



What do I do with him now?

By Bryan Silva, OMI

[Bryan Silva, OMI, is a member of the Missionary Oblates of Mary Immaculate. He works as the Director of Special Services for the United States Province and works at St Luke Institute in Silver Spring, Maryland, as a therapist.]

Many of the major superiors with whom I speak have questions about how to proceed when a congregation member returns from in-patient psychological treatment and goes to out-patient treatment. They sometimes have told me that they do not know how to find an appropriate referral for the type of therapist the member may need or the superior may not even know the expertise demanded in a certain case. Others deal with a member who appears to be a “professional patient” who has been in therapy for an extended period with little noticeable result. These questions and many others are integral to how a member gets help for mental health issues. The major superior has a variety of concerns in mind when referring an individual to psychotherapy. Among these concerns are the needs of the individual, his history of interpersonal and intra-personal problems, the needs of the congregation, and the criteria for assignment to ministry. To balance these issues, the superior must have an idea of the desirable outcome for the individual. He must also have a measurable way to gauge success in treatment. A plan for monitoring the help which the individual receives is also essential to this process.

In this article I hope to give some general observations that will be helpful for major superiors in obtaining-appropriate help for their members, a rapid review of the issues involved in choosing the therapist and managing the therapy. Finally, I will offer some trouble-shooting tips for evaluating lapses and relapses.

Coming Home

In cases where the individual religious has come from an in-patient setting where the demands of life are managed for him and resources are varied and firmly scheduled, the individual will be in transition to a more self-structured lifestyle. The in-patient protective environment has been one of the aids to the individual in finding some stability and “normalcy” for examining issues related to his problem behaviors and initial referral. When he is ready to move forward and to re-enter a ministry position, as limited as this position may be, he is in need of a *predictable and structured environment*. This environment allows him to have the time and supports in place to continue examination of old behavioral patterns and practice of new ones.

One element of this structure is identifying and arranging for a *contact person* and/or *support group*. The member has come from a “holding environment.” This is a setting in which he has been offered protection from undue worries and distractions for an extended period. It is also one where his freedoms have been monitored and he has had assistance in managing spending, social

interactions and other tasks. Now the individual will need to have others around him who can offer a helping hand and a listening ear. It will be helpful to the member if he can live with others with whom he can share his story and from whom he can receive constructive feedback. There ought to be a structure to provide for scheduled reviews with the member. Asking how things are going or confirming his attendance at therapy sessions is a good beginning. He has now moved from a structure focused on compliance with outside time frames to a setting where he must set his own structures. He will need to know that the superior is serious about compliance. Once this is established, he will be at lower risk of falling off in attendance or returning to old patterns of behavior. Sr. Margaret Crowley, SHCJ, briefly discusses the issues around continuing care in a *Lukenote* from April of 1998.

She outlines various elements of on-going care and points out that there are critical times in the healing journey of a recovering religious. Members may be most vulnerable to lapses in behavior or a relapse at set periods during treatment. A particularly vulnerable time for the first relapse is immediately after leaving in-patient treatment. At this time the member is experiencing return to a familiar setting, others around him have not changed and so he is faced with the task of becoming a new person in an environment which may pull him in old directions. Caution should be exercised when finding an assignment for the member when immediately leaving treatment. The other periods of risk are approximately at two and one-half years, and five years. By that point in time the member has enough recovery to become complacent and to take short cuts in recovery. He may begin to believe that he has "beat the old behavior." An example of this is the alcoholic who begins to believe that one drink will not cause a relapse after a long time of sobriety. In much the same way, a member may come to believe he has changed significantly enough to be able to experiment with sexual sobriety or compliance with taking needed medication and thus risk lapses to the old behavior.

Secondly, the ministerial or other work of the individual should be *identifiable yet flexible* for a period of time. In this way he can predict where he needs to be and what he needs to be doing without excess pressure or vague expectations. This will be an important concern especially if he is attending individual therapy, group therapy and 12-step groups as a part of his weekly routine. The environment should foster honesty and *open communication* which allows for affirmation as well as challenges when needed. In the past, those around the member may have believed that his behavior was not their business or they did not want to meddle in his life. The new environment will have to include an understanding that he cannot continue to change if no one risks offering constructive feedback to him or his problematic behaviors are ignored. The construction of this healing environment should be an important aspect of choosing the residence for the individual.

