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COVENANT

Southdown Introduces

Obesity Treatment for Clergy and Religious

by Sam Mikail, PhD, ABPP

North America has come to be known as a society of consumption and consumerism. This is reflected most clearly in the epidemic rates of obesity in Canada and the United States. Figures from the Center for Disease Control indicated that in 2004, 30% of Americans were obese. Statistics Canada data for the same year suggest that nearly 25% of Canadians were considered obese. The percentage of the population considered over weight is even higher, 60% in the U.S. and nearly 40% in Canada. Not surprisingly, the highest proportion of obese individuals is between 45 and 64 years of age. Several factors likely contribute to this reality, including increased consumption of processed and fast food, higher caloric intake, decreased rates of physical exercise, more automated and sedentary work, and increased rates of stress.

Obesity is not simply an issue of vanity or physical attractiveness. Research has shown that obesity can shorten life span by as much as 10 years. In fact, obesity is associated with five of the 10 leading causes of death in North America including heart disease, stroke, diabetes, several forms of cancer, and pulmonary disease. The disease burden associated with obesity now exceeds that of smoking, as are the associated healthcare costs.

Clergy and religious have not been immune from this disturbing trend. The demands associated with many forms of ministry make it difficult to be attentive to one's health. Long and irregular work hours, responding to the dual pressures associated with one's responsibility to a particular ministry and one's community or diocese, caring for aging parents or other family members, facing the stress of ministering to increasingly diverse and complex constituencies and doing so with fewer and fewer members; these are but a mere sampling of factors that contribute to the gradual, yet potentially fatal neglect of one's health. Of course, all of this is occurring within a broader social context in which the food we eat contains more calories than it did 20 years ago.

According to a recent study by the Center for Disease Control and Prevention, in 1971 men consumed an average of 2450 calories per day, compared to 2616 calories per day in the year 2000. The differences for women are even greater (1542 cal/day vs. 1877 cal/day). Although 200 calories per day may not seem significant, when multiplied over the course of a year and then a decade, the impact is astounding. For illustrative purposes, compare these differences; 20 years ago the average cheese burger contained 333 calories. Today, a typical cheese burger contains 590 calories. The bagel of 1990 contained 140 calories, but the new and improved 2010 model packs 350 calories.

Walk into any bookstore and you'll encounter a myriad of self-help books and DVD's aimed at weight reduction. Turn on late-night television and you are bound to see advertisements for various weight loss programs. Some of these have been shown to be helpful; others are frankly dangerous, and may have no efficacy whatsoever. Weight reduction and weight management are complex. They require sound, scientifically-based information, behaviour management, appropriate medical management, nutritional counselling, and attentiveness to relevant emotional and spiritual dimensions.

In response to an often requested need for assistance in this area, Southdown has, over the past year, invested time and resources to develop an interdisciplinary program aimed at addressing obesity treatment. The program will launch in October, 2010, and is specifically designed to address obesity and ongoing weight management for clergy and religious, whether living alone or within a community setting. A professional team comprised of psychologists, psychiatrists, dieticians, nurses, fitness instructors and spiritual directors are assigned to work with each person.

The length and design of the program are based on the latest research from leading

Continued on Pg 4

What Was I Thinking ?

by Wendy Cope, MA, C.Psych Associate

In sitting down to write this article, I found myself stalling while staring at the blank page. I wondered why I was hesitating. So, instead of focusing on my feelings, I asked myself what thoughts I was having that were preventing me from writing. The process went something like this:

Right now I am thinking…

I have nothing to say that is helpful.
I shouldn't have offered to write this article.
People don't care.

Hopefully tomorrow I may be thinking...

I am glad to have the opportunity to teach others.
My other articles were well received.
Maybe there is someone who will be helped by this article.

The stereotypical question that a psychotherapist usually asks is, "How do you feel about that?" Yet, there is a tremendous power in how our cognitions influence our feelings. Perhaps, the leading question could be, "What were you thinking?" This concept in modern psychology has been the root of Cognitive Behavior Therapy (CBT) that is now recognized as a highly effective treatment approach for those suffering from depression, anxiety, phobias, addictions, or eating disorders. Not only has CBT become a first choice for dealing with significant psychiatric and psychological problems, it can be helpful in managing our daily interactions with one another.

