Recovery Start Kit
Therapist Manual
The First 130 Days

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EDITOR’S INTRODUCTION

We are beginning a new series in sexual addiction recovery. *Recovery Start* is the first kit in a series that will be published in the next few years. As managed health care becomes a greater concern for those who are limited to a number of six to eight sessions to fix what took years to develop into an addiction, we have found ourselves struggling to give everyone who seeks help a chance. We have nick-named the *Recovery Start* kit, “In-patient for the Out-patient.” It may sound very simple, but the premise is that even in an out-patient setting, deep therapy and recovery can be accomplished.

We know some of you are very experienced at diagnosing and working with sex addicts if you are a Certified Sex Addiction Therapist (CSAT). If you are not a CSAT, we highly recommend that you read the first section, about diagnosing and treating sex addiction, carefully. For more information about training in the treatment of sex addiction, please visit [www.IITAP.com](http://www.IITAP.com) or call 480-575-6853.

We have given you a general overview and several scenarios of how you may incorporate *Recovery Start* into your own practice. Please direct any questions you may have concerning the kit to info@gentlepath.com.

Best regards,

The Staff of Gentle Path Press
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UNDERSTANDING SEX ADDICTION

HISTORY

Since James Orford’s classic article on sexual dependency appeared in the *British Journal of Addictions* in the late 1970’s, there has been a growing awareness among medical professionals of problematic sexual behavior that did not fit traditional categories, such as the paraphilias. In these cases, sexual behavior had similar patterns to substance abuse, pathological gambling, and compulsive eating, and frequently co-occurred with these problems. Loss of control, significant adverse consequences, and continuation despite consequences emerged as beginning criteria for patient identification. Compulsive sexual patterns, coupled with extreme preoccupation, characterized these patients who often incorporated diverse normal and abnormal behavior. Cultural changes worked to reveal and to accentuate the problem. Public awareness and accountability connected to sexual exploitation and harassment in religious, political, military, and business contexts generated more patients seeking help. Furthermore, the acquired immune deficiency syndrome (AIDS) epidemic brought more patients who were behaving in self-destructive ways counter to their own wishes. Finally, Internet sex dramatically escalated the frequency of patients seeking help from clinicians. In 1999, the late Dr. Al Cooper published a landmark study that revealed that six percent of Internet users manifest problematic online behavior. Many of those in trouble with cybersex probably would not have a problem without the Internet. Parallel to sexual awareness, the 12-step groups, such as Sex Addicts Anonymous (SAA), have grown dramatically as an adjunct to therapy.

PROBLEM RECOGNITION

The nature of sexually compulsive behavior interferes with problem recognition. Patients often are not candid about their behavior, nor are they likely to reveal that specific behaviors are actually part of a consistent, self-destructive pattern. Patients frequently hide the severity of the problem from others, delude themselves about their ability to control their behavior, and minimize the impact on others. Their shame extends to being deceptive with their physician. Sometimes, their role as leaders in church, business, community, or political settings compounds the problem because they expected to exhibit behavior that is beyond reproach. When an event precipitates a visit to a physician, the incident is represented as a one-time occurrence, a moral lapse, or an event brought about by marital problems. Careful assessment and data assembling may reveal a much deeper pattern that requires specific therapy for sexual compulsion. These patterns may emerge in widely diversified forms, including compulsive masturbation, compulsive prostitution, cybersex, exhibitionism, voyeurism and criminal sexual misconduct. There is seldom just one pattern, but rather a collage of patterns affected by hierarchies of preference, situation, combination, and opportunity. For example, pornography on the Internet may serve as a portal to other addictive sexual behaviors such as prostitution and affairs, or it may be a gateway to solicitation and stalking of underaged children.

An inappropriate sexual incident does not necessarily mean the presence of addictive illness. A long-term extramarital affair, for example, may be a problem for a spouse but does not represent a compulsive pattern. Additionally, exploitive or even violent behavior does not indicate a sexually addictive illness. A study of sex offenders revealed that only 72 percent of pedophiles and 38 percent of rapists fit the criteria for sexual addiction.
Sex addiction surfaces in many guises. The common thread is that all patients report a loss of control and life consequences. Age or sex excludes no one. The ratio of men to women is 3:1, which parallels alcoholism and compulsive gambling. The notable exception is problematic online sexual behavior, for which 40 percent of patients are women. The Internet has also pushed boundaries: younger and elderly people are becoming involved in compulsive cybersex.

ETIOLOGY

Addiction is a complex biosocial illness. More than 87 percent of sex addicts also report having other addictions, which adds to the complexity. In the period from 1985 to 2003, the author performed a series of studies which provides a profile of sex addicts. Six hundred fifty patients attended an addiction interaction workshop, which was designed to understand the patterns in the interaction of their compulsive behaviors. In order to conduct an appropriate assessment of these patients, professional helpers needed to understand the etiology of sex addiction, as well as the objective criteria by which to evaluate sex addicts.

In the aforementioned studies, it was determined that sex addicts tend to come from families where addiction is common. For example, mothers (25%), fathers (38%), and siblings (46%) had significant alcohol problems. Mothers (18%), fathers (38%), and siblings (50%) had similar problems with sexual acting out. Parallel patterns existed with eating disorders, pathological gambling, and compulsive work habits. Only 13 percent of sex addicts reported a family of origin with no addictions. Consequently, we know that growing up in a family with existing addictions is a factor.

Family type was also a factor. Seventy-seven percent of sex addicts in the study experienced their families as rigid, dogmatic, and inflexible. They also found their families to be disengaged (87%), i.e. detached, uninvolved, and emotionally absent. Thus, they came from environments in which failure to bond was the norm.

Another major area of impact was the role of child abuse. Addicts reported physical abuse (72%), sexual abuse (81%), and emotional abuse (97%). Furthermore, the more sexually and physically abused the respondents were as children, the more addictions they had as adults. Emotional abuse was a significant factor in addicts who abused children themselves.

THE ROLE OF TRAUMA

It is clear that for sex addicts, trauma or high stress and addiction are inextricably connected. Addiction in its various forms becomes a solution to the anxiety and stress of the trauma. In reviewing the literature and reports of the research population, it was determined that eight different trauma responses are typically manifested by victims. From this research, an instrument called the Post Traumatic Stress Index was developed. Following is a brief summary of each dimension of trauma. Percentages are those sex addicts who scored high in the category:

1. **Trauma Reactions**: Physiological/psychological alarm from unresolved trauma experiences (64%)
2. **Trauma Pleasure**: Seeking or finding pleasure in the presence of extreme danger, violence, risk, or shame (64%)
3. **Trauma Blocking**: Efforts to numb, block out, or overwhelm residual feelings due to trauma (69%)
4. *Trauma Splitting*: Blocking traumatic realities by splitting or dissociating from painful experiences and not integrating into personal or daily life (76%)

5. *Trauma Abstinence*: Compulsive deprivation that occurs especially around moments of success, high stress, shame, or anxiety (45%)

6. *Trauma Shame*: Profound sense of unworthiness and self-hatred rooted in traumatic experience (72%)

7. *Trauma Repetition*: Repeating behaviors and/or seeking situations or persons that re-create the trauma experience (69%)

8. *Trauma Bonding*: Dysfunctional attachments that occur in the presence of danger, shame, or exploitation (69%)

We can now correlate trauma profiles with patterns of dependent, compulsive, and obsessive behaviors, and therapists can identify traumatic experiences as a factor in compulsive sexual behavior.

**BEHAVIOR PATTERNS**

While the process of addiction is common for all those with sexual compulsion, the focus of the behaviors will vary. Through a series of studies using hundreds of specific behaviors, it was determined that sex addicts tend to cluster into ten distinct types of behavior. These typologies have a specific erotic focus that seems to correlate with distinct phases of courtship that have become distorted. They are:

1. *Fantasy Sex*: Becoming lost in sexual obsession and intrigue, including behaviors that support preoccupation, such as stalking, compulsive masturbation, or being a “romance junkie”

2. *Voyeurism*: Visually-oriented behaviors, including pornography, strip shows, and peeping

3. *Exhibitionism*: Exposing oneself inappropriately or in self-destructive ways

4. *Seductive Role Sex*: Serial or concurrent exploitation of relationships, usually in pursuit of power and conquest

5. *Intrusive Sex*: Violating boundaries as a high arousal experience, such as obscene phone calls or frotterism

6. *Anonymous Sex*: Compulsive sex, often in high-risk circumstances, often with strangers

7. *Trading Sex*: Using sex as part of a business transaction. (This is addictive because of the risk, cost, or repetition of early trauma).

8. *Paying for Sex*: Purchasing sex as in compulsive prostitution or phone sex services

9. *Pain Exchange*: Sex that is most pleasurable when one is hurt physically and diminished personally

10. *Exploitive Sex*: Serious sexual misconduct at the expense of vulnerable persons.

These archetypes are useful to the clinician because the clusters help to reveal the addict’s arousal patterns. For example, intrusive sex includes patients who compulsive use frotterism and toucherism. The goal of those behaviors is to touch people sexually without them being aware of the behavior and without being caught. If they exhibit those behaviors, they are also likely to
make obscene phone calls, or to insert inappropriate sexual humor into conversations. If they are professionals, such as physicians, dentists, clergy, or therapists, they touch patients inappropriately under the guise of their professional tasks. Empirical evidence shows that the behaviors are related. For the clinician, it becomes a guide to the internal world of the addict. In intrusive sex, the courtship distortion has to do with fear of rejection and having somehow to steal sex, even in fleeting ways. It also reveals eroticized rage, common in sex addiction, wherein the patient notices the sex but not the anger.

Sex addicts are often active in more than one cluster of behaviors. They may, in fact, shift focus. An exhibitionist who wishes to avoid arrest may go to a massage parlor, where it would be safer to be seen. Compulsive affairs may replace prostitution. Most often, there is a variety of ways to act out, including paraphilic and offending behaviors. One of the distinct advantages of the addiction paradigm is that it allows clinicians to see that not only do currents of compulsive behavior transcend specific categories, but they also have the same common self-destructive results and obsessional purposes.

The key for clinicians is to understand the escalation factor. Addicts act out using more of the behaviors, add risk and danger, or seek new behaviors, often with great risk and danger. Escalation is tempered with plateaus, efforts to reduce risk, and sexually aversive periods. Most addicts are able to pinpoint moments of escalation and resulting consequences.

An essential part of the treatment process is identification of the arousal template. In 1985, John Money used the term love map to describe the internal guide as to what was erotic. This arousal template is more dynamic than a map, for it usually contains a scenario based on an abuse experience, a fantasy, or something historical. Clinicians approach this issue by having the patient identify the ideal fantasy – if acting out were perfect, what would it look like? Therapy is about tracing back the origins of the arousal, understanding its functional and dysfunctional parts, and reimaging healthy sexual practice. In this way, the organizing principles of the compulsion are exposed and, with psychological distance, can lose their power.