A third important element of the recovery environment is regularly *scheduled psychotherapy*. The major superior may find it helpful to suggest local therapists when the individual is assigned to a particular locale. In this way the superior can choose a set of therapists known and trusted by him. A list of local therapists with an understanding of the Church might be gathered by asking the local Catholic Charities clinical services, local Diocesan Offices dealing with clergy, religious and family life as well as other congregations in the locale to find out whom they consult. In this way a "short list" of three to five therapists' names can be quickly generated. The individual religious would meet with these suggested therapists and choose an appropriate one to work on his specific issues. Offering the member choices within a set of options is a very constructive way to assure that the major superior gets the expertise and information he may need while allowing the member a comfortable relationship in which to explore difficult issues.

A therapist should have an *understanding of* religious life, the authority structure of the congregation and a sense of the rigors of pastoral ministry. With a clear understanding of religious life, the therapist can offer help to the individual in a more balanced and productive manner. Some very good work on issues around major superiors and psychological treatment of members has been done by Msgr. Steven Rossetti in an article on misconceptions about psychological care. In his article, Msgr. Rossetti discusses in more detail some of the points I will highlight below. The major superior may want to establish a *feedback system* with the chosen therapist. Often superiors will ask for an update in writing on the progress of the individual or schedule a meeting with the therapist and individual on a regular basis. My practice is to get this type of feedback on the efficacy of treatment every six months. When this is done for at least the first few years following in-patient treatment, it allows for a tailoring of the treatment so that the individual is working on the issues most relevant to both his own needs and those of the congregation. Without this scheduled feedback, it is very easy to fall into a feeling that nothing is changing or that the issues are not being adequately addressed. I suggest this so that it does not sound like all the emphasis is on what the authorities want.

In order for this to happen, the therapist will need an openness to *information sharing* and will need to acquire a release of information signed by the individual religious. Although the major superior must not coerce the individual to sign such a document, it is obvious that the major superior cannot assign someone to any public ministry without some assurance of his mental health and, in this case, his continued growth in interpersonal maturity. It is also helpful to know that although the therapist may be reluctant to offer too much information, the major superior can offer information to the therapist as often as needed.

A fourth element of treatment planning is the *permanence of information* across administrations. I have spoken with major superiors who are reticent to put too much on paper for fear of jeopardizing the name of the individual involved or of creating "a paper trail" which can be problematic in the future. When important information has been lost or destroyed, a long-term approach to growth is not possible for this member. When these actions are taken it reduces the chances that the individual religious will make long-term and meaningful change. Agreements with previous administrations will not be kept and the risks of a return to old and ineffective modes of behaving by the member are increased. When there is continuity in the flow of information between administrations, the newer and more positive behaviors can be reinforced over time. This means that the individual involved is not able to lapse or relapse as easily because the new administration is aware of all historical aspects of the treatment regimen. Some congregations have a person in the administration who oversees health issues or problem behavioral issues across administrations. This offers the possibility of consistency in working with these individuals and the opportunity to provide challenging support of them over the long-term. Ideally the major superior will have access to some written materials and verbal background with regard to the treatment of congregation members. A valuable and brief exploration of this topic is contained within the document *Psychological Care of Members*, published by the Religious Formation Conference. Dr. Donna Markham, OP gives some ideas about the need for a written file and outlines the necessary information contained in that file. The written file should include the names of therapists who have done treatment, dates of review sessions or written notes regarding treatment, any correspondence between the superior and the individual with notations of restrictions on ministry. Briefly, since this file may be legally discoverable, the written file includes information that would show that the congregation has acted appropriately. The verbal background should include information about the interpersonal aspects of working with the member, any sensitive and personal information about the member. It would also include a clear understanding of any manipulative behavior by the

member. In this way the new superior has a basic understanding of the history and can help the member move forward in continued growth.

Specialized Treatment

With the issue of individual therapy in mind, what expertise should one look for in the chosen therapist? Depending on the nature of the problem being addressed, a variety of factors might be kept in mind. One will be the *comfort of the individual* with the therapist. If the relationship is not a trusting and compatible one, therapy may suffer because the member will not be open and honest with the therapist. The other side of this concern is that the therapist needs to be open to communication with the superior and able to share pertinent information with leadership so that assignment and residence issues can be considered in a realistic way. Speaking beforehand with the therapists on the referral list mentioned above would be a help.