The importance of the impact of our thinking upon our feelings has been recognized for over 2000 years. In the Book of Proverbs (23:7) it is said: *"For as he thinks within himself, so he is."* CBT arose out of the work of Dr. Aaron Beck, a psychoanalyst from the University of Pennsylvania who, during the 1960's, was seeking empirical support to prove the benefits of psychoanalytic therapy. In the course of interviewing depressed patients he noted a pattern of thinking that was common to all those who were depressed. The thought patterns of depressed individuals were universally negative, pessimistic, biased by a punishing moralistic stance, narrowed by their overly personalized interpretation, rigidly dichotomous and contained an attitude of hopelessness. They used common negative terms to describe themselves, such as being a "loser" even though their actual life accomplishments showed them to have been quite successful. Dr. Beck concluded that depression was actually a disturbance in thinking. He reasoned that if you could help someone to change their distorted thinking patterns, their mood would improve. Psychologist Dr. David Burns continued this work, publishing his first book outlining CBT methods, *Feeling Good: The New Mood Therapy*, in 1980. He later developed *The Feeling Good Handbook*, which offers patients a practical, user-friendly guide.

The basic building block of CBT lies in the identification of one's **automatic thoughts**, which are defined as, *"the moment-to-moment mental content experienced by an individual"*. We are often not aware of these thoughts; they seem to exist like a low hum, just below our immediate consciousness. The more distressing a situation is, the more likely it is that our thoughts will contain distortions of reality. These **cognitive distortions** form an inner dialogue that leads to forming erroneous conclusions which, in turn, impact our feelings and resultant behaviors. There have been

ten typical forms of cognitive distortions identified and each individual tends to have various "favorite" ways to distort their thoughts. These ten cognitive distortions have been named as: all-or-nothing thinking, overgeneralization, mental filter, disqualifying the positive, jumping to conclusions, magnification (or minimization), emotional reasoning, should statements, labeling, and personalization. In CBT, the individual is taught how to analyze these thought patterns as they arise in different situations. Eventually, one can begin to recognize the common forms of distortions that keep emerging across all types of situations.

Certain themes also repeatedly arise that can lead to an identification of one's **core belief.** According to CBT theory, a core belief is, *"the fundamental way in which individuals regard themselves."* It is a deeply held concept of self that has been learned through developmental experiences, and reinforced by one's cognitive distortions. Some common core beliefs are: **I am unlovable. I am unworthy. I am a failure.** These self-perceptions become the lens through which the individual perceives the world. For anyone who struggles with depression, anxiety or other psychological problems, the identification of the core belief can serve as a significant turning point in recovery. Once a person is able to name the fundamental false belief about their self-concept, they can start to challenge other basic distortions, eventually arriving at a more realistic self view. The techniques of CBT help the individual to discover ways to challenge their self-defeating perceptions and to begin to articulate rational responses to counteract the distortions. Ultimately, this leads to changes in behaviors and a positive shift in feelings.

There is a third level of understanding that arises from the initial building block of the automatic thought, which leads to identification of one's core beliefs and ultimately can lead to one's schema. The concept of **schema** has been defined as: *"A relatively enduring unit of belief from which moment-to-moment cognitions are derived. They become the rules that govern how an individual assigns meanings."* The schema is essentially a perception of one's world view and it is based upon the cognitive distortions held by the individual. For example, if someone suffering with anxiety is frequently misinterpreting events as being dangerous or threatening, they may be holding onto a core belief such as, "I am powerless." This personal concept of viewing oneself as at the mercy of events around them can lead to a more generalized view of the world as an unsafe place. This schema of viewing the world in this way influences one's spiritual, social and political views. The goal of CBT is to help the individual challenge these views, starting from the automatic thought level which will eventually yield a change in one's schema.

Continued on Pg 4

From the CEO's Desk:

Numbers that Count

by Miriam D. Ukeritis, CSJ, PhD

For many of us, the prospect of working with "numbers" coupled with the added task of statistical analysis could be sufficient to bring on the symptoms of an anxiety attack. The challenge of measuring "progress" in therapy brings on questions such as "How can your quantify something so sacred as interior conversion or emotional healing?" Yet, asking a question such as "Is this working?" is ethically responsible for professionals in any realm of service – including psychotherapy. For that reason, clinicians at Southdown are committed to ongoing assessment of the clinical program and its effectiveness for our clients. We do that qualitatively through feedback, exit interviews and reflection with residents on their experience. We also do this through quantitative means.

