teams, twelve-step groups, therapy groups, etc.).

c) ***Tertiary Relations.*** These are distant or temporary relationships and attachments. These relationships may experience honesty, vulnerability, communication, touch and risk taking but do not involve long term association and commitment. Sometimes it is easier to be open and honest with such relations because we know that we will not see these people again nor can they use information about us against us.

These three levels describe relationships that are mutual. They will involve give and take. Relationships between clergy and parishioners may involve elements of category b and c, but are not mutual. Clergy are care givers by definition of their role. Parishioners are care receivers. The concept of transference should inform clergy that a parishioner may be assigning power to the clergy role even if the clergy person, at a personal level, does not feel empowered.

When we were both student chaplains at the University of Iowa Hospital, one of us was assigned to the Coronary Care Unit. Regular visits were made for several days to an elderly Jewish woman. The visits were friendly and not particularly "religious." An assumption was being made by us that these visits were more mutual because of the difference in religious background. A part of us liked them being mutual out of our own insecurity and loneliness. At the end of her time this woman said to us, "Thank you, Rabbi." To which we replied, "I'm not a rabbi." The woman emphatically said, "You've been a rabbi to me!"

Examples like this illustrate that a parishioner, or a person assigned to our care, may have very different perceptions of the relationship than we do. It is important that we continually seek to articulate these perceptions of relationship. When such articulation is not possible, we should always assume that the relationship is not mutual and that clergy role is being empowered.

We must also remember that there will also be times when a parishioner consciously says that they would like the clergy relationship to be more mutual but unconsciously feels differently. The unconscious transference by the parishioner still gives the clergy definite power.

Our work in Part One demonstrates that clergy may often long for the parishioner relationship to be more mutual. The clergy role is often isolating and lonely. Unconscious wounds may make clergy extremely vulnerable to their own relational needs. When emotional and sexual needs are felt, as we know, this is a very dangerous situation.

It is always safer to assume an imbalance in power and mutuality between clergy and parishioner. This is a healthy boundary to maintain as lonely as it may be for clergy. Due to the constantly shifting nature of the **relationships between people in ministry and the peop**le they live and work with, guarding this boundary is often difficult. One moment clergy are working like peers on a committee; the next, they are playing volleyball together in the church gym; later, they may visit one of them at their hospital bedside. Then, clergy see them in their office to deal with personal crises. Just as a child marvels at the ever-shifting arrangements in a kaleidoscope, so those in ministry often wonder just what their role with a particular church member might be at a given moment. Are they committee colleagues, fellow members of the faith community, prayer partners, volleyball team mates, or counselors?

In recent efforts to empower the laity, this issue occurs even more frequently. There is a sense in which clergy are being asked to become more collegial than ever and to share more authority and leadership influence with lay people. This calls for a constant alertness to how the roles and boundaries are to be safeguarded. People in ministry need to be constantly aware of the ways that the settings they work in shift and how those shifts affect boundaries and roles. The person in ministry must be responsible at all times to monitor and safeguard those boundaries of people under their care, whatever the setting.

Our model of healthy sexuality assumes that a person must maintain healthy relationships at all three levels – primary, secondary and tertiary. Some of us in recovery from sexual offending or addiction have found that maintaining healthy relationships at all levels helps to mitigate unhealthy sexual expression. One cannot expect his or her primary relationship to meet all emotional and spiritual needs. When there is this expectation, there is often great tension. For example, a person cannot expect a yes or no answer from a sexual partner to symbolize all acceptance and relational needs.

If this assumption is true, it is imperative that clergy maintain healthy relationships at the primary, secondary, and tertiary level that are not subject to the authority of their role. These are mutual relationships: spouses, partners, colleagues, and friends outside the immediate community of faith. One of the questions that is inherent here is: "Where do clergy find their own community of faith of which they are not the leader?"

Candidates for ministry should be able to demonstrate an ability to form and maintain such relationships as a prerequisite to ordination.

3. The Behavioral Dimension

The **two basic question** of this dimension are: "Am I able to exercise positive choice in my sexual activities?" "Am I able to be emotionally and spiritually intimate with a partner in **appropriate ways** or do I participate in other behaviors that allow me to escape my feelings."

It is helpful to look at this dimension in terms of extremes. Pat Carnes first described a polarity in unhealthy sexual expression very similar to that found in eating disordered people. Diagrammed it looks like this:

Under Eating	Normal Eating	Over Eating
Anorexia		Bulimia
Avoidance	Healthy Sexuality	Overindulgence
"Acting In"		"Acting Out"

Aversive		Immersive

Figure 4

Sexually, there are those who exhibit unmanageable avoidance behaviors. They virtually turn off their sexuality. They are sexually "anorexic." They may avoid others, be aversive to contact, and use rigid and tight controls to stop being sexual. This rigidity has been referred to as "Acting In." For some, consciously and unconsciously, this lack of sexual expression may be an attempt to control painful memories of sexual trauma and experience. For others, it may be an attempt to control the despair of future acting out.