The *expertise* of the therapists is another important issue. Almost all licensed therapists will have expertise in dealing with depression, anxiety and the effects of burnout on one's mental health. However, understanding the unique pressures of religious life and ministry, the particulars of Catholic clergy and unique qualities of a given congregation will be specialized knowledge. Another area of specific expertise will be *sexual abuse treatment* issues. A member who has been abused sexually may need to deal with that abuse as an issue in developmental terms. However, that abuse is not commonly the reason for later acting out sexually. Only a very small percentage of those who are victims of abuse go on to abuse others. While the member may want to assert that they acted out due to their own victimization, this is not the whole story when a member abuses another. If the member is dealing with accusations of sexual abuse or offending behavior, it would be helpful to ask about the therapist's particular expertise in these areas. A therapist who is a member of the Association for the Treatment of Sexual Abusers (ATSA) will typically have specialized training and an ethical preparation for dealing with the issues surrounding sexual offending behavior. While an expertise in sexual addiction may be helpful in working with religious, it can also bring some added difficulties. The 12-step model of sexual addiction is much like the alcoholics anonymous model in that abstinence and a "day by day" approach to life is emphasized. This may be a positive factor in the member having the support of others outside of the religious community. However, framing the sexual activity as out of the member's control and his being "powerless" over his behavior is a two-edged sword. When dealing with offending behavior and accountability to superior, especially if the member has work in a public ministerial setting, a 12-step approach can have complications. Lapses in behavior or a relapse in offending can affect more than just the individual and may jeopardize the congregation's mission or ministry. Therefore, caution ought to be exercised when seeking therapists with training around sexual abuse, sexual addiction and sexual offending.

Signs of Problems

From the perspective of trouble shooting or tracking positive change, the superior will need to look not only at the short term behavioral change of the individual but will have to see the personality changes as *long-term goals*. I have spoken with superiors in the past who have wondered if therapy worked when the individual member is having problems within the year after in-patient treatment. In many cases the member has had problem behaviors for many years. It will take time and energy to make significant behavioral changes. It will be helpful to create a firm structure with regularly scheduled follow-up meetings, measured goals and objectives, as well as clear understandings around timeliness and accountability. The confreres who live with and near the member are likely to want to "cut him some slack" or "give him a break" when it comes to compliance with written or verbal restrictions. This can lead to the member getting the impression that he has a broad road

rather than seeing his recovery as taking the narrow path. Caution should be exercised in this regard. I have counseled superiors in the past that if the member misses a meeting with them, is late to a scheduled appointment or avoids the superior in some other way; these should be interpreted as signs of slipping. The issue is not that the member has relapsed but that they are not placing sufficient priority on their recovery or on the rules of their return to ministry. These infractions can be brought to the member as examples of compliance issues and talked through. In this way the expectations are clear and the member is not allowed to manipulate (or hedge) on needed compliance.

Another area to be aware of will be *shifts in mood* or temperament. The member will be returning to the same general life issues as before but will have a new set of behaviors and new ways to cope with these issues. He will need the opportunities to practice these new skills. This will mean that he needs feedback about how well he is doing in using these skills. If he begins to show old patterns, even in the smallest ways, it will be important to bring this to his attention. He may begin to show changes in temperament or mood over time. The hope is that he will change in positive ways, becoming more able to cope, more appropriately social, and increasingly "happy in his own skin." If character changes are negative, the member may be having difficulty maintaining his new behavior and this ought to be brought to the attention of the member and his therapist. In this way the changes can be discussed and worked through so that the member maintains an awareness of his on-going recovery and need for perseverance in working with new behaviors.

In closing, I believe the heart of the matter is "balance" in lifestyle. The individual member has begun to identify old behaviors as problematic and has, hopefully, begun to implement new behaviors and ways of relating. To the extent he becomes more balanced in his approach to life, he will move in a healthy direction. When he sees the need for work and also a healthy need for recreation, on-going therapy and appropriate sharing with others, he is in good space. When he begins to move toward a return to the old patterns of thinking, to avoid difficult emotions, to defend moving away from treatment or 12-step groups and to overdo things, he may be moving in a problematic direction. A strong sense of the fragility of sobriety and the immediacy of potential lapse will serve the member and the congregation better than complacency.

Resources:

Markham, Donna (2006): "Suggestions concerning personnel files and mental health records," in *Psychological Care of Members*, CMSM Religious Formation Conference.

Rossetti, Steven (2008): "Seven common misconceptions about the psychological care of members," *The Legal Bulletin*, Feb. 2008, 85: 3-8.

Crowley, Margaret (1998); "If nothing changes, nothing changes," St. Luke Institute *Lukenotes* v II: 2, <http://sli.org/services/lukenotesarticles.html>.