

From the CEO's Desk:

Faithful to Mission, Responsive to Need: A Look at Southdown's New Residential Program

by: Miriam D. Ukeritis, CSJ, PhD

Some years ago, in a study of the factors related to vitality and viability of religious organizations, we identified two key elements in this equation: fidelity to founding purpose and responsiveness to current unmet needs. These principles are equally relevant to mission driven organizations such as the Southdown Institute.

More than 45 years ago, Southdown was founded to provide "restorative care" to priests who struggled with alcoholism. Staff soon recognized the reality of dual diagnoses, and acted to address those concerns. Since that time, our programming has evolved to include treatment of a variety of addictions and the range of mental health concerns. In response to requests from leaders of religious congregations, we welcomed members of religious orders – men and women – to our residential program. Our programming has also changed with the times as our staff consistently attended to developments in the psychological sciences. In short, we have been a leader in providing a space of healing for church ministers who suffer from addictions or mental health problems. Our mission of ensuring "Healthy Leaders for a Healthy Church" remains central and has grounded each new adaptation of our program.

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treatment goals ..."*

These principles of fidelity to purpose and responsiveness to need have shaped the thinking of our Board and staff as we have sought to respond creatively to a changing world. We are now pleased to introduce the next generation of programs of care.

Southdown's new residential program reflects a significant departure from the former four to six month length of stay. During the newly designed 14-week program, the residents focus more intensely on treatment goals identified at assessment, work to address the identified issues, and plan with their diocese or congregation for a smooth transition to post-residence life. Communication with the leadership of the resident's diocese or religious congregation forms a central pillar to ensure clear identification of and realistic follow-up to the residential program.



Continuing in our tradition of adapting to changing times and responding to concerns raised by religious superiors and diocesan leaders, our new treatment model addresses length of stay, finances and contemporary clinical practice. Designed to assist clergy and religious from across North America and beyond who desire to return to their ministry healed and whole, it draws on new and emerging advances in the field of mental health while relying on the proven effectiveness of an interdisciplinary treatment model. Practically speaking, our interdisciplinary team consists of professionals with backgrounds in psychology, psychiatry, spirituality, nutrition, addictions, fitness, and nursing.

Let me elaborate on the 14-week time frame. We see the first four weeks as time for residents to adjust to their new environment, define their goals and begin to address them. The next six weeks allow for intense work on these identified goals using individual psychotherapy, large and small group opportunities, and other modalities that include psycho-educational seminars and focal groups addressing such topics as Grief and Loss, Nutrition Awareness, Cognitive Behavior Therapy, and Addictions. Fitness and expressive therapies round out the program. As residents explore the dynamics related to a time of transition during the final four weeks, the focus moves to actual planning for post-residence life and ministry along with possible ongoing treatment needs.

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THE ROLE OF SPIRITUAL DIRECTION

by Janet Crocker, M.Div. STB



Last Sunday, the homilist closed his reflection with: "I talk too long, don't I?" Yet the people keep coming back. Why?

The premise that grounds my approach to spiritual direction is that "God is (and desires to be) in all things." God does not want to be left out or left on the edges but desires to be intimately involved in every aspect of my life: the holy, yes, but also the mundane or 'less than

holy' corners. God longs for eye contact with me so that we can read the unspoken words, hurts, fears, hungers and thirst that lie at the heart of each of us – my heart and God's heart. God will wait for me as in the Prodigal Son/Father story or draw alongside me as in the Road to Emmaus account, accepting the agenda of my present moment in the hopes of opening it up with me to an ever deeper understanding and growth.

In the early encounters with those engaging in spiritual direction, whether at Southdown or elsewhere, the director seeks to 'draw alongside,' to listen without judgement, and to make eye contact with the person possible as they speak about his/her relationship with God or the desire for it. One learns

that for some they have known a deep intimacy with God but they believe that they have lost it: they cannot **feel** God's presence anymore and they are desperate to experience it once again. Others wish for intimacy with God but are unsure of what it might look like. Still others may be faithful to the expectations for prayer but prayer remains in a pocket quite separate from the rest of life. Of the latter, some would wish for a more intimate relationship with God while others are quite happy to have pockets which keep the parts of their lives separate. In one way or another they all recognize that there is a disconnection with God, be it large or small.

As much as the word 'integration' can be overused, it speaks to the heart of the journey in which the person in direction is involved if the journey is to lead to a psychologically healthy spirituality. One could list many characteristics of such a spirituality. Among these would be authenticity: a willingness to stand in one's truth, whatever the cost. Another would be the letting go of

past hurts that prevent a person from moving ahead. Love of and compassion towards self as well as others and similarly forgiveness of self and others are critical to a mature and healthy spirituality. Peace, freedom, and joy are also markers of a mature integrated spirituality. But the starting point is standing in one's truth. This is the root on which the others can/will build.