Sexual "Over Eaters" overindulge in sex. This pattern has been called sexual addiction by Carnes and others because it reflects several key features. It is repetitive, degenerative, and destructive. It becomes unmanageable. Sexual addicts may also be trying to control and dedicate (mood alter) early memories of trauma, feelings of despair, and/or a sense of abandonment and loneliness. Sexual "bulimia" may also reflect an addictive pattern. It differs in that a person will do something to themselves to self-punish and purge the experience. One of us worked with a man who plucked out both of his eyes (a biblical injunction in Matthew 5:29) because of an uncontrollable pornography addiction.

Screening candidates for ministry for one of these two unhealthy patterns will involve a detailed sexual history. Carnes, for example, has published two instruments that can be helpful in such a history. The Sexual Dependency Inventory can be used to aid in diagnosis but assumes the strong possibility of sexual addition. In this assumption it provides detailed information on the nature of the problem and also investigates etiologic factors. The validity of both such instruments depends on a candidate's ability to be honest.

We believe that candidates for ministry should be able to demonstrate freedom from any sexually dysfunctional pattern, addiction or not. In the presence of dysfunction or addition, a process of healing and/or "sobriety" must be a part of the formation process.

In addition to a sexual history, the behavioral dimension also asks if a candidate is practicing any other behavior that would **prevent him/her from being present and vulnerable to their emotions and available to relationships.** Alcoholism, for example, would be such a behavior. Any other addictive or avoidance pattern should be diagnosed. Just as with sexually dysfunctional behavior, a candidate must be able to engage in and maintain a process of healing and/or sobriety.

The behavioral dimension assumes that those who suffer from addiction may be using the addictive substance or behavior as a substitute for intimacy. Food addicts, for example, may use food in general or a particular food when they are lonely. Similarly, sex addicts use sexual experience and real or imagined sexual partners as a substitute for real closeness. Particularly those who use sex as a substitute for love will be vulnerable to sexual misconduct in ministry.

One of the important clinical factors in the behavioral dimension is to assess whether or not a candidate experiences a dissociative process. Trauma survivors may experience, for example, Post Traumatic Stress Disorder (PSTD). This is a condition in which a person literally "leaves" or dissociates from their painful emotions when they are triggered by painful memories.

Those in recovery from addiction, trauma, PSTD, and other dysfunctional pattern can be wonderfully effective pastors. They demonstrate a humility and capacity for empathy because of their own accepted brokenness, and that can be a wonderful gift.

4. The Physical Dimension

The basic questions of this dimension are: "Is my body responding physically to its full sexual capacity? Do I understand like, respect, and nurture my body?"

Intimacy with one's body demands that one knows it and understands how it functions and dysfunctions. Even in our enlightened time as heir to the pioneering work of the last several decades, many are totally ignorant of the human sexual response and sexual anatomy. This may be particularly true if there is sexual dysfunction present. Acquiring such knowledge and/or therapeutic intervention is part of the work of this dimension.

Being comfortable with one's body is also part of intimacy in the physical dimension. Historical experience of sexual shame may prevent a person from this level of comfort. This would certainly be true of sexual-trauma survivors. It can also be true of those who have been sexually teased or made fun of based on some physical characteristic. Then, too, are those who grow up in silence about sexuality and physical bodies. They are left feeling like sexual outcasts for what may even be normal sexual feelings. If people do not feel comfortable with their own bodies, no other person can really convince them that they are attractive.

Being intimate with one's body means that one is able to nurture it in healthy ways. Eating right, exercising, seeking appropriate medical care, getting enough rest, and wearing comfortable and attractive clothes may be indicators of this kind of physical intimacy. Medical assessment can be a part of the screening process of this dimension. Where there is a sexual dysfunction, medical intervention and therapy will be necessary.

All of the dimensions overlap. Here we see how medical and psychological assessment must cooperate. If a man experiences impotence, for example, there can be emotional or physical etiologies present. Obese persons, similarly, may experience medical, genetic, or psychological reasons for a pattern of overeating.

5. The Spiritual Dimension

The **basic question** of this dimension is, "Am I centered and connected with God? Do I feel validated as a sexual human being, and can I experience meaningfulness in my relationships, behave in congruence with my values, and express my physical/sexual functions as my God intends?" Do I reverence and respect the guidelines of Scripture for my sexuality? Am I willing to live according to those guidelines?

Candidates for ministry should be encouraged to have spiritual intimacy with God as they understand God, and with each other. Various denominations will differently interpret how spiritual intimacy should be formed. However, we recommend avoiding extremes such as spiritualizing all problems, on the one hand, or, on the other, ignoring the power of the spiritual life and assessing it simply as a psychological function.