We know that "numbers count," not only in the raw data that surveys generate but especially in the information that we glean from them, in the knowledge that this information yields, and, hopefully, in the wisdom that comes through pondering what we have come to know.

In the recent Annual Report, I reported on some of the ways we have tried to capture a sense of the changes that occur as our residents move through the residential program. I will review some of our findings here, and take a moment to sketch out what we have learned about the ministerial futures of the women and men who have participated in our program.

Treatment Outcome. Each person who entered the residential program from October, 2004 through June, 2007 was invited to participate in a "Treatment Outcome" study. The volunteer participants (totaling 182) completed two clinical instruments: the 90-item *Revised Symptom Check List (SCL-90-R)* and the *OMNI-IV*, an instrument that assesses qualities related to the range of personality disorders. OMNI-IV ratings of Current Distress, and the General Severity Index of the SCL-90-R all showed a significant decrease in distress/severity between the beginning of their residence experience and their departure. The same was true for ratings of Anxiety and Depression, the two complaints most frequently noted by residents. The gains made during residence were typically maintained over the 14 to 18 month post-residence period of continuing care. Interestingly, and perhaps not surprisingly, men's ratings of distress and severity tended, in general, to be lower than the women's. Whether this reflects a tendency of men to minimize problems or the fact that women who seek treatment actually do experience greater emotional distress is not clear.

As residents received feedback on their profiles at the end of their stay, they frequently commented on the convergence of their qualitative experience and the quantitative findings. While secure in their experience of healing, the shift reflected in the numbers often served to provide an external validation of their lived experience. In reflecting on the experience of participating in this study, residents spoke of its value, and suggested that we also use the measures during the course of treatment.

Resident Progress. Based on feedback received from those who participated in the Treatment Outcome study regarding the significance of obtaining quantitative feedback on one's progress during the course of residence, and committed to determining more effective ways of assessing the effectiveness of treatment, we instituted a "Resident Progress" component in our resident review process. Beginning in January, 2008, residents complete two surveys prior to each clinical review (typically every three to four weeks). As in the case of the Treatment Outcome study, the two brief measures – the *Inventory of Interpersonal Problems -32 (IIP-32)* and the *Brief Symptom Inventory (BSI)* - assess both personality functioning and clinical concerns. Once again, we generally find that differences in a resident's ratings of Anxiety, Depression, and General Severity of clinical symptoms are significantly different – significantly lower – when Admission, Third Review, and Discharge scores are compared.

At various points in treatment, results of the residents' ratings are shared with residents. At times they serve as encouragement when a resident may be experiencing a particularly difficult period. At other times, these ratings may serve to prompt one to focus his or her energies in an area which they have been resisting. They also serve as additional points of clinical progress to the treatment team.

Ministry Status. One of the frequently asked questions when speaking about treatment outcome is "how many of the residents return to ministry?" While acknowledging that "return to ministry" is not necessarily an indication of "successful treatment," it is an important question. Since January, 2004, we have systematically recorded what a resident's projected ministerial status is at the time he or she leaves Southdown. Based on the 562 men and women who have completed Southdown's residential program since that time (June 2010), we know that nearly 73% of the women and more than 55% of the men have returned to ministry. An additional 13.8% of women and 10.5% of men have returned to their communities or dioceses too ill or otherwise disabled to engage in ministry. This data certainly challenges the opinion of some that time in residential treatment is a first step out of priesthood or religious life. While true for some, our experience indicates that the great majority – nearly 85% of the women and more than 65% of the men return to their communities and dioceses.

What about the others? Around 18% of the men who completed treatment left Southdown facing significant ministerial restrictions or suspensions. This was also true for just under 4% of the women.

Continued on Pg 4

What Was I Thinking?...