As the director, one listens intently for the readiness of the person and the openings of the Spirit to offer a word, to ask a question that invites the person to go deeper, to risk a little more as they try to put words to their truth. Can the person begin to see where God is in the experience or to name where grace is at work? Can the person begin to bring it as a focus of prayer? For someone who has written a letter to another in the context of grieving a loss or has written a dialogue with God or another about the anger or fear that keeps them bound, can they now sit down in the presence of God and read it aloud? Can the person bring the release or the challenge arising from a workout in psychodrama or CBT as the text of their prayer and then talk openly with God about it? How about taking the sexual or addiction history one has written and reading it aloud to God, a chapter at a time, allowing space for eye contact and God's response? These are the moments for risking inviting God to be intimately involved

in one's life rather than holding God at the periphery. It calls forth deep trust in God. Attending to these moments and providing a safe and non-judgemental presence in which the person can speak of the fruits of these encounters is one of the sacred tasks of the director.

Integrating the psychological and spiritual aspects of life in dialogue with God brings about the intimacy for which God longs and for which our best self strives.

When this knowledge of God and of oneself is deeply rooted it brings a rich awareness of how deeply one is loved by God and a willingness to risk even more. There is no need for secrets. Here we can be ourselves and engage in an easy rapport with the One who accepts us as we are. To be a witness to this integration is gift.

We hear at the end of the Emmaus story: "*Were not our hearts burning within us?*" It is this fire, ignited by the Spirit, which carries over into ministry; a fire that is witnessed by those to whom we minister, a fire for which they too are thirsting.

So, why do the people keep coming? (Probably not for the 'too long homily.') More likely, they are drawn back to the warmth of the fire they experience in the homilist's presence to them and to his God. They recognize the authenticity, the love, compassion, forgiveness, and the peace, joy and freedom of a mature and integrated spirituality. They see in him what they want for themselves.

*"I TALK TOO LONG,
DON'T I?"*

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BURNOUT

by Sam Mikail, PhD, ABPP

From time-to-time all of us experience distress. Distress is defined as a subjective emotional state arising in response to ongoing stress, life challenges, conflicts, or demands. Distress is a natural state that cannot be avoided. However, when distress is protracted our functioning is compromised and distress turns into impairment. If left untreated, impairment begins to impact one's personal and professional competence. Distress and impairment are neither fully present or absent, but rather exist on a continuum. In 1975 Herbert Freudenberger coined the term "Burnout" to describe the terminal phase of distress.

Burnout is characterized by a feeling of emotional exhaustion, a diminished sense of satisfaction or accomplishment, and a feeling of depersonalization. Emotional exhaustion reflects the emotional dimension of burnout and involves feeling depleted of one's emotional resources. Diminished accomplishment and satisfaction involve feelings of reduced competence, productivity and self-efficacy. These are expressions of the self-evaluative dimension of burnout. Finally, depersonalization is often manifest through increased negativity, cynicism or feelings of detachment from others. This reflects the interpersonal dimensions of burnout.

Research suggests that emotional exhaustion is the most stable and consistent dimension of burnout. Typical warning signs include:

- becoming frustrated more easily than usual,
- feeling impatient,
- feeling angry with less provocation in dealings with colleagues, employees or parishioners,
- increased boredom,
- experiencing a lack of focus,
- increased fatigue
- decreased motivation
- decreased work fulfillment or enjoyment

Researchers have suggested that burnout is caused by the loss or threatened loss of material, social or energetic resource valued by the individual. Burnout is seldom the result of a single event, but rather follows multiple losses. In ministry this typically takes the form of physical fatigue (loss of physical energy), emotional exhaustion (loss of emotional energy), and cognitive weariness (loss of mental energy). These three forms of energy are highly interrelated so that the depletion in one tends to be associated with a diminishment of the others.

To take an example, let's consider the case of the diminishing number of vocations. Fewer vocations coupled with an aging population of priests and religious means that fewer people are available to do work that traditionally has been the life-blood of a diocese or religious order. In many instances, this has translated into greater demands being placed on those still able to serve. Thus begins the cycle of depleted physical energy and fatigue. This can serve as the beginning stage of burnout in which the human response is to cope by working harder and longer. When this proves ineffective, as it often does, anxiety, demoralization, and a resignation can follow. At the same time, near constant busyness often means being less available to offer or seek emotional support. Praying together, dedicating time for faith sharing, or simply playing and eating together become the exception rather than the rule. Hence, we witness a slow and gradual erosion of emotional support and energy that can ultimately lead to detachment, cynicism, and social withdrawal.