Some attempt should be made to assess the nature of spiritual intimacy that a candidate experiences. Is it true connection with God, or is it performance of learned practices? It is easy, for some, to learn the ways and practices of a certain religious community or faith tradition. Does such a candidate mimic common practice in order to fit in, or does he or community, there is she sincerely feel the transcendent connection?

We have known many candidates, for example, who rigorously perform spiritual practices. They pray, read Scripture, and attend religious services. They do not experience, however, spiritual intimacy or peace nor freedom from any dysfunctional behaviors. Martin Luther is an example of someone who as

a seminarian could not pacify his spiritual anxiety.

If the spiritual life is pursued in isolation without community, there is also a danger of losing touch with reality. We have known some, for example, whose religious life was experience in such isolation that they were capable of compartmentalizing their mental life, especially their fantasies, from it.

The spiritual identity of a healthy candidate for ministry will have a sense of true calling. It is dangerous to try to evaluate such subjective experience for someone else. An attempt should be made, however, to determine if a candidate is trying to please someone else, inner voices from the past, or a true sense of calling from God. A friend of ours, for example, threatens to write a paper entitled "Being Ordained by Your Mother and Not by the Church."

True calling also suggests that a candidate is not trying to heal old wounds or find approval in the role of ministry. In an earlier paper we referred to this as "Ordination as a shame reduction strategy." It is the hope that one will be transformed into a new being, free of shame, and full of external approval. One female pastor who has offended against men in her church referred to this hope as the "Wish for Ontological Transformation."

Finally, the spiritual dimension suggests that a person be able to live in a way that is consistent with his or her sexual values. Do they have a history of violating their own sense of morals? If they have done so even in minor ways historically, they are vulnerable to doing so in major ways in the future. Sexual offending is full of delusions, denial, and rationalizations. None of the offending pastors that we have known have been fully sociopathic personalities. At some point they had to talk themselves into crossing their own moral boundaries.

Perhaps one of the areas of investigation that is important is how candidates understand the integration of their sexuality with their spirituality. What role do their faith and beliefs play in dealing with sexual relationships? Do they respect the bodies and boundaries of others? Do they humbly and repentantly accept grace for any past sexual sins, or do they rationalize their sins?

All of the dimensions of the healthy sexuality model are interrelated. They affect each other and can really only be isolated for the reason of academic clarity. The integration of the dimensions is most clear when we see how dysfunction in one dimension affects the other four. For example, if a person has not resolved sexual trauma issues, it will affect all of the other dimensions in some ways. Relationally, the person will be withdrawn and unable to disclose important parts of his or her past; behaviorally, various addictive, compulsive, or dysfunctional escapes will be used to avoid feelings; physically, the genital sexual relationship will be impaired and physical self-care compromised, not to mention various psychosomatic complaints that are possible; spiritually, a person's ability to trust has been impaired particularly in those cases in which the perpetrator is a religious authority.

More positively, if a person is healthy in one dimension, there can be a positive impact on the other four areas. Relationally, intimacy with one's spouse and others makes it less likely that a person will look for substitutes for intimacy behaviorally. It also mitigates against anger and any others for personal gain. The understanding of one's roles at various social and professional levels and how these roles affect others is a form of healthy relational empathy that can prevent abuse of power and role. Physically, if one can respect and nurture one's own body, one will be better able to respect another's and maintain healthy boundaries. Spiritually, intimacy makes it more likely that a person will know the true intentions of one's heart and would be more likely to act in congruence with one's morals.

Outcomes

A healthy candidate for ministry will be working on all dimensions of the healthy sexuality model at the same time. This can be very challenging. In summary, candidates will demonstrate the following qualities:

a) Be comfortable with their own sexual identity and sexual preference
b) Be in a healing process for any early life trauma
c) Demonstrate the capacity to be intimate and have healthy attachments and bonds.
d) Understand the difference between different levels of intimacy and the appropriate boundaries between them.
e) Understand the power of the ministerial role and the dynamics of transference and countertransference.
f) Maintain sobriety from any addictive or unhealthy behaviors.
g) Demonstrate a healthy ability to be in touch with and express feelings.
h) Maintain appropriate physical self-care
i) Work through the various reasons for a call to ministry, examining their motives and expectations
j) Demonstrate a healthy private and communal spiritual life.

It has been our intention in this chapter to describe an emotionally healthy person so that candidates for ministry can be assisted in comparing the sexuality they perceive in their own internal framework with this model in order to be able to make corrections and predictions about their own attitudes and conduct. Now we move to the educational efforts seminaries and ecclesiastical bodies can make in order to help candidates deal with the cognitive, spiritual, contextual, and social aspects of their sexuality.