Continued from Pg 2

To more fully illustrate the connection between one's thoughts, self-concept, feelings and behaviors, let's look at an example. Individuals with an avoidant personality frequently hold a core belief of: **I am undesirable.** Based upon this distorted self-perception, the avoidant person believes that others will ultimately reject them. They assume that if people actually knew their true self, they would be rejected. In order to guard against such rejection, the avoidant person feels compelled to put on a façade of being likeable in order to be accepted. They engage in a variety of people-pleasing behaviors that ensure that no one will become disappointed or angry with them. There is a clear avoidance of any behavior or situation that could bring forth conflict. However, there is an enormous cost to not relating to others in an authentic and real way. Such superficiality prevents the development of healthy intimacy. In order to change the behaviors, the core belief must be challenged. This is where the techniques of CBT are useful.

One particular tool is known as the Cost-Benefit Analysis. It is similar to a "pros and cons" list that can aid in making decisions. In this case, the individual is asked to list the advantages and disadvantages of living their life according to the core belief of: **I am undesirable.**

Advantages of Believing This	Disadvantages of Believing This
Don't need to take risks.	Loneliness and social isolation
Feel safe when I am alone.	Life experience is narrow and boring.
Don't need other people.	Miss out on having close friends.
People won't expect much from me.	Lack of emotional supports.
I won't be disappointed in myself.	Low self-esteem and lack of confidence.

If the secondary gains of holding onto a negative core belief are great enough, the person is unlikely to change. But, if the disadvantages are creating a significant enough negative impact, the motivation to change increases. At times, an individual may find themselves returning to old perceptions and behaviors and being confused about why they have not managed to let go. By using a tool like the Cost-Benefit Analysis, the reasons behind the resistance to change acquire greater clarity.

Patients often will ask if they can completely rid themselves of self-defeating core beliefs. However, recovery seems to be more about being able to recognize when the self defeating beliefs are coming into effect and learning to manage the thoughts better. At first, it is important to actually do the written exercises in order to identify the automatic thoughts and core beliefs. However, with enough practice and exposure to one's cognitive style, the recognition can emerge spontaneously, even when in the middle of a situation. The individual can then correct the distorted beliefs and arrive at a more realistic decision on what choices of behavior would be best.

A three month Cognitive Therapy Behavior group has been offered as part of the residential program at Southdown for several years. The residents are introduced to the concepts and techniques of CBT and asked to work on specific homework exercises throughout each week. The group then offers feedback or analysis to each other. During the last month of the modality, each resident is given the opportunity to present a project in which they apply CBT to a particular personal issue. Some topics have included self-esteem, conflict management, anger and codependency, in addition to more traditional diagnostic topics of depression, anxiety, phobias and addiction. Feedback from the participants has been very positive and they feel that they have been taught a specific, easy to use tool to aid them in their ongoing recovery.

Obesity Treatment...

Continued from Pg 1

academic and healthcare institutions in Canada and the U.S. Typically, participants will begin with a comprehensive, interdisciplinary assessment. The treatment component extends for a period of 24 months, four months of which involve focused residential treatment aimed at life-style and behaviour change, education, pharmacotherapy, and increased mobility. The non-residential component of the program includes a combination of on-site aftercare workshops, weekly contact via computer or phone link, and monthly phone check-ins. Ongoing support is available whenever and however it is needed.

To inquire further about the program, to discuss individual needs, or to make a referral, you are encouraged to email **proberts@southdown.on.ca**, or call us at **905-727-4214.**

Numbers that Count...

Continued from Pg 3

A closer look at the data indicates that, in recent years, this percentage for men is closer to 13 or 14%, with the overall numbers reflecting more significant problems in this area in the earlier years. Most of these men and women have returned to the dioceses or congregations as well.

Those who left their communities or sought laicization represent just under 8% - 9.4% of the men and 4.4% of the women. And, for various reasons, we have no information on the ministerial status of about 6% of our former residents at the time of their departure.

The more significant reality is that those who have concluded treatment leave with a clearer sense of their call and vocation. As Southdown strives to provide healthy ministers for a healthy Church, we are aware that ministry takes many forms. Experiencing the fulfillment of Jesus' desire that all may experience life in its fullness enables the men and women whose life journeys bring them to Southdown to carefully discern and courageously choose to be faithful to God's call to them.

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