Is the 14-Week Program Effective?

We will soon have a sufficient number of individuals who have completed their period of involvement in Continuing Care to enable us to assess the effectiveness over time of our current program and compare it with previous efforts. We look forward to sharing these and other learnings in future Covenant offerings. Based on what we have learned to date—from the data and from the qualitative reports of our residents and their leaders, the answer to “Is the 14-week program effective?” is YES... knowing, as ever, that much depends on what an individual brings and the mysterious working of God’s grace.

Times of transitions in our lives provide opportunities for growth and self-understanding. It is the process we go through to come to terms with change, our internal attitude, and adjustment to the routine ups and downs of our lives. Whether we anticipate the change or not, whether we choose it or find it imposed on us, in the end we make the choice of who we wish to become by how we respond. Critical to assuring the best success during a transitional process is ongoing support and encouragement.

Continuing Care at Southdown is the long term view of transitional life beyond residential treatment through the health lens: mental health, emotional health, physical health, and spiritual health—all including quality self-care. Southdown’s program offers a supportive process beginning with residency and continuing through the eighteen months following discharge. Diarmid O’Murchu once stated that when individuals become informed and enlightened, they are empowered to make choices. We support residents in making healthy choices at the onset of their residential stay. During the first weeks, each person learns the various components of the Cycle of Change, an integrative model used to help conceptualize the process of intentional behavioral change. Understanding the importance of each stage in the cycle empowers each individual to make choices for healthy change. Change does not come easily. We have our moments of resisting, denying, rationalizing, railing or even digging in, feeling angry and reactionary. The Cycle of Change takes into consideration the challenges we face as we make personal changes in our lives by including in this the “relapse,” returning to previous behavior. As we seek to change any long standing pattern of behavior in our lives, we will have slips, relapses, and returns to our former comfort zone. This is especially true during the beginning of any transition.

Transition issues and this relapse cycle are significant concepts for Continuing Care. Each person begins his or her final month of residency preparing for transition to ministry and mission. This provides the opportunity for them to prepare to return with a new self-image and a clear understanding of their interpersonal dynamics. It affords the opportunity to practice new approaches and experience the challenges they will face in the future. To assist in this process, each person formulates a strong Relapse Prevention Plan which identifies problematic behaviors, risk factors, stressors, warning signs, intervention skills and a support network. This plan along with support systems identified at home (a weekly support person, spiritual director, therapist, counselor/sponsor), and a monthly phone/Skype visit to Continuing care personnel, assists in consolidating gains made during residence.

In addition, two or three retreat style-workshops called Connections are offered during the 18 months following residency. The educational input and time for reflection and sharing provides an opportunity to address recovery concerns; provide encouragement, and renew motivation to continue the growth process. Leadership involvement at all stages of the Continuing Care process is encouraged and welcomed not only through the Clinical interview opportunity at Connections but through phone contact throughout the 18 month period as well.
Guide to Selecting an Effective Therapist

By Sam Mikail, PhD, ABPP

Over the years we have been asked to suggest specific clinicians who can provide ethical and effective services to our graduates who have completed an assessment or the residential program and are in need of outpatient psychotherapy. Although, we have some connections throughout Canada and the United States they are relatively few in comparison to the number of locations to which our graduates return. However, what we can provide are guidelines of what leaders and graduates of our program as well as those seeking psychological treatment should consider when choosing a practitioner. Although these criteria were intended for those seeking the services of a psychologist, they apply equally to other health care services.

In many jurisdictions anyone can present themselves to the public as a psychotherapist or counsellor. In selecting a mental health professional it is important to seek someone representing a health sector which is regulated by a professional credentialing body. Typically this includes psychologists, psychiatrists, and clinical social workers. In some states and provinces general practitioners and other physicians can present themselves as psychotherapists; therefore credentialing alone is not sufficient. It is also important to ask about the nature and extent of a person’s training. Attending workshops on psychotherapy will not make someone an effective psychotherapist. Proper training is intense and involves several years of supervised practice. Having established that the person is a regulated mental health professional with adequate formal training in psychotherapy, we recommend that you look for a practitioner that is skilled in delivering evidence-based treatment. Such treatment methods have been evaluated through extensive research and shown to be effective in bringing about desired change for specific conditions or disorders. Following are some general guidelines to inform your decision:

What is effective psychological treatment?

