



# LUKENOTES

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## **Will I Get Better in Treatment?**

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Vol. XI, No.1

January/February, 2007

People often make erroneous assumptions about the efficacy of treatment. The skeptics do not believe that psychotherapy ever works. This is more akin to a fundamentalist perspective that asserts prayer alone heals and is suspicious of psychotherapy, while a Catholic perspective supports the use of medicine and psychology in conjunction with prayer and the sacraments. Other people reject psychotherapy because they simply do not believe that psychological treatments work. They know individuals who have chronically relapsed and they generalize this to all those with psychological problems or addictions. Still others reject treatment because they do not understand how "just talking about" problems can work. They often belong to the "stiff upper lip" approach to problems and do not understand the complex and entrenched nature of many psychological disorders.

The other extreme is those who expect psychotherapy to always work. When someone goes into treatment, they expect this individual to come out completely healed. They think that psychotherapy is somewhat like a medical cure: the individual is treated for a problem, the individual is cured, and there is no trace of the disease left. As a result, when a psychologist advises that the individual in residential treatment will need to continue his or her recovery work for a long time, this statement is likely to be met with disappointment. "Why did we pay all this money for treatment and she isn't cured?" they will ask. This approach, like the former, is too simplistic.

### **Realistic Expectations**

The truth is somewhere between these extremes. In reality, psychological treatment works extremely well in some circumstances, fairly well in others, and sadly, at times, has no effect at all. Looking at the over five thousand priests and religious who have come to Saint Luke Institute, about eighty percent have returned to an active and productive ministry. I would estimate that about thirty percent improved significantly, with a remarkable turnaround. They are our success stories and they make our ministry especially satisfying. Another fifty-five to sixty percent of our clients have improved in varying degrees. These clients are on the road to recovery, have markedly gotten better, and they have a long journey ahead of them. Finally, there are about ten percent who have not improved in treatment at all. Some of these may "get it" later on in life; sometimes we are surprised by a turnaround months or years later. Some will not get better at all.

Can we predict who will get better before treatment begins? Several factors strongly affect treatment outcomes. Perhaps *the most important factor is the client*. Does he want to get better? Is she prepared to make significant life changes to get better? An unmotivated client usually does not get too far in treatment. Either they become motivated or they drop out.

Many times religious superiors and bishops will “encourage” an individual to go into treatment. This is often necessary since clients sometimes begin treatment with varying degrees of ambivalence. Even the most motivated of clients will harbor doubts about whether they will or can change. For example, more than a few alcoholic priests and religious have sat in front of me at the beginning of treatment and have told me directly “I cannot live without alcohol.” My response is always the same: “Hundreds have done so before you; you need simply to trust that it can happen.”

Another major factor related to successful treatment is the type of problem a client brings into treatment. Success rates are often related to the diagnosis. For instance, our relapse rate for alcoholism is less than twenty percent. This good rate is related to “high functioning” and motivated clients, our long-term, intensive treatment program and 2-5 years of continuing care. Our clients return to a supervised environment where they are gainfully employed and supported. These are important factors contributing to success. We all know chronically relapsing alcoholics; thankfully, they are not the majority.

Individuals who are addicted to crack, cocaine, heroin or other kinds of drugs tend to do less well. While we have had a number of success stories of priests and religious who have gone on to clean lives after drug dependence, the ferocity and tenacity of such addictions make any clinician hesitant to predict success. A key factor for those who remain clean is ongoing participation in 12-step programs.

Similarly, some eating disorders can be resistant to treatment. For example, one of several clinical problems that some clients bring to treatment is compulsive overeating. We have a full-time nutritionist, a full-time exercise and physical therapist, and a comprehensive medical program through which we thoroughly address and monitor diet and exercise. Our focus here is on healthy eating and a healthy life style, which includes regular exercise. Clients may lose many unwanted pounds before the end of treatment. But, unless they are motivated to continue the healthy patterns developed during treatment, the likelihood that they will put back many of those pounds is fairly high. It is difficult to permanently sustain weight loss when one is faced with the daily necessity of looking at food and eating.

Many diagnoses have high success rates. Depression, for example, is very treatable with the advent of newer classes of anti-depressant medications and recent cognitive-behavioral treatments. More than eighty percent of depressed clients at SLI will experience varying degrees of improvement, many with total remission. We also find that many compulsive behaviors, such as sexual behaviors, internet addictions and spending problems, respond well to treatment. Again, newer cognitive-behavioral therapies, including relapse prevention work, and 12-step groups are highly effective.

One diagnostic area that is resistant to change are the personality disorders. Individuals who enter treatment with narcissistic or borderline personality disorders, for example, will not exit therapy with “easy-to-get along with” personalities. While some progress can be made and moderating their disorders is possible, it is just as important for communities to learn how to contain such individuals.

Because of the dynamic increase in newer psychotropic medications and many kinds of psychotherapeutic treatment modalities, the efficacy of modern treatments has increased markedly. However, we rarely, if ever, speak of “cure.” Rather, progress has hopefully been made and we help clients set out on the road to a life of recovery and health. Some get stunningly better. Others improve a great deal. Still others get a little better and a few do not improve at all. Having a realistic understanding of the efficacy of treatment can be important, especially for religious superiors and bishops when their priests and religious walk through a therapist’s door.

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