Research has shown that adverse organizational or situational factors are more significant in the onset of burnout than personality factors. Although healthy self-esteem and self-efficacy (having a sense of agency and perceived control) can buffer an individual in the face of mounting stress, ministerial situations in which the individual experiences success, feels effective, and feels affirmed, are essential to healthy adjustment. Perhaps the most potent means of reducing, or even eliminating, burnout is to ensure the availability of support. Yet availability of support alone is not enough however. Many of us have multiple sources of support that we can access. A willingness to make use of that support is an essential ingredient to guarding against burnout and emotional depletion. This is where personality is most influential. For some of us, accessing support is viewed as a defeat or failure. Others of us struggle with feelings of low self-worth and feel unworthy of support, engaging in an internal dialogue in which we convince ourselves that others' problems are more significant or that our concerns will simply burden others needlessly.

At times, we may become aware that someone requires a slight nudge to seek appropriate support, particularly if they appear to be exhibiting signs consistent with the early stages of burnout and most of their energy is being channelled into working longer and harder. Community and diocesan retreat days, education days, deanery meetings, community prayer faith sharing groups are all structural vehicles that serve to guard against burnout by ensuring that such support is both available and used. In more advanced stages of burnout, psychotherapy or residential treatment may need to be considered.



IN MEMORIAM



Bill Volk was a member of Southdown's Board for many years and served as Chair since December 2009. We were stunned and saddened to hear of his death on January 20, 2011. We will miss the wisdom and generous spirit that marked Bill's work with us, and are most grateful to him for his hours of advice and consultation during our time of transition. We promise our prayers for Bill and his family – Wendy, his wife, and his three children, Graham, Hannah and Ryan.

New Residential Program... *Continued from Pg 1*

As in the past, our new residential program combines the best of the psychological sciences with the wisdom of the Catholic spiritual tradition. Spiritual direction, spirituality groups and theological reflection continue to constitute a central element of the program.

Having heard some of your questions in response to our announcement of this change, let me take this opportunity to share some of our answers with you.

*“Our mission of ensuring
Healthy Leaders for a Healthy Church
remains central...”*

How did you arrive at 14 weeks? The 14-week stay is both a response to the needs of those who use our services and an application of what we have learned from ongoing research. Over the past three years, residents have regularly completed standardized surveys to measure their progress. The data shows us that while positive change continues throughout residence and into the 18 months of continuing care, the greatest change takes place in the first ten weeks of residence. Using that knowledge, we have opted for a program that will capitalize on those weeks and provide an additional time for consolidation of learnings and transition planning. Other residential programs with similar goals have also found that a length of stay of approximately three months is optimal.

You have also told us that planning for an indefinite length of stay consisting of four to six months creates problems in ministerial commitments. An anticipated absence of approximately three months is more realistic. Finally, there is the cost of treatment. While we strive to assist those dioceses and congregations that cannot afford the full cost of treatment, the shorter time frame lessens the cost of a residential stay for a sponsoring group.

Change takes time. Are you sure 14 weeks will be enough? We are well aware that during the 14 weeks of this residential program clients will probably not accomplish the depth of change observed after a lengthy stay in residential treatment. We do believe, however, that during these three months a resident will develop the tools needed to continue the growth and healing begun at Southdown and, in due time, may achieve the same gains. This program will also assist residents in identifying resources in their local area.

Do you expect that this program will fit the needs of all? We know that there can be no “one size fits all” program. This has not been the case in the past, and we do not expect that this will change. In those instances where we are reasonably certain at the outset that a longer time frame is required, we will assess our ability

to address the need and communicate clearly with residents and their leadership concerning an anticipated lengthier stay. If we do not believe we can address the presenting concerns, we will work with those involved to make an appropriate referral. We will continue to offer our Assessment Plus program for those needing additional neuropsychological assessment or adjustment in psychotropic medications.

What about aftercare? In planning for these changes, we are acutely aware of the critical role that Continuing Care will play. During the first four weeks of their residential stay, residents become acquainted with the role of continuing care in their ongoing healing. For 18 post-residency months, former residents and members of their leadership teams will have planned contacts with our Continuing Care staff. Former residents will also return at appropriate intervals (typically 6 and 18 months) for our on-site Connections workshops.

Will Assessment services still be available? Southdown continues its commitment to providing excellent clinical, candidate and neuropsychological assessment services. The strength of an interdisciplinary team that marks our working in the residential program will continue to be available in our assessment service. While helpful in identifying goals for a residential stay, the assessment experience can also provide an individual with a concentrated opportunity to explore problematic areas and identify underlying issues to be addressed in outpatient therapy. The assessment typically begins on Sunday and concludes on Thursday.

What about other Southdown services? In addition to the Continuing Care and Assessment services already mentioned, Southdown staff will always be available as a confidential resource to Church leaders in need of consultation. Members of our staff are also available to offer workshops, facilitation and team building experiences, either here at the Carter Centre or at locations determined by the sponsoring group.

In terms of other services available to the local Church, our staff offers outpatient psychotherapy and spiritual direction. A Formation Consultation Group, now in its seventh year, continues to offer an opportunity for education and consultation to formators and vocation directors in the Toronto area.

THE
Southdown
INSTITUTE



The Southdown Institute is a registered non-profit charitable organization.

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