**CYBERSEX: CRACK COCAINE OF SEX ADDICTION**

One of the greatest escalators of sexual addiction is the Internet. Cybersex has been termed the crack cocaine of sex addiction. In 2002, sex-related sites became the number one economic sector of the Internet, recording sales that exceeded that of software and computers. Pornography alone has become a problem in the workplace. Seventy percent of Internet pornography traffic occurs between 9AM and 5PM. Seventy-two percent of companies that have faced Internet misuse reported that 69 percent of those cases were related simply to pornography. Leading software publishers estimate as much as 83 billion dollars per year in lost productivity for American companies. Serious researchers showed in large samples that one in six employees was having trouble with sexual behavior online.

Researchers have noted problems with compulsive and addictive behaviors online, especially in the areas of gambling and sex. Others have noted behaviors such as online trading, gaming, and compulsive computer use. In addition to Dr. Cooper’s original articles, others who work with compulsive sexual behavior patients documented problematic online sexual behavior in which people’s daily ability to function was affected by their cybersex activities. Specific patterns of arousal emerged in these online compulsive scenarios:
**Rapid escalation of amount and variety.** Patients report consistently that they experienced a rapid increase in the amount and diversity of the behavior. People who have significant problems often find that the problems start almost immediately. The pattern of rapid escalation is common enough to be noticed by clinicians. Factors that contribute to escalation include the appearance of anonymity and ease of access. Also, a pattern of denial quickly emerges in which the behavior is viewed as having no consequence.

**Escalation becomes obsessional, with new, specific behaviors becoming quickly fixated.** Patients report that they become obsessed with specific behaviors that they had never experienced or even knew of before their Internet experience. This pattern is intriguing, given that sexual science has long taken the position that the arousal template or *love map* is established early. John Money suggests that arousal patterns are firmly established between 5 and 11 years of age. Patients, however, report being unable to stop thinking about behaviors they did not know existed until they were in their sixties and on the computer. Thus, under the influence of the computer, users are experiencing high degrees of arousal of which they have no history and that are difficult to stop. This finding also counters much of the traditional addiction and compulsion literature that traces obsessive behavior in adults to experiences of childhood or adolescent sexual abuse.

**Relational regression occurs,** in which absorption in Internet sexual activities results in serious withdrawal from sexual contact with partners as well as withdrawal from overall intimacy. Patients report that sex with spouses or partners declines in frequency and appeal. Further, they note a withdrawal from social contact with family, friends, and colleagues. In part, that is a result of many hours spent on the computer and the emotional depletion that accompanies Internet bingeing. There also appears to be a shame component that leads to isolation and despair. Although some have reported that pornography in general leads to a decline in intimate sexual interaction, the intimacy avoidance with cybersex appears to be quite profound and needs to be studied systematically.

**Internet sexual behavior can accelerate existing addictive and compulsive behavior and can precipitate new compulsive off-line behavior.** A common finding is that patients who are already having trouble with compulsive sexuality found the Internet to be a significant behavior intensification catalyst. The Internet not only intensified the problematic eroticization but also adds new resources. If compulsive prostitution was a problem, it became even more so as a result of Internet activity. Some patients report having had no history of compulsive sexual behavior until they discovered the Internet. When their sexual behavior escalated online, they started behaviors off-line that became compulsive as well.

One theory of explanation for escalation, intensity of arousal, and compulsive behavior is that, through the Internet, patients *access the unresolved.* All people have sexual experiences that leave them unfinished. Sexual play as a child, for example, may leave a person with unfinished experiences. As a person matures, s/he realizes that s/he no longer has an interest in that behavior or that those experiences are no longer appropriate in adults. Yet, a person might experience the right image or story that is an absolute overlay of something unfinished from childhood or...
adolescence. The nature of marketing for pornography sites is to bombard potential clients with a variety of images to stimulate the purchase of memberships. When that which is unfinished is accessed, the individual begins to search for more the same genre. The marketing loops of sex sites are literally labyrinthine; each choice may bring a person closer to the types of images that most closely fit that unresolved, unfinished aspect of the sexual self. Patients often report the phenomenon of a *burned-in image* – a specific scene out of their Internet experience about which they cannot stop thinking. This phenomenon is similar to the intrusive images that PTSD patients describe. Patients report that preoccupation with a specific image became so troublesome that they would delete it from their files only to go back to the original source and retrieve it. This happens over and over again.

**ADDICTION INTERACTION DISORDER**

Empirical data that have connected sex addiction with other addictions was collected in a study of 932 sex addicts conducted by the author. Within that sample, 42% reported chemical dependency, 38% reported an eating disorder, 28% reported compulsive working, and 26% reported compulsive spending. As part of their recovery, they also identified multiple addictions in their mothers (22%), fathers (40%), and siblings (56%). Over time, there have been numerous studies documenting the comorbidity of sex addiction and other addictions. These reports have documented this phenomenon in clergy (Irons & Laaser, 1994), health professionals (Irons & Schneider, 1994), chemical dependency populations (Gordon, Fargason, & Kramer, 1995), and eating disorders (Schwartz & Cohn, 1996).

Similar patterns have been noted from the perspective of other disorders. Within substance abuse, there is a wealth of documentation concerning the concurrent use of alcohol and drugs. Miller, Belkin, and Gold (1990) put it succinctly, “For the contemporary drug addict, multiple drug use and addiction that includes alcohol, is the rule. The monodrug user and addict is a vanishing species in American culture”. Studies of substance abuse patients also find significant co-morbidity with gambling (Sweeting & Weinberg, 2000) and eating disorders (Stewart, Angelopoulos, Baker, & Boland, 2000). Conversely, studies of pathological gamblers have found symptoms of dependency on alcohol and drugs (Winters, Bengston, Dorr, & Stinchfield, 1998). Petrucelli and Stuart (2001) argue persuasively about the connection between eating disorders, sexual compulsion and other addictions. Reflecting this emerging research have been collected efforts to show parallels across many addictions. One of the most recent and thorough is the interdisciplinary studies collected by Robert Coombs titled *Handbook of Addictive Disorders: a Practical Guide to Diagnosis and Treatment* (2004).

For clinicians who treat sex addiction, we must go beyond noticing the coexisting patterns. If each addiction brings unmanageability to the patient’s life, to think that the resulting chaos from each does not compound the problems with the others would be clinically negligent. The truth is that the whole may in fact be more than the sum of its parts. Further, to borrow from Miller and Gold, “unless contemporary treatment methods are adapted to fit changing patient characteristics, attempts at rehabilitation may be futile” (1990, p.596).

This opens a number of key questions. What does happen when a patient population of sex addicts is assessed for other co-morbid disorders? What conceptual foundations might we look to in terms of possible etiology and clinical intervention? Are there ways these addictions interact making the whole more than just the sum of the addictions themselves? Can we explain these interactions from what is known from neurobiology? Finally, are these interactions?
comprehensible to patients? In order for the paradigm to be useful to patients, they have to be able to recognize them. There are ten dimensions in which addiction impact or in some way relate to one another. They are:

1. **Cross tolerance**: a simultaneous increase in addictive behavior in two or more addictions
2. **Withdrawal mediation**: one addiction serves to moderate, relieve, or avoid physical withdrawal from another.
3. **Replacement**: one addiction replaces another with a majority of the emotional and behavioral features of the first.
4. **Alternating Addiction Cycles**: addictions cycle back and forth in a patterned systemic way.
5. **Masking**: an addict uses one addiction to cover up for another, perhaps more substantive addiction.
6. **Ritualizing**: addictive rituals of behavior of one addiction serve as a ritual pattern to engage another addiction
7. **Intensification**: one addiction is used to accelerate, augment, or refine the other addiction through simultaneous use
8. **Numbing**: an addiction is used to medicate shame or pain caused by other addiction or addictive binging.
9. **Disinhibiting**: one addiction is used frequently to chronically lower inhibitions for other forms of acting out.
10. **Combining**: addictive behaviors are used to achieve certain effects that can only be reached in combination.

**DIFFERENTIAL DIAGNOSIS**

The addiction model has long defined addiction as present when there is compulsive behavior. The author has also made the case that not only does sex addiction involve multiple sexual behaviors, but it is highly interactive with other co-morbid disorders that have common underpinnings.

Historically, clinicians have used criteria similar to those used to substance abuse and pathological gambling. These criteria are based on the three standard principles of evaluation of addictive disorders: 1) loss of control (compulsivity), 2) continuation despite adverse consequences, and 3) obsession or preoccupation. Ten elaborated criteria are used. They are:

1. Recurrent failure (pattern) to resist sexual impulses to engage in specific sexual behavior.
2. Frequent engaging in those behaviors to a greater extent or over a longer period of time than intended
3. Persistent desire or unsuccessful efforts to stop, to reduce, or to control behaviors
4. Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experiences
5. Preoccupation with the behavior or preparatory activities
6. Frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations
7. Continuation of the behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior
8. Need to increase the intensity, frequency, number, or risk of behaviors to achieve the desired effect or diminished effect with continued behaviors at the same level of intensity, frequency, number, or risk
9. Giving up or limiting social, occupational, or recreational activities because of the behavior
10. Distress, anxiety, restlessness, or irritability if unable to engage in the behavior

Other diagnoses must be considered in the differential diagnosis of excessive sexual activity, including the following:

- Impulse control disorders
- Bipolar affective disorder
- PTSD
- Adjustment disorder
- Substance-induced disorders
- Dissocialize disorders
- Delusional disorders
- Obsessive-compulsive disorder
- Gender identify disorder
- Delirium, dementia, or other cognitive disorder
- Personality disorders

Several authors have described how these disorders can be expressed as excessive sexual behavior. For example, a hypersexual patient who is in the manic phase of bipolar illness usually demonstrates other features of the disorder, such as grandiose thinking, excessive activity, and short attention span. An alcoholic with inappropriate sexual behavior will likely exhibit other signs of intoxication. An Alzheimer’s patient with disinhibited sexual behavior will show other cognitive deficits. Conversely, addiction is a pervasive pattern of behavior that is present for months and years.

**TREATMENT: THE PROCESS**

Treatment can be divided into three phases, whether it is outpatient or inpatient:

**Phase One: Intervention**
- Survey extent of problematic behavior
- Teach about illness
- Referral to 12-step program
- Confront denial
- Agree on behavior contract
Phase Two: Initial Treatment
- Twelve-step program attendance
- Complete first step of 12-step process
- Agree on writing an abstinence definition
- Written relapse prevention plan
- Complete a period of celibacy
- Develop a sex plan
- Partner and family involvement
- Multiple addiction assessment
- Trauma assessment
- Group therapy
- Shame reduction

Phase Three: Extended therapy
- Complete steps 2-4 of 12-step process
- Developmental issues
- Family of origin issues
- Grief resolution
- Marital and family therapy
- Career issues
- Trauma therapy

The first phase is about intervening in the cyclical compulsive process. The physician must extend the patient’s sexual history to include all aspects of the problematic behavior. This survey is important, because it gives the patient and the physician an awareness of the extent of the problem. The physician’s inquiry helps the patient understand the severity of the problem, and the physician most likely may be surprised by unpleasant disclosure that occurs later in therapy; however, sometimes surprises happen regardless of what preventative measures are taken.