Psychologists have been trained to draw on research to guide their professional practice. This approach is referred to as Evidence-Based Practice and it allows psychologists to use the best available information. This includes:

- To help fully engage those seeking their services in a collaborative relationship and to actively participate in therapeutic experiences that enhance good outcomes.
- To monitor treatment progress and outcome.
- To adjust their treatment approaches if the treatment isn’t working optimally.

Why is it important to use Evidence-Based Practice?

- The use of Evidence-Based Practice means that the treatment approach is considered by other health care professionals and researchers to be effective or likely to be effective in addressing your concerns. It provides a type of quality control.
- Treatment approaches that are part of Evidence-Based Practice are guided by a coherent and systematic theory, methodology and science.
- Evidence-Based practice encourages full and open communication between those seeking services and the psychologist throughout treatment. It ensures that you are informed about the evidence supporting your treatment and about your treatment progress.

How do I select a psychologist who follows Evidence-Based Practice?

- The psychologist should be willing to provide information about the treatments he/she is offering so that you can decide whether or not you wish to participate.
- This information might include the likelihood of success and the best way to manage your condition.
- It is perfectly legitimate, indeed very sensible to ask, “Does the research support the use of this method to address my particular concerns?”
- If the research evidence related to your concern does not yet exist or is not sufficiently strong, the psychologist should be able to provide a coherent rationale for the approach suggested and also to describe alternative approaches for you to consider.
- If there are any risks associated with use of that approach, the psychologist is expected to be able to outline these and explain them fully so that you are in a position to make a fully informed decision about the service that you are receiving.

Beginning in early 2008, Southdown’s clinical staff undertook a comprehensive program review to assess the effectiveness of our programming, study what others in the field were learning, and to address changes in demographics and needs of the population of religious and clergy whom we serve. A major outcome of the endeavor was the move in January 2011 from an open-ended four-to-six-month length of stay to a 14-week program. As we announced this change, several leaders as well as potential residents asked, “Do you get the same results?” “Will this work for her unique difficulties?” “What if he needs more time?”

Applying the principles of Evidence-Based Treatment that Sam Mikail has outlined on the preceding page, we continued to monitor the effects and effectiveness of our programming. Not wanting to rely solely on impressions and verbal feedback, we initiated a quantitative analysis of change in January 2008 with our Resident Progress Review. Using two existing measures (the Brief Symptom Inventory and the Inventory of Interpersonal Problems), we tracked changes over time in scores on a number of scales in the instruments. This allowed us to attend to shifts in interpersonal styles and the resolution of difficulties associated with anxiety, depression and other clinical concerns. Ordinarily, residents complete these instruments at Admission and Discharge and at three weekly intervals between. This offers an understanding not only of change from beginning to end, but also gives a glimpse of the progress and fluctuations in these areas as treatment progresses. Completion of these surveys is also part of our Connections retreats, thereby enabling us to assess whether gains made during residence are sustained and even continue.

At this point in time we would like to share some of what we have learned using this method. Because this Resident Progress Review had been in place for three years before changing our program structure, we are able to compare the data obtained from individuals who participated in our lengthier program with those who have been with us since inaugurating the 14-week model in 2011. What we are reporting here are scores on four of the measures: Anxiety, Depression, General Severity Index (GSI) and Positive Symptom Distress Index (PSDI). While the Anxiety and Depression are self-explanatory in this context, GSI and PSDI need a bit of explanation. The General Severity Index is computed by obtaining the average of severity ratings on all 53 items on the Brief Symptom Inventory. The Positive Symptom Distress Index is the average of severity ratings on only those items endorsed by the resident as problematic.

Our first question asked, “Are people who are coming to our ‘shorter’ program as distressed as those who entered the four to six month program?” Looking at all four scales described above, and considering profiles of men and of women, the answer is “Yes!” The accompanying charts offer data in terms of T-scores (percentiles) with a population mean of 50. We have found that the Admission scores for all scales are around or above the 60th percentile, in some instances reaching the 65th. Distress levels of residents entering the “old” and the “new” programs were similar.

We then considered, “What about when people leave?” Again, as we compared scores at departure, we found that outcomes of the two versions of the program were similar. In nearly all cases, means at Discharge were below the 55th percentile, which is the score we would expect to see in the general population when people are not reporting a need for treatment.

While this brief overview does not comprise a comprehensive assessment of our current program, we believe that it affirms the direction we have chosen. One outcome of our shift in length of stay was the strengthening of our Continuing Care Services. Dorothy Heiderscheidt, OSF, offers a perspective of that aspect of Southdown’s work in this issue of the "Connections".