During the initial phase of treatment, therapy focuses on teaching the patient about the illness. In addition to coaching from the therapist, the patient must read and learn about the problem. This is also the time to refer the patient to a local 12-step group for sex addiction or sexual compulsion. As the patient starts to trust the therapist and becomes more familiar with the disorder, it is time to start confronting areas of significant denial in the patient. The best place to start is with the most obvious and the most dangerous areas. Clearly self-destructive behaviors, such as exhibitionism in a shopping mall, unprotected sex with prostitutes, or sex with dangerous persons, have to stop. At this point, the therapist develops a behavioral contract with the patient about behaviors from which the patient will abstain while in therapy. For example, if exhibitionism in a shopping center is a problem, or if compulsive use of prostitutes occurs in a certain area of town, the patient agrees not only to refrain from these behaviors, but also to avoid going to these areas alone. The patient also agrees to report any problems.

Once this foundation is in place, the second phase of treatment can begin. The following strategies are typically used at this time (during the first four to eight weeks of treatment) for inpatient or outpatient treatment:
• **Completion of the first step.** The 12-step program starts with a first step in which patients acknowledge problems that, on their own, they have been unable to stop. Inventories of efforts to stop and consequences of sexual behavior are used to break through denial. This step is presented in the support group and in therapy.

• **Written abstinence statement.** This is a carefully scrutinized list with three parts: (1) the destructive behaviors from which the patient agrees to abstain; (2) the boundaries needed to avoid those behaviors; and (3) a full statement of the positive sexual behaviors that the patient wishes to cultivate. All of these are carefully reviewed in therapy and in the support groups.

• **Relapse prevention plan.** With the therapist’s help, the patient prepares a comprehensive plan to prevent relapse, including understanding triggers and precipitating situations that are not directly related to sex, as well as performing addiction fire drills (automatic responses to prevent relapse).

• **Celibacy period.** The patient is asked to make a commitment to celibacy, which includes masturbation for 8 to 12 weeks. If the person is part of a couple, his or her partner must also commit to this process. This period is designed to reduce sexual chaos and to teach how sex has been used as a coping mechanism. It also creates a window in which patient and partner can explore conceptually what constitutes sexual health. Often during this period, the patient experiences memories of early childhood sexual and physical abuse.

• **Sex plan.** At the conclusion of the celibacy period, the therapist and patient create a sex plan, which further articulates the difference between destructive and healthy sexuality.

• **Partner and family involvement.** Partners and family members go through therapy about the impact of the behavior. This is to further confront denial, but also to help those close to the patient engage in therapy for themselves.

• **Multiple addiction assessment.** Addictions and compulsions work together in various ways. The therapist helps the patient see that addictions, compulsions, and deprivations are all part of the repetitive pattern. The relapse prevention plan and sex plan are adjusted accordingly.

• **Trauma assessment.** A complete assessment of abuse and assault is done by the physician. This assessment helps clarify the goals of long-term therapy. For many patients whose behavior stems from early abuse, this becomes the key to understanding their behavior as the acting out of a scenario and provides important psychological distance from the addictive pattern.

• **Group therapy.** Patients participate in an ongoing group. Optimally, this would be a group whose members share the same issues, but follow-up studies have indicated that any ongoing group makes a substantial difference.

• **Shame reduction.** The therapist works with the patient in using various strategies to reduce sexual shame and shame about past behavior.

Once a period of relapse-free behavior has taken place, the third phase of treatment may begin. This phase focuses on underlying developmental issues and family-of-origin issues (as they are reflected in the patient’s sexual acting out). If substantial abuse is part of the picture, therapy to deescalate reactivity and to defuse sexual triggers to inappropriate behavior is required. Furthermore, therapists find substantial amounts of unresolved grief, which requires attention because it can lead to slipping into old behavior patterns. Unattended grief can
precipitate total relapse. During this period, the patient must continue to work the steps of the 12-step program. In an unpublished outcome study, the author found that only 23 percent of patients actually completed steps one through nine of the 12 steps in 18 months. Among these patients, relapse was rare.

Many patients’ careers have been adversely affected by their behavior. Some may never return to the career for which they were trained. This becomes an issue that must also be dealt with therapeutically. Similarly, marriage partners and family members require extended therapy to overcome feelings of betrayal and loss, as well as to understand the role of family dysfunction in the compulsive cycles. Helping professions, including physicians and clergy, also require special intervention and monitoring.

Finally, if the behavior involved criminal sexual misconduct and was part of a compulsive pattern, treatment time is usually extended dramatically. In part, this is usually a developmental issue requiring other therapeutic components, which promote victim empathy and accountability.
### The Course of Recovery Over Time

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<tr>
<th>PRERECOVERY</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
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**Developing Stage**
- Up to 2 years

**Crisis/Decision Stage**
- 1 day to 3 months

**Shock Stage**
- About 8 months

**Grief Stage**
- 4 to 8 months

**Repair Stage**
- 18 to 36 months

**Growth Stage**
- 2 years and cont.
## Tasks 1-7

<table>
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<th>RECOVERY TASK</th>
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<th>LIFE COMPETENCY</th>
<th>THERAPIST COMPETENCY</th>
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<td>1. Break Through Denial</td>
<td>Creates a problem list</td>
<td>Understands the characteristics of denial and self-delusion</td>
<td>Understands typical denial patterns of sex addicts</td>
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<td>Records a secret list</td>
<td>Identifies presence of self-delusion in life</td>
<td>Recognizes disclosure “testing” process</td>
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<td>Completes list of excuses</td>
<td>Knows personal preferred patterns of though distortion</td>
<td>Knows personal delusional patterns</td>
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<td>Completes Consequences Inventory</td>
<td>Accepts confrontation</td>
<td>Understands counselor transference issues in working with sex addicts</td>
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<td>Learns 14 ways to distort reality</td>
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<td>Recognizes signs that sex addiction is present</td>
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<td>Inventories 14 distortion strategies in personal life</td>
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<td>Understands and identifies stages of recovery</td>
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<td>Accountability – Victim Empathy exercise</td>
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<td>Confronts delusional patterns in clients</td>
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<td>Makes full disclosure to therapist</td>
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<td>Utilizes crisis to break through denial</td>
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<td>Capacity to gather data from all sources including client, family, victims,</td>
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<td>2. Understand the nature of addictive illness</td>
<td>Completes assigned readings on sex addiction</td>
<td>Knows information on addictive illness</td>
<td>Understands different ways of defining addiction</td>
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<td>Learns different ways to define sex addiction</td>
<td>Applies information to personal life</td>
<td>Understands professional controversies around sex addiction</td>
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<td></td>
<td>Understands addictive system</td>
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<td>Understands key factors in the genesis of sex addiction</td>
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<td></td>
<td>Understands deprivation system</td>
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<td>Assists client in understanding sex addiction</td>
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<td></td>
<td>Maps out personal addictive system</td>
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<td>Contracts with client to limit current behavior</td>
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<td></td>
<td>Understands criteria for addictive illness</td>
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<td>Develops relationship with family members</td>
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<td>Applies criteria to personal behavior</td>
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<td>Contracts with family members</td>
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<td>Learns key factors in the genesis of sex addiction</td>
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<tr>
<td>RECOVERY TASK</td>
<td>PERFORMABLES</td>
<td>LIFE COMPETENCY</td>
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| **2. (Continued)** Sexual Addiction Component | Understands sexual modularity  
Understands sexual hierarchy  
Knows ten types of behavior  
Reviews ten types for personal patterns  
Completes and shares sexual history  
Completes ideal fantasy list  
Completes and shares fantasy contamination exercise | Understands sexually compulsive patterns  
Knows specific stories/scenarios of arousal template | Knows personal sexual limitations as a therapist  
Recognizes sexual modularity and hierarchy  
Conducts effective sexual history  
Identifies sexually compulsive patterns  
Identifies “drivers” of arousal template  
Discerns and interprets dysfunctional scenarios |
| **3. Surrenders to process** | Understands context of change, grief, commitment  
Understands existential position on change – essence of recovery  
Understands principles of anxiety reduction  
Completes sexual addiction history  
Completes powerless worksheet  
Completes unmanageability worksheet  
Identifies ten worst moments  
Understands guidelines of step completion  
Gives first step | Acceptance of addiction in life  
Knows personal limitations  
Discerns difference between controllable and non-controllable events | Uses first step methodology  
Understands criteria for successful step work  
Utilizes first step results for long-term commitment  
Teaches existential position in twelve step principles |
<table>
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<tr>
<th>RECOVERY TASK</th>
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<th>LIFE COMPETENCY</th>
<th>THERAPIST COMPETENCY</th>
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</thead>
</table>
| **4. Limits damage from behavior** | Understands 1st and 2nd order change  
Understands concept of paradigm shift  
Records provisional beliefs  
Completes damage control plan  
Completes a disclosure plan  
Writes a “turning it over” letter to higher power  
Completes and second and third step | Integrates self-limitation into personal paradigm  
Responds to crisis plan fully  
Uses boundaries at a minimum level  
Has internal skills for anxiety reduction  
Develops resolve for change and commitment | Understands core process of paradigm shift  
Assists in crisis management  
Utilizes damage control plan to teach boundary development  
Utilizes disclosure plan to teach boundary development  
Integrates second and third step work into therapeutic processes of trust, control, anxiety, boundaries, change |
| **5. Establish sobriety** | Understands sobriety as boundary problem  
Commits to and completes celibacy contract  
Writes sobriety statement  
Understands relapse process  
Writes relapse plan  
Establishes a date | Uses clearly stated boundaries of sobriety  
Manages life without dysfunctional sexual behavior | Facilitates relapse prevention planning  
Utilizes sobriety definition and celibacy process as part of boundary restoration  
Supports sexual health plan of client  
Understands sexual health dimension from a twelve step framework |
| **6. Ensure physical integrity** | Learns physical aspects of addiction  
Completes physical  
Completes psychiatric assessment  
Learns neuropathways of addiction  
Maps person neuropathway | Understands physical aspects of addiction  
Identifies neuropathway interaction  
Identifies dysfunctional arousal | Identifies co-morbid mental health problems  
Understands breadth of physical complications  
Identifies neuropathway activity |
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<tr>
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</tr>
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<tr>
<td>7. Participate in a culture of support</td>
<td>Participates in a twelve step program Develops relationship with sponsor Completes sponsor debriefing Does service in program Knows signs of a healthy group Has celebration date</td>
<td>Maintains a healthy support system</td>
<td>Knows differences in fellowships Maintains relationships with members of recovering community Knowledge of twelve step work Knows signs of healthy support group Uses steps “therapeutically” Understands control/anxiety paradigm of twelve step life</td>
</tr>
</tbody>
</table>
The Seven Tasks

1. Make problem list
2. Make secret list
3. List of excuses
4. Consequences inventory
5. Find therapist, sponsor

1. Read books on sex addiction
2. Map out addiction cycle
3. List of unmanageable moments
4. Sexual anorexia/binge-purge cycle
5. Self-assessment; history

1. Sex addiction history
2. Powerlessness inventory
3. Unmanageability inventory
4. Financial costs worksheet
5. Ten worst moments

1. Sobriety challenges worksheet
2. Identify relapse scenarios
3. Fire drill plan
4. Abstinence list, boundaries list
5. Personal Craziness Index

1. Damage control plan
2. Disclosure plan

1. Attend regular meeting
2. Regular contact with sponsor
3. Meeting presentation
4. Outside activities
5. Daily rituals

1. Physical exam
2. Sex addiction matrix
3. Sexual health matrix
4. Arousal Template

Task 1: Break through Denial
Task 2: Understand Nature of Illness
Task 3: Participate in Culture of Support
Task 4: Limit Damage from Behavior
Task 5: Establish Sobriety
Task 6: Enhance Physical Integrity
Task 7: Sustain the Process

40 - Day Focus
90 - Day Prep
90 - Day Focus
Recovery Start
Clinical Foundations

Frequently treatment professionals in the addiction community use the phrase “the elephant in the room” to describe denial in a family which pretends some big issue does not exist. This is akin to acting as if there is no elephant in your living room when in fact there is one. Ironically there exists an elephant in the room within the addiction community itself. Massive resources (for those that can afford it) are spent on programs that last from four to six weeks. Yet the bulk of recovery work takes three to five years of dedicated effort and very little structure or resources are devoted to this process. The assumption is that once sober, the addict and the family can find local resources and use twelve step communities to pursue their recoveries.

From the outset I wish to make some things clear. I believe in the twelve step process and live that way of life myself. As a researcher, I have contributed to the growing body of literature which shows that without this process most people cannot sustain the changes sobriety requires. I also believe in treatment in an intensive inpatient environment. I have done that for myself. I have worked in that industry for years and witnessed the miracles that happen daily in that context. There are some people who would never have a chance without the structure and medical support provided by inpatient treatment. In my heart of hearts and in the best of all possible worlds, I think everyone should have a chance at treatment in their adult life because of the profound opportunity this experience offers to reexamine your life. Here however are the problems:

- On the average, over four million people every year need treatment for chemical dependency desperately and will not be able to afford access to help. This is not counting sex addiction, eating disorders, gambling, or the profound compulsive attachment issues which usually accompany these disorders. Of the people who do get treatment many could do it meaningfully on a local level. Most therapists and indeed most intensive outpatient programs have not had training in how to structure long term care in ways that would supply long term support.
- Many addicts leaving treatment fail within days of leaving treatment. The transition from the supportive environment where people understand their dilemmas to the real world is too abrupt, often poorly structured, and results in dispiriting failure.
- A great deal of evidence from different perspectives including such diverse viewpoints as neuroscience, evidence based practice, and harm reduction all point to recovery being a three to five year process. Even from the most basic brain imaging we know that changing and altering the synaptic connections to healthier functioning takes at least two years to show substantial improvement.
- One of the major problems is focusing exclusively on chemical addiction. Seldom do addictions occur in isolation. They are most a complex web of excessive and deprivation behaviors including eating disorders, sexual disorders, financial disorders (including gambling) and other co morbid mental health issues. The major chemical dependency institutions steadfastly resist the obvious. The patient is left to thread through this array of challenges knitting together as best they can a series of solutions.
Further, there are significant underlying issues around shame, grief, trauma and family that when not addressed in a planful way invariably sabotages the recovery effort.

Very little attention is provided to help recovering people as consumers of health care to understand and develop skills in healing their brain. Mental health in general is the only branch of medicine that does not systematically examine the organ it is treating. Even less effort goes into teaching the patient how to “care for their brain” and why and how that is important.

The result is sobriety rates that range on the average 32% to at best 47% without relapse. For every 100 people who go through treatment, our best “guess” (versus outcome) is less than half will maintain sobriety, a quarter will relapse and may eventually get sober, and a quarter are simply lost. There will be some argument about that, but the truth is that is what happens – and it has been that way for years. Getting viable outcome data also remains a problem.

Another real challenge is the commoditization of health care and mental health specifically. Therapists and institutions are squeezed by funders so that only those with means get the help they really need. This will only get worse until a new standard of care has been demonstrated as a medial bottom line. In the meanwhile, 3.7 million people will not have access to any care at all. 800,000 will receive some help but it will be incredibly variable depending on personal wealth.

Being sober does not mean that they have recovered mental health which is vital if we are at all serious about prevention. Unless we stop the cycles in the multigenerational quality of addiction we will ultimately fail. It is the very first line of prevention. And that means restoring the individual and the family to some meaningful level of functionality.

Addiction is our number one problem. Eating disorders, chemical addictions, sexual disorders, nicotine, fuel our health care costs. It is our number one social problem. Most crime is committed under the influence. It is key to all forms of child abuse. It is our number one problem in schools. And it our number one source of violence. Yet we cannot get it paid for, we have not been able to document the efficacy of treatment, and prevention efforts have been dramatically slashed.

The outline of the elephant in the room is very clear. We have a major problem we are not addressing. The professional community is part of the problem because of their unwillingness to go beyond the silo mentalities of chemical addictions only, not treating the underlying issues long term issues, and focusing on the residential facility with its thirty day program. Finally, advances in neuroscience tell us that addiction as a disease is like a stroke. Part of the brain literally can no longer be used. To make significant change requires a deep attention and discipline which alters the nature of how therapy is done.

When all of these issues filter down to a bottom line, the results are simple: we need an evidenced structured process which:

- accommodates neuroscience research and innovates applications that patients can use.
- reflects the three to five year process
- promotes and teaches the deep attention such change requires
- documents success with good science
builds on what has worked for people who have made successful recoveries
reflects not only addictions but the extreme deprivations which seem to weave into patient’s lives
empowers local therapists and programs to provide a more rewarding and effective context for therapy
creates program and growth opportunities for the local clinician
adapts readily to residential environments so that inpatient and outpatient clinicians can collaborate more easily and effectively
is competency based so that specific learning activities create new competencies which in turn supports neuronal growth and altered perception

This leads us to what is called the task centered approach to addiction treatment.

Towards a Task Centered Approach

A task centered approach is a viable way to demonstrate and create an alternative. It is built on careful documentation of what has been successful for recovering sex addicts. Out of that research emerges a recipe. If addicts and their families follow the “recipe” early studies show that recovery is quite attainable. This recipe is broken down into “tasks” which contain measurable activities. These tasks can be performed in a residential as well as in outpatient context. Success is related to how much the patient does. For example, in an early outcome study we did, we found that only 23% of our patients actually did steps one through eight of the twelve step program within eighteen months. Of those that did, relapse was very minor. The real challenge is making the recipe as an orderly set of tasks both accessible and measurable.

In order to accomplish the tasks the patient needs to have a structure within to work, therapists and treatment professionals who can teach and support their work, and a system to monitor and support their progress. The tasks must be well defined, easily accessed, and add significantly to the recovery process. These tasks must be measurable and create a concrete way to pinpoint success and outcomes. Finally, the tasks lend themselves to use on the internet. Even for those challenged by problematic on-line behavior, the computer can be extraordinary tool to help therapy and recovery. The tasks are designed ultimately to have an internet base.

Another key assumption is that sobriety is not the sole goal. We now understand that people of great achievement access their brains in many of the same ways addicts do. The brain thrives on challenge. The old Buddhist wisdom applies that if you are to say no, you must know what yes is. Sobriety is essentially saying no. Recovery succeeds to the degree that the patient’s motivation and challenge to live life to the fullest exists. Getting sober has not been the problem. Staying sober has been the problem. And that will remain elusive until you have done four things:

1. Completely understand how addictions are really about the unresolved issues in your life.
2. Resolving those issues in a way that restores resilience and meaning to your life.
3. Defining a proven map to that helps you sort this recovery process out.
4. Providing an optimal process that is rewarding and sustainable even though it will require some years of your life.

The current version of the task centered process specifies thirty task domains along with performable activities and competencies. Taken together they are a statement of an optimal process of recovery. Also their design is built on the premise of finding the personal zone in which there is challenge and meaning as well as safety and stability. It provides a viable alternative to inpatient care for some who really do not need that. Further, for those that do need inpatient care, their long term chances of success become significantly better. A full statement of the tasks can be downloaded from iitap.com. Those therapists who are current Certified Sex Addiction Therapists already have been trained in the tasks and implementation.
Recovery Start and the First Seven Tasks

The first seven tasks which focus on establishing sobriety are encoded in the book *Facing the Shadow: Starting Sexual and Relationship Recovery*. The accompanying chart summarizes these seven tasks. This book and these tasks have been used in both inpatient and outpatient contexts effectively for some time. *Recovery Start: the First 130 Days* is designed to help a patient focus while working on these tasks. It is built on the following clinical premises:

1. Part of the challenge of early recovery is insufficient structure in a private practice or even outpatient setting. The fifty minute hour, reading assignments and meetings often fail to provide psychological “traction” necessary to establish a meaningful sobriety.
2. Structure must supply both focus and context to learn the early tools of recovery. The early “tasks” of the task centered model require deep attention which is hard to achieve in busy lives in which recovery is now added, or worse, in which significant unmanageability causes distractions and chaos.
3. Two thresholds exist in creating meaningful sobriety. Two to four weeks of sobriety is easily accomplished because of desperate despair, fear, or unmanageability. When the dust settles, the addiction reasserts itself in “slips” which with momentum can mean sliding back into the old patterns. Thus we have the all too often experience of going to therapy and continuing to act out without reporting it to the therapist. Therefore, getting significantly past the first month establishes a base to go to deeper work. Hence the goal is forty days of problem free behavior with a very high degree of accountability.
4. Once that success is achieved, the next three months are critical. As the shock wears off, grief emerges. Plus there are significant changes which have to happen which add to feelings of loss. Concurrently, therapy is working towards “unconscious competence” in recovery skills. Like developing fluency in a language the more you use it, you become competent and are able to think less about it. Finally, there must be a bonding period that exceeds the crisis management phase. This anchoring process may take over a year, but must have at least three months to incubate according to attachment research.
5. From the very beginning of recovery, a primary factor in success is to confront the fragmentation and compartmentalization core to the addictive process. Starting with the forty day focus, the design of the program is for the addict to appreciate the inconsistencies of the addictive life.
6. After 130 days of initial focus, there will more likely to be the habits in place and the motivation present to do the deeper work of significant recovery. At this point the patient should be ready for the next phase of the tasks (8-19) we call the Recovery Zone.

*Recovery Start* is structured into three parts. First, is the forty day focus during in which the patients focus on tasks one through three and the basics of accepting they have a problem. During this time period they have meditations built around a “curriculum” of basic recovery concepts. Further, they utilize a methodology called the core dialogue queries which is essentially a journaling process using structured thematic questions. In this manual is also a ten module curriculum in PowerPoint for psychoeducational workshops (three hours) which integrate the tasks in *Facing the Shadow* with the *Recovery Start* materials. This in
conjunction with therapy and twelve step work empowers the patient to achieve a more intense level of focus.

The second part is a series of exercises called the “Ninety Day Prep”. The patient works through these exercises as assigned by the therapist either individually or as a group in their psychoeducational labs. These experiences prepare the patient with skills, insights, tools, and a recovery plan to make the next ninety days (post the original forty) a success. An additional advantage of this approach for inpatient care is that it helps facilitate the transition back home. When done on an outpatient basis the advantage is the immersion in a therapeutic community with seamless transition.

The third part, called the Ninety Day Focus, is the implementation of the plan emerging from the Ninety Day Prep activities. Intense focus on sexual awareness and lifestyle change become critical in relapse prevention. Also a strong effort is made to accelerate the usage of other recovery resources and to integrate into the larger twelve step community. Core to each is a reflection process which integrates affirmation, visualization, and the continued use of core dialogues. Each is built around specific pieces of “best advice” distilled from addicts who have been successful in their recoveries. Chart Two provides an overview of the process with a timeline of the various activities.

There are essential design criteria which have guided the preparation of these materials:

- **Processes that require focus** – the patient learns the “deep attention” that is required to alter neuronal networks.
- **Repair of addiction damage** – the patient limits further damage and works to repair all systems – biological, interpersonal, social, and family
- **Paradigm shift** – patient can understand what a paradigm shift is, how knowledge and insight powers change.
- **Growth and stimulation of the brain** – the patient learns about addiction as a brain disease and the processes that create healing.
- **Systematic interaction with others** – communication and bonding are critical factors in brain change and successful recovery
- **Methods to uncover contradictions** – addiction can survive only with the compartmentalization of contradictions.
- **Developmental awareness** – making sense of the personal deficits that are now the focus of therapy
- **Visualization of growth** – imagery, rehearsal, and goal development shapes the quality of recovery
- **Consolidation moments** – periodic times of summarizing and learning from progress
- **Self awareness** – learning and memory are critical to disrupting dysfunctional behavior patterns
- **Positive focus** – discerning personal “excellence” shapes a sobriety based on meaning and life purpose
- **Clear indicators of progress** – perfomables, progress points, and measures of success help the focus process

Using these principles *Recovery Start* from the ground up was designed to create flexible platform for a variety of methodologies. It integrates the twelve step programs, therapy, recovery resources, and emerging technologies around integrating internal fragmentation
and affect regulation. Most importantly it can be used and tailored in a variety of settings including inpatient, outpatient, workshop, and private practice. This creates a process flexible enough to follow through a variety of levels of care.

For the provider, initially *Recovery Start* may seem overwhelming. Our experience is that once clinicians use it and see the positive rewards, it all starts to fit. It takes a time or two, but by using it a section at a time, you will see how things fit together. In order to make it easier for you, we have included the following:

- a set of compact disks to provide an overview of the program
- an introduction to each phase of the program with specific suggestions for using the materials. After each introduction the instructions for the patients are also reprinted for the convenience of your preparation.
- a selected reading list to help backfill clinicians on information they may wish to pursue that were critical in formulating the program.
- For those with no background with this problem, the whole first section of this manual is a summary of information and research on sex addiction

It is very important that the user listen to the audio cd’s provided and read through the instructions as well. As part of your preparation, listen to the patient audio cd’s as well. Complete exercises that are intriguing to you. Most of the CSAT therapists have done this as part of their training or continuing education. Many of us have found them personally helpful. It adds significantly to the impact of your presentations.

We know from experience that as people use our materials they discover ways to make them better. We invite you to contribute to the next version any ideas for improvement. We are grateful that you have joined in our effort to create a better, stronger, more flexible way to start sex addiction recovery. We look forward to your participation in the future.
Key Selected Bibliography

By Dr. Patrick Carnes:
Don’t Call It Love – the original research which underlines the recipe used by those who achieved successful recipe
Anatomy of Arousal – addresses eroticized affect and internet use
Bargains with Chaos – summarizes problems implicit in multiple addiction treatment
Facing The Shadow – the basic patient text that this program is designed around
Out of the Shadows – the original book by Dr. Carnes which brought attention to the problem

Other authors:
Jacob Needleman, Money & the Meaning of Life – while on financial disorders this is the best book on the contradictions addiction creates
Mihaly Csikszentmihalyi, Flow – landmark book makes the connection between the achieving brain and the addictive brain
Louis Cozolino, The Neuroscience of Psychotherapy – this book will change how therapy is done on all issues and a great introduction to neuroscience and therapy
Daniel J. Siegel, The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are – Siegels updated classic documents the fundamental premise of interaction as a brain modifier
Dr. Michael J. Bader, Arousal: The Secret Logic of Sexual Fantasies – this book speaks to the principle of the soul window exercise which is that sex really reflects deeper issues which manifest in other non-sexual ways.
The Forty Day Focus

The forty day focus is organized around two basic technologies. First is the meditation process consisting of forty key meditations. Second is a nightly journaling process called the Core Dialogue Queries – or sometimes just “CDQ’s.” Patients report that both are useful, painful, and the “best part” at times. Taken together they form a context with which to do the important work of accepting they have a problem and taking responsibility for their behavior. Thus, they start the day and end the day with a focus which enhances their ability to do their therapy. During this time they will be in group and will do the psychoeducational experiences. They will start the twelve step process including a detailed first step.

Taken together there is embedded a “curriculum” of core issues and information. Much thought, time, and experimentation has gone into the development of this “concealed” course. By completing them a subject at a time, patients adsorb concepts and skills essential to the recovery process. We also formalize the curriculum throughout Facing the Shadow and the psychoeducational curriculum at the end of this manual. Each time they do a meditation or a CDQ, they add a piece important to their recovery – one bit at a time. The meditations have four dimensions:

- Key skills necessary for successful recovery
- Key concepts about addiction
- Reality issues and addiction
- Principles for surviving bottom

Each dimension contains ten meditations. Together they form the forty critical elements early recovery people need. The content is summarized in Tables 1-4. All forty are summarized in Table 5. They are also reviewed in the attached CD on the forty day focus.

The second technology is the core dialogue queries or CDQ’s. Recovery starts when patients confront the fragmentation and compartmentalization that supports secrecy and the double life. We often use the metaphor of “windows” software. An addict keeps opening windows until the system crashes. A number of factors contribute to this phenomenon. First, over two-thirds of sex addicts come from rigid/disengaged families. This means first that there are significant attachment issues and problems with trust. Also developmentally children in order to preserve a sense of self learn to hide their desires and differences from the rest of the family. They probably discover significant “secrets” in their family and conclude that living a double life is the solution. Compound this dynamic with trauma and neglect, children take refuge in their ability to dissociate.

Many have noted in the Lord of the Ring series, the character Gollum has points of internal dialogues that are striking in how they parallel the internal world of the addict. Gollum debates with himself about whether he should give in to temptation. In many ways we all have internal “parts” of ourselves that we have internal dialogues with. There is a long clinical heritage discussing this internal fragmentation. We have used terms like archetypes, introjects, subpersonalities, and neuronal subsets. Perhaps the best description of this literature is in Robert Schwartz’z book, Internal Family Systems Therapy. Schwartz himself uses the term “internal constellation.” For deeper or more hidden aspects we use terms like “shadow” or metaphors like Robert Louis Stevenson’s Jekyll and Hyde. In the world of addiction, and particularly sex
addiction this ability to split one’s life into compartments allows excessive, self destructive behavior. Throughout Recovery Start and the sequential task centered programs, helping with internal integration is critical and part of the “deep attention” process.

This starts with the query process of the core dialogues. Each night the patient is presented with key questions to dialogue with the addict within themselves. This journaling process is rewarding and also provides extraordinary insight. Therapists, who use technologies such as EMDR, will find this process generating extremely useful material about trauma and family of origin issues. As in all metaphorical interventions, the patients access their own wisdom. They find themselves recording things that were unbearable to acknowledge to themselves let alone to a therapist. But in the safety of the dialogue, these truths come out. The queries are organized around ten core topics:

- denial
- relationships
- addictive patterns
- relapse
- multiple addictions
- unresolved issues
- affect tolerance
- commitment
- crises
- self-sabotage

They are organized in a definite progression of four phases. First, is understanding the addiction and where it comes from. The second focuses on building an alliance with the internal addict to build recovery. The third explores what is necessary for sexual integration. The final phase queries assist in recovery planning. Unlike the meditations which can be used in any order, the CDQ’s have a definite progressive order which builds on previous work. Table Six summarizes the questions used as queries.

Each night there is also a self-monitoring process. Patients rate themselves in two dimensions: withdrawal (preoccupation, irritability, anxiety, sleep disturbance, and sadness) and recovery practice (peer support, staff connection, self care, honesty, program practice). This evening process becomes a point of consolidation. Where there is patient contact everyday, it is useful to see where everyone is the next morning. If patient contact is weekly, there is a weekly summary which includes the most significant learnings from their CDQ work. Most therapists simply make it routine to turn in these at the beginning of group. Invariable helps focus on the most fruitful places to work in that session. There is a forty summary chart as well which at the end, provides perspective on the whole process.

The CDQ process will continue in a modified fashion in the Ninety Day Focus as well. Expansion of integration continues as the task centered process approaches issues such as trauma, shame, and grief after patients have completed the 130 day process. So in essence we are introducing a tool for self awareness that will begin what some have termed the transformational cascade. One realization leads to a number of key learnings. Patients are then more open to adopting other strategies and tools with which to build their recovery.

At the very beginning of the forty day focus guide are a series of task cards. These are cards which allow patients to check off performables as they complete them. Part of focus is
having constant benchmarks of success. The tasks listed, of course, are addressed across the whole 130 day process. Once they start, they can keep referencing what they have done and what remains.

The optimum way to maximize patient utilization of these materials is to involve them in the psychoeducational curriculum provided at the end of this manual. These modules integrate the forty day focus materials, the tasks set out in Facing the Shadow, and the ninety day prep materials. The latter is a set of processes and self assessments used to plan out the ninety day focus (described in the next section). There are ten modules each taking about three hours to complete. Typically they fit in the forty day process as evening presentations and one all day workshop. The first introduces the basics of the process and initial tasks. Then they intensively work on this over a six week period. At which point they will be ready to move on to the ninety day focus.

The modules are designed so they can be integrated into existing program or practice – inpatient or outpatient. They can also be embedded in a week long intensive format. Think of them as building blocks around an essential process. The goal is to enable maximum flexibility for the clinician and to support maximum focus for the patient.
Instructions for Patients

RECOVERY START INTRO

One of the greatest challenges to an addict in early recovery is finding and maintaining structure in a support system. One can visit a therapist regularly, read the required material, and even belong to support groups, and still not possess the fundamental structure that is needed to establish a meaningful sobriety. There are two tools to help you with this challenge.

First, there is the book, Facing the Shadow, which is organized on a “task-centered” system. Our research has shown there are specific tasks that, if addicts do them, build strong recoveries. If they do not complete the tasks, the probability of relapse is high. This recipe of thirty tasks takes about three years for most people to do. Each task has specific “performables” which are activities that help addicts build skills and change how the brain processes information. Facing the Shadow focuses on the first seven of the thirty tasks. These seven tasks are the backbone of your new recovery.

Recovery Start is the second tool, which helps you focus on the tasks, plan your recovery, and reclaim your positive sexual focus. This program is organized into phases. The first phase helps you focus on your first step and establishing sobriety. This is a forty-day process. The second phase is what we call the “ninety-day focus”; it helps to structure deep change at a personal, behavioral, and neuronal level.

Research has shown that building a solid foundation for your recovery process is crucial in the first four months. Although it is relatively simple for everyone to maintain sobriety in the first couple of weeks (due to despair, fear or unmanageability), the addiction reasserts itself after this short period and this is where “slips” occur. Therefore, getting significantly past the first month of sobriety establishes a base to go deeper. Hence, the goal is forty days of problem-free behavior with a very high degree of accountability.

During the first forty days, we ask that you complete the “Ninety-Day Prep” with your therapist. This is a collection of key exercises, which will help you prepare for a successful ninety-day focus. This section contains several areas of deeper work; here are some of the major exercises:

In the first, the System Transformer, you will concentrate on your addiction cycle, what you want your recovery cycle to be, and the steps you need to take to get there.

The second is an exploration of the nature of sexualized rage, which often plays a key role in addiction, and how cybersex has impacted your life.

The third is called the “soul window,” and builds on work done in Facing the Shadow.

Next are two exercises that work together, the Three Circle Worksheet and the Positive Sexual Focus exercise. These exercises will help you with boundaries and the ability to see your future as a healthy sexual being.

The fifth is called “emotional restitution,” an exercise in honesty to be completed with a partner.

The last exercise, which takes you into the ninety-day focus, is called the Personal Craziness Index, and is meant to get you back on track with daily functions and activities.

In one of these exercises, the Ninety-Day Planner, we find a useful way to simplify and
focus your recovery efforts. It pulls together all the work of the first forty days into a cohesive day-by-day effort.

Once forty days of success are achieved, and you have a plan, the next three months are critical. As the shock wears off, grief emerges. There are also significant changes that will add to the feeling of loss. At the same time, you will be developing an “unconscious competence” in recovery skills. Much like becoming fluent in another language, the more you use your recovery skills, the more automatic your recovery behavior becomes. After you come through the crisis management phase, there is a period of bonding, which can take from three months to over a year to achieve.

Beginning with the forty-day focus, you will learn the inconsistencies of the addictive life. After 130 days, you will have developed recovery habits and the motivation to do the deeper work of significant recovery. At this point, you will be ready for the Recovery Zone, the book series that follows Facing the Shadow.

In order to help you picture how Recovery Start works, we have provided two graphics. First is an overview of the tasks with Recovery Start modules linked to the center. Second is a timeline, which shows you how the pieces fit over time. The goal of the graphics is to show how the pieces fit together. Remember that this is a day-by-day process and, with time, will become easy for you. At first, it seems overwhelming. By proceeding a section at a time, the tasks will guide you through a process that has worked for many.

Recovery does not have to be just a story of pain and struggle. It is also a journey of discovery, of new relationships, and at times, humor. We have structured a path for you which, if you follow it, will bring all of the above. It will not be easy, but the rewards are rich.

We wish you the best of journeys.

Patrick J. Carnes, Ph.D., C.A.S. and the Gentle Path Press staff
Patient Instructions for 40-Day Focus:

In the early days of twelve-step programs, the idea of “ninety and ninety” emerged. The concept was that to stimulate the recovery process a person would go to ninety meetings in ninety days. People found over time that the daily focus could often make all the difference in sobriety.

With the advent of modern residential and intensive outpatient programs, we have added new resources and structure to the process. Also, there is a growing realization that most addicts probably have more than one addiction. Further we are learning new information about the brain which further alters our understandings. Yet, the principles of a structured, intense time period where there is a real focus on recovery activities stands as a tried and true strategy.

With sex addiction it has been hard to establish norms. In part, that is because of the rapid improvement in therapy and treatment available. What was true fifteen years ago has been altered as we have become better at helping people with their addictive cycles.

This start-up kit really helps to structure the early work for sex addiction recovery over the first eighteen weeks. While the recovery process is literally a three- to five-year journey, the very foundations are laid early. Without those foundations, recovery can be a roller coaster-like experience, with three steps forward and two steps back, because the fundamentals were not accomplished. Facing the Shadow is a map to those fundamentals. This package is designed to support establishing this foundation in a sound way.

The forty-day focus becomes the platform upon which all this is based. Part One of this program creates an intensive structure to focus on recovery for your sex addiction over a forty-day period. Sex addicts often can go eight to ten days with no problem. Going thirty seems to be the next threshold to staying sober. If they pass forty, relapse probability starts to diminish significantly. Most addicts are then ready to do the deeper work of long-term recovery.

You will use three key strategies for the first forty days while you are working on the seven beginning tasks of recovery. The first is a series of forty meditations which are designed to support those early tasks. Each day, you will read a meditation and record a reaction. It does not matter which day you start with. So if your group or program is focusing on one meditation that day, you can pick up where they are and still complete the series. It is important that you date each entry as you make them.

The second strategy is what we have termed “core dialogues”. This process structures an internal dialogue between you and your addict. This practice helps you access how your addiction developed its power. It is based on a series of questions or “queries” utilized to think about your own life experience. We call these core dialogue queries, or “CDQs”. Part of the goal is to introduce introspective practice to your recovery life. Plus, this format will teach you basic principles we will use extensively in the next part of this series, called The Recovery Zone. Thus, the CDQs will be valuable in your later recovery as well. You will notice that your morning meditation reactions and your CDQs will mutually support your therapy.

Finally, we ask that you chart your progress each day. First, you mark off each day of consecutive sobriety with the goal of achieving forty days free of problematic sexual behavior. In addition, you record that you have completed both a CDQ and a meditation that day.

We ask that you monitor the following withdrawal dimensions, which will help measure your transition into sobriety and are added up to compute a withdrawal score for the day:

Addictive Urges – a measure of your preoccupation
Irritability – a measure of feelings of frustration, anger, or rage
Anxiety – a measure of feelings of fear and worry
Sleep Disturbance – a measure of inability to rest
Defensiveness – a measure of your own resistance to feedback

We ask that you also monitor the following recovery dimensions and compute a recovery score for the day:

Peer Support – a measure of how close you feel to peers
Staff Connection – a measure of how supported you feel by staff
Self Care – a measure of your efforts to do good things for yourself
Honesty – a measure of how honest you are being with others
Program Practice – a measure of your using program tools and principles

By tracking the ratings each day you will start to see interesting relationships between your urges and the other dimension(s). Also, marking off each day is an affirmation of your progress and effort. Please follow the instructions on your daily progress chart. Bookmarkers have been supplied to help you keep track of where you are in the meditations and CDQs.

The question remains as to what happens if there is a slip or relapse during the forty days. You simply start the forty days over again. The meditations and the core dialogues are designed to be re-used and your therapist can supply a new progress chart. We have learned that it is helpful to revisit meditations and CDQs you have already responded to. Thus you can react with the perspective of your relapse which helps deepen the commitment to the process.

Some residential facilities require completing the forty days twice. The first forty days are done as inpatients and the second forty when the patients are actually living again in their home situation. The logic is twofold. Usually those in a residential context have more issues and greater severity to their addiction. Thus, making the extra effort of repeating the forty-day focus makes sense because that foundation simply has to be there in order to succeed. Also, this work by comparison might be easier in an environment in which there is safety and structure. To accomplish the same goals as an outpatient for many is tougher, so it is suggested to use the system twice to assist in the transition from residential to outpatient. As in all stages of early recovery, let your therapist be your guide as to what is best for you.

In the case of a relapse after significant sobriety, therapists may require another round of forty focus days. The purpose here is to go back and reestablish the recovery “platform” upon which your recovery efforts are based. These decisions are often highly individualized and we suggest that doing a second forty would best be decided with the support of your therapist and your support group.
The Ninety Day Prep

The Ninety Day Prep package contains a series of awareness exercises and self-assessments as well as critical recovery planning tools. Each one is designed to ask patients to examine their challenges from a new perspective. Their purpose is to assist the “paradigm shift” critical to maintain a recovery program. Plus there are critical tools which enhances decision-making and “focus.” They also push the patients into a new level of honesty with themselves – and with others including their therapists.

Most of the prep processes can be assigned as stand alone projects. That way they can be integrated into different points of your program or process. Not all will be applicable to everyone. For example, if a patient has had no problem with cybersex, the cybersex assessment would not be appropriate. Taken together they generate information that defines the work for the ninety day focus. The last process is called the Recovery Planner which collects much of the work during the first forty days. It includes the results of tool development in *Facing the Shadow*, realizations from their therapy and twelve step work, and the completion of the Ninety Day Prep package. This includes also a category called “Growth Goals” which is co-determined in conversation with their therapist. Essentially these are the treatment objectives for this critical ninety day period.

Sexual awareness tools start with the Mirror of Erised exercise in *Facing the Shadow*. This exercise serves as introduction to the Soul Window process. Both share the assumption that sexual behavior reflects deeper wound and personality issues that emerge in many other places besides. These core issues are the very grist of therapy.

The Positive Sexual Focus builds on a model of sexual health which in many ways is consistent with twelve step principles. An audio cd is provided to assist with preparation of the focus planner. Completing the positive sexual focus is essential for using the three circle tool in recovery. An expanded three circle worksheet is provided on the reverse side of their planner.

The cybersex self assessment gathers information to help the patient and the therapist locate sexual issues played out on the internet. Critical to this is understanding the role of eroticized rage in compulsive cybersex. Also provided is a helpful timeline which helps the patient explore the relationships between time on-line, risk, on-line behavior, and off-line behavior.

Emotional Restitution is a process designed by Ken Wells at Psychological Consulting Services in Scottsdale. The purpose is to expose the ways that the addict would cover their behavior and create victim empathy awareness. Reading these letters in a group is an incredibly instructive and powerful experience.

Critical to recovery planning is the Systems Transformer. It utilizes the critical survival perspective found in the Stocksdale paradox: to survive one must have a clear image and confidence of a different future and at the same time recognize how really serious the problems of the day are. The Systems Transformer takes the Addictive System and a future vision of the Recovery System and poses the question: how do I get there. This very clarifying process helps in the early days of recovery pinpoint what must be done now.

Among the planning tools, some initial models are started in Facing the Shadow. The Personal Craziness Index and the Three Circles already exist in the book. The Prep package contains enhanced versions of both of these technologies. The monthly monitor is introduced as another way to daily examine their progress. This tool helps focus on lifestyle change and sexual
health plus tracks important elements of recovery. Three monthly sheets are provided for the ninety day process.

The recovery planner is the consolidation tool for planning out the next phase of the program. The clinician needs to carefully read the instructions and make sure all the pieces are in place for the patient to finish. We have color coded and simplified all that must go into the planner. It is in the review of this document between therapist and patient that critical therapeutic opportunities emerge and our clarified.
Patient Instructions for 90-Day Prep

In the movie, *Something’s Gotta Give*, Jack Nicholson plays the role of Harry Sanborn, a lifelong bachelor who refuses to date anyone older than thirty. He is a very successful author who, in his sixties, is advanced in middle age. The opening scene of the movie shows Harry and a thirty-year-old woman on their way to her family beach house for a tryst. Much to their surprise, her mother, Erica (played by Diane Keaton), also happens to be here. Erica is dismayed to see her daughter involved with a man who old enough to be her father. Clearly the age discrepancy is not a few years, but rather can be measure in decades. Fate intervenes, however, and Harry has a heart attack. The daughter has to return to the city, which leaves him convalescing with her mother. One thing leads to another, and Harry and Erica begin a tender and what appears to be significant romance. Nicholson’s character recovers and returns to the city.

The movie’s turning point comes when Erica decides to surprise Harry and drives into the city, where she finds him having a romantic dinner with yet another young woman. Distraught, Erica leaves and Harry chases her. When he catches up with her, he asks why she is so upset. Keaton, in a superb moment of acting, looks at him with so much pain that he sees that there is truth he has clearly missed in his life. Nicholson is so moved by the integrity of Keaton’s pain that that he embarks on a journey; going back to other women he had hurt over the years. Some are still so angry that they will not talk to him. But some do. Harry listens to the painful trail of people that he has hurt. This pilgrimage takes about six months but clearly changes Harry. When Erica and Harry meet up again, she can see the new integrity.

In many ways Harry’s journey parallels the tasks of the ninety day focus. In the first forty days, there are all the issues that occur when you start a program. Usually there are problems to confront or some messiness to be resolved. Then there are issues of accepting and surrendering to the problem. Additionally, there is an entire new language to learn and new skill sets that are challenging. Now that you have started, we need to proceed to a deeper level of focus. In part, recovery requires a deeper understanding of our impact on others. So like Harry, we need to reexamine the behavior that used to feel natural but was also painful. The story we told people about ourselves was not true. We must delve into reality so that it is more than just a firm grip on the obvious. Rather, we need to be “rigorously” honest, which is a recovery phrase for saying we tell the truth on ourselves. All of which means we leave the image management behind us.

By this point we have already planned out the quarter and how we will monitor ourselves each day. We have made specific goals and have planned how we will emotionally support ourselves. This plan leaves us free to explore some of these deeper and more disquieting issues. We start to look at the shadow side of our lives that our addiction used as its base of operations.

Returning to the movie, when Harry asked for feedback, he opened himself to expending and deepening the awareness. Years of psychotherapy have shown that in that process, things come out from that part of us that no one knew. It is a rich but difficult process to create what Jung called the “examined” life. Those that weather the process do live happier and more fulfilled lives. For those in recovery, it is an inevitable process. This section contains several areas of deeper work, which will help you forget the work you need to do during the ninety-day focus. The tools you will use now will fall into one of two categories: Recovery Planning or Sexual Awareness.
Recovery Planning Tools:
In addition to your work in the Facing the Shadow workbook, these tools clarify recovery goals for the critical days of the ninety-day focus. They include the System Transformer, which helps you create your recovery goals. A special version of the Personal Craziness Index, or PCI (pronounced “pickey”) will help you re-engineer and monitor your lifestyle. You will need to complete the “Fire Drill” exercise in Facing the Shadow (p. 173). This along with your Three Circle process will specify basic parameters of staying relapse free. Finally, your Ninety Day Focus Planner pulls all of your work during the first forty days together into a cohesive plan for the next ninety. These are the preparation steps that will help make your next ninety days a success.

Sexual Awareness Tools:
Beyond establishing sobriety, recovery requires sexual awareness at a deeper level. These tools are assigned by your therapist to further your understanding of the underlying issues of your acting out behavior. The Soul Window combines with the arousal template work in Facing the Shadow to uncover hidden aspects of our arousal patterns. The Positive Sexual Focus helps to answer the question what sexual health is for you. Finally, Emotional Restitution is a letter-writing process which teaches profound lessons about the ways you have hurt others. These tools help create critical awareness for creating a vital sobriety and sexual health.

Your therapist may assign these tasks over a period of weeks or in two one-day workshops. Because they often create difficult moments, it is important that you have support when doing this work. You will need to access your family, therapists, twelve-step communities, treatment and groupmates, and your sponsor. Their support will be essential. At the other end of this ninety-day prep process you will have ready:

- a sexual health plan
- a emotional restitution letter
- a foundation for affirmation and visualization processes
- a monthly monitor to track your progress for your PCI and Positive Sexual Focus
- a ninety-day detailed plan
- specific growth goals to help you and your therapist plan treatment
- preparation for steps four and five

The figure on the opposite page illustrates how these tools work together to help you sharpen your ninety-day focus.

Your therapist may assign none of these and provide some other tasks for you to do. Or your therapist may ask you to work through all of them. Your therapist may assign these as additional work. Such assignments vary to match the work of recovery with your specific situation. The important theme of this work, then, is to see to whom and how we have created harm. In this sense even our very dishonesties have become “offending” behaviors in that they take advantage of the gullibility of others. Your therapist is already aware of how important your ninety day focus is in reclaiming your integrity. As you proceed, we believe you will become aware “of that which you did not know about yourself.”
The Ninety Day Focus

The Ninety Day Focus starts with a plan. Completing the prep has provided structure including:

- readings
- activities
- meetings
- groups
- relapse strategies
- treatment goals

Plus the patient starts with a framework for looking at each day. The framework is now anchored in familiar concepts including the Personal Craziness Index, the Positive Sexual Focus, and the Three Circles. Benchmarks now exist for both client and therapist to monitor progress. Clear ways are laid out for deeper, systemic involvement in the twelve step community. And the work of therapy can deepen because complex problems have been broken down into specific, identified issues.

Working at a more profound level is enhanced by the affirmation process the patient does each evening. After they complete their monthly monitor worksheet for the day, the patient starts a reflection anchored in the Addict’s Best Advice. These distilled pieces of “advice” originally emerged from the follow-up conducted with one thousand people who achieved successful recovery. They were collated and used as part of the book *Don’t Call It Love*. Later they appeared in various different formats designed to assist the recovery process.

Each best “advice” is presented with a statement of the skills necessary to be able to implement that advice. While all pieces of advice may not “fit” every addict’s situation, the skills do. The patient is then asked to remember a time when they actually demonstrated that they had one of the skills or abilities. They record this memory. Then they create an affirmation for themselves that they have the capacity to do what it would take to implement the advice. Model affirmations are included so that they can build one appropriate to their experience.

Since there is much evidence that indicates that affirmations have much more impact when coupled with visualization, the patient then writes down a visualization which pictures them using the skill in the future. This process actually generates lots of information to be brought to group and meetings. The visualizations can impact in a variety of ways including:

- anchoring confidence
- uncovering fear
- prompting action around specific problems
- rehearsing a difficult moment or conversation
- revealing unresolved or unacknowledged issues
- accessing grief over specific losses
- increasing focus on specific treatment goals

After the visualization, a specific Core Dialogue Query is prepared for the topic of that day. This presents the patient a way to process their reactions to the affirmation and the visualization. The
patient then logs critical events of the day as well as reactions to their PCI and their Positive Sexual Focus. The final act of the day is recording the affirmation in their Recovery Planner. As the ninety days progress, patients report extraordinary reduction in shameful feelings. For sure, in part that is due to their ability to see the accumulated affirmations of self they have prepared. Table Seven presents graphically the order of the evening affirmation process.

Recovery Start develops habits a person uses in an “examined” or conscious life. By using this process we are teaching:

- developing unconscious competence in internal, recovery skills
- teaching the process of “deep attention” for significant change
- structuring a way to develop an enduring sobriety
- creating therapeutic community
- fostering the paradigm shifts necessary for a congruent life

Most of all we have laid the foundation for an even deeper level of change that will occur over the next two to three years. The patient can now start with what we have called the Recovery Zone.

When Scott Peck selected the title of his book *The Road Less Traveled*, it was a master stroke of authorship. His whole message was in the title. His described the “examined” life as not easy. It takes time, courage, and diligence. That is why fewer people do it – hence taking the road less traveled. Completing Recovery Start is not easy, and it does require diligence and courage. The difference is that our patients really do not have a choice. They have to examine their lives and make radical changes within a matter of a few months. We set out making this program to help make that path clearer. We appreciate your role and commitment to joining us in that effort.
Patient Instructions for the 90-Day Focus

Congratulations. You have made it through the first forty days. In our experience this is the first major threshold in changing compulsive sexual behavior. You deserve credit for your effort and commitment over the last six weeks. Moreover, you probably feel better now that some of the initial chaos and pain is subsiding. Because of your initial work including the ninety day prep section, you will have looked at personal and sexual issues about which most people in our culture have little awareness. You have become somewhat aware of what a great achievement recovery is and how the recovery experience deepens one’s life experience.

This momentum must continue. The next major threshold is the Ninety-Day Focus. There is an “ambush” implicit at this point in time in most addicts’ experience. Now that you have made this progress, the temptation will be to think you have “mastered” the problem and can maybe return to acting out at some minor levels. Or it is time to relax a little and catch up on some of the other pressing issues of your life. Or you have got the “concepts” and to do all the work of self monitoring and planning in the next ninety days might seem unnecessary. Your addict will ambush you with this thinking. You will lose your momentum and become vulnerable again. Remember your story and how your addict deluded you about your abilities to handle your illness.

Here is the reality. The next ninety days you will lay the foundation for your whole recovery. The first forty days is the window of time in which you do the core work of admitting to yourself that you have this illness and then learning about it. Now you begin the process of engineering your life to be different. Your therapist will now be assisting you with the goals that emerged in your ninety day prep period. Together you will be laying out the core issues of personality structure, or trauma impact, and family of origin. Plus there is the critical issue of “paradigm shift” in which dysfunctional beliefs are discarded and replaced with a “firm grip on the obvious.” Mapping out a different way to live your life to reduce the risk of relapse is another critical focus.

To face these issues in a piece by piece manner over an extended period of time has been shown to contribute to relapse. A coordinated intense focus of effort raises the probability of success dramatically. Without question this is a lot of work. But you already understand the importance of “deep attention” in order to achieve what you already have accomplished. Remember this program is based on the assumption that addiction is a brain disease and the “ultimate attention deficit disorder.” Our goal is to help you keep the “focus” that makes for change. Remember the principle ways you can change your brain:

- Daily careful focus on your behavior
- Daily reflection process which stimulates your brain and alters ways of thinking.
- Writing and rewriting in your own handwriting goals and reflection
- Developing new skills which stimulate your brain functioning in a different way
- Acquiring concepts, information, and perspectives which create a “psychological distance” from old, addictive ways of thinking
- Developing sexual reward systems that are functional
- Identifying your passion and abilities so that you have the reward of being at your best
- Dismantling the old beliefs and defusing voices from the past which undermine the changes you are making
Your recovery plan is the road map for the next ninety days. You have developed goals with your therapist and there is much to accomplish during the next twelve plus weeks. You also have been provided with what we call “tools of attention.” The Positive Sexual Focus and the Personal Craziness Index are combined in the Monthly Monitoring Worksheet. This becomes a quick but useful way to review each day in the dimensions of critical personal and sexual lifestyle areas of your recovery work. These tools will provide a context for your therapy, tasks four through eight in Facing the Shadow, and your continuing twelve-step work.

Daily Meditation
In the first forty days, we supplied a daily meditation for you. We wish for you to continue the meditation process as you start each day. Most recovering people use daily meditation books which become a rewarding way to start the recovery focus of each day. There are three meditation series by Hazelden we recommend you start with:

- *Answers in the Heart*. A wonderful book designed for all sex addicts.

These books provide daily readings which help with the daily mindfulness of recovery. We also highly recommend that you start to learn how to meditate by developing skills with specific meditation methodologies. For example, if you are familiar with yoga or use another specific meditation process, integrate your practice into your morning reflection. In you have no such experience, here are three recommended ways to start:

- *The Artist’s Way*, by Julia Cameron. This book was designed to help artists and other creative people to regain their focus. The author describes a process called the morning pages which is a writing process that is very fruitful at clearing the mind. Recovering people who use this process call it my “recovery pages.” Simply described your morning pages are three pages of intense journaling about whatever is on your mind.

A number of good meditation books exist to help you start developing meditation skills, including:

- *The Relaxation Response*, by Herbert Benson and Miriam Z. Klipper
- *The Language of Letting Go*, by Melody Beattie
- *The Reflecting Pond*, by Liane Cordes
- *Night Light*, by Amy E. Dean

Also, Dr. Carnes has collaborated with a group of recovering musicians to teach an approach to meditation and spirituality, called The Spiritual Skill Set. All users of Recovery Start can receive a discount on the spiritual skill set series by contacting New Freedom at 480-488-0150.

Daily Affirmations
You have noticed spaces on your recovery planner for ninety affirmations. Recovery Start provides another “tool of attention” for your evening reflection process. Each evening you will complete your Monthly Monitoring Worksheet for that day. Then you will complete a daily affirmation process. You will actually create an affirmation for you to use based on your own
experience. When complete you enter your work into your recovery planner. At the end of the
days you will have created a body of affirmations which will help substantially in your “re-
programming” process.

The affirmations are organized around a group suggestions we call the “addict’s best
advice.” The research team who followed the 1,000 families described in the book, Don’t Call It
Love, carefully cataloged what worked best in their recoveries. This “best” advice was
summarized in the book as part of those things which made for successful recovery. These
sumaries were so useful they have been reprinted many times in pamphlet form. The problem
with that format was there was no way beyond reading and reflection to integrate these
suggestions into one’s life. The following tables summarize the best advice for your benefit.

The daily affirmations are a way for you to capitalize on this extensive successful
experience of others. For each day of the ninety days a daily affirmation sheet has been created
for you. At the top is one segment of the addict’s best advice. It is followed by a statement of the
competencies necessary for a person to implement that key piece of recovery wisdom. A space
has been provided for you to remember events in your life when you have shown one or more of
those competencies. Record memories that you have when you really knew you were competent
at meeting the specified challenge.

Then the sheet provides an example of an affirmation. Usually an affirmation is a positive
statement about you. Examples would be “I am an honest and forthright person” or “I am a
talented, creative person” or “I am a smart person about priorities.” When saying these positive
statements you are restructuring your belief system about yourself as well as challenging your
brain to rewire itself. Affirmations are important to write, to say to yourself, and to say out loud
to others. In therapeutic communities often people will stand up and announce key affirmations
they are working on, and the other group mates will affirm them as well. By doing this
affirmation process, the reprogramming of the brain becomes more intentional.

The Recovery Start process, however, goes further. First we start with a proven critical
element necessary for recovery. Second, you anchor your confidence by recording a specific
memory of success. Then you structure an affirmation. We provide at least one and sometimes
more examples to give you ideas about creating your own unique affirmation. After you record
the affirmation, the worksheet will ask for you to visualize a concrete way for you to express that
competency in the future. Having the affirmation is only part of the work. There is growing
evidence that affirmations work best when there is a concrete visualization of the affirmation
being used in your life. Thus each night you are concretely recording a vision of your recovery
future.

The final step is to return to the methodology of the core dialogues with which you are
already familiar. You query your addict about your memory of success, your affirmation and its
wording, and then your vision of you using this positive aspect of yourself. In that reflective
dialogue determine if you need to go back and add to any of the memory, affirmation or vision.
When complete, take out your recovery planner and enter the affirmation you have finalized.
Your therapist will routinely inquire about your affirmation work often at the beginning of
group.
At the end of ninety days you will have significantly added dimension to the reprogramming of
your mind. You will have generated much new information for your therapeutic work. The
process of structuring these affirmations will stimulate issues that will provide additional
momentum to your therapy. Most important you will have integrated into your life in the most
concrete way possible the best advice of those who have preceded you. To assist you in
understanding your routine in this program, we have summarized the schedule:

Morning
Daily readings, and a consistent practice of some organized meditation process.

Evening:
Complete the Monthly Monitor self assessment including the Positive Sexual Focus and the Personal Craziness Index.
Read the Addict’s Best Advice for the Day
Read the suggested areas of competence necessary
Record specific memories when you have demonstrated those qualities or abilities.
Read the suggested affirmation(s) and create an affirmation for your self.
Record a visualization of you using those strengths to enhance your life and recovery
Complete a Core Dialogue with your addict about the process and modify if appropriate.
Enter the result into your recovery planner.

The Daily Affirmation section starts with one example day completed so that you will have a model to follow. Your therapist and support persons can also help whenever you are stuck.

It is of critical importance that you follow through each day with this regimen. Remember what you have learned about deep attention. Those who have used Recovery Start before you rank this as one of the most important accomplishments of the ninety-day process. Your addict will ambush you about it being too much effort, about you having the problem well in hand, or about this being “extra,” “unnecessary,” “silly,” or even “childish.” Reality is different. Those who take the time to be conscious and intentional do live a better life and change their destructive behavior.

If you miss an evening or two, please catch up at your very next available window of opportunity. This needs to be part of your “automatic pilot” in order to get the maximum benefit. This schedule will be the context over the next ninety days of work you have planned. It will be the glue that knits all of it together.
Audio Compact Disk Discussion Points

After listening to the accompanying compact disk audios, therapists may wish to think about, discuss, or research further the following discussion points:

1. Freud was the first of modern clinicians to use the word addiction in conjunction with sex. He did it in an 1898 paper and repeated the idea in 1928 in a paper on gambling.
2. Consolidation points are absolutely critical to the transformation cascade described in the audios. They consist of periodic times where a patient summarizes, synthesizes, and re-records learnings.
3. Clearly the twelve steps are action processes which can be described as both a grieving process as well as a developmental process. Part of the strength of the steps, is that they are repetitive consolidation points especially the inventory steps.
4. There is no doubt that the growing acceptance of sex addiction as a real problem stems from people struggling with compulsive sex on line. Most therapists are now seeing it and realizing they need resources to work with it.
5. Al Cooper’s analysis of MSNBC participants was a landmark in sex addiction research for many reasons. One of the most significant was that the majority of pornography was downloaded between nine and five making it a workplace phenomenon.
6. One of the most important happenings in contemporary psychotherapy is the integration of research from neuroscience. Two clear examples of that are the recent works of Louis Conzolini and Dan Siegel.
7. The transformational cascade does refer to how one new significant insight can generate a series of additional breakthroughs. Happens individually and culturally.
8. Even early theorists like John Dewey recognized the role of dissonance in learning. Thus one of the ways to promote the transformational cascade is activities, assignments, and exercises that force the patient out of their comfort zone.
9. While the transformational cascade was identified in trauma literature, it was about how internal paradigms would shift of which memory could play a part. It was not that reclaiming one memory led to the inevitable claiming of others.
10. There is a growing body of literature which documents that affirmations are much more powerful when coupled with visualization.
11. One of Csikszentmihalyi’s (spelling) primary contributions to addiction medicine was his profiling how people of achievement accessed their brains in much the way addicts do.
12. Louis Consolini wrote about psychotherapy and neuroscience.
13. Jacob Needleman’s work on financial disorders is a great introduction to issues of contradiction and alignment.
14. Michael Bader’s work on sexual arousal was in part the inspiration for the Soul Window exercise. His work had no connection with Milkman and Sunderwirth’s conceptualization of arousal addictions.
15. Two-thirds of sex addicts do come from rigidly-disengaged families.
16. The Emotional Restitution process deliberately avoids requests for forgiveness which could be seductive in a process which exposes methods of seduction.
17. The fundamental goal of the Core Dialogue Queries is to assist integration of the core compartmentalization of the addiction process.

18. The forty meditations can be used in any order. The Core Dialogue Queries are built in an ordered, progressive fashion. Each builds on the previous queries so must be done in order.

19. The ninety day prep presents options to the therapist. Not all parts are relevant to everybody. For example, the cybersex materials would not be relevant for the patient who never had a problem with the internet.

20. The curriculum at the end of this manual is designed to knit together critical elements from the first seven tasks in *Facing the Shadow*, content from the Forty Day Focus, and Ninety Day Prep.
Organizing Recovery Start to Fit Your Setting:  
The Recovery Start Agenda

The psychoeducational curriculum for the Recovery Start materials is organized into ten modules to support your use of the program. In many ways Recovery Start is like a cube, where you keep arranging the blocks to make the pattern you want. The important goals remain the same of structuring the forty day and ninety day thresholds to create a sustainable recovery.

The modules break the work down into manageable pieces. At first it may seem overwhelming, but with your knowledge of the principles and of the contents of Facing the Shadow mastering the process goes quickly. Remember, however, that we are asking the patient to do much more in order to promote early success. This means the therapist has to do more, but is providing better care and creating more income for the practice with less time.

Key to these benefits is the psychoeducational modules. In a practice with multiple groups, all the patients can participate in the psychoeducational process. Most therapists keep the billing for group psychotherapy and group psychoeducation the same. But the staff ratio is different and much more profitable for the practice.

Clinically this fosters a therapeutic community of participants who sees each other in groups, meetings and in the psychoed group. The larger the size of the group (twelve patients and up) the benefits accelerate for the patient. Also the larger the group, the easier it is to teach. Remember from your training that in many ways critical breakthroughs will more likely occur in that environment that from a simple group process. To summarize, more people means more discussion, examples, and interaction. The results can then be brought to therapy and group to process further. While this is a departure from a standard outpatient practice it allows a higher level of intervention.

Note also for outpatient programs that there is a lot that patients have to do. By setting the agenda, the therapist is also making clear that the work is necessary in order to successfully deal with the problem. The therapist sets the expectation. If the patient cannot do the work and slips, a residential setting is appropriate. To expect the deep changes necessary within the fifty minute hour for many sex addicts at the beginning of recovery significantly underestimates what in fact has been necessary.

Residential facilities have the advantage of the patient’s undivided attention. Yet, every inpatient program has the problem of patients returning from high structure programming to almost no structure. Recovery Start creates a process that creates structure to transition into outpatient work. By having the 90 Day Focus Prep work done, prior to discharge will increase dramatically the probability of a successful transition. Notice also that a very viable option is to repeat the Forty Day Focus when they return to their referent.

This agenda is to assist you in teaching the modules. The modularity allows you to schedule your programming in ways that match your setting. A powerpoint presentation is provided to accompany each module. Step by step instructions for each module are provided along with goals, assignments, and suggestions.

To illustrate, three scenarios follow. Each scenario suggests a viable way to present the materials:
Scenario I – The Eight-Week Integrated Practice Model
This model utilizes existing sex addiction groups and combines them in the psychological sessions. This addict’s “schedule for the week” would include one psycho-educational group, individual session, twelve-step meetings, and group psychotherapy. During this time, a one-day (two-module) workshop on Saturday allows the opportunity to complete curriculum and to enrich community experience together. Week One is a start-up week. Weeks Two through Six is the Forty-Day Focus. Week Eight is transition to 90-Day Focus.

Scenario II – Consecutive Saturday Model
Five Saturday Workshops can be presented as a series. During the week, the patient can attend meetings and group therapy, as well as do individual therapy. The advantage here is concentrating the work within a five-week period. This model also works well for residential programming on weekends.

Scenario III – Week-Long Intensives
For patient populations whose travel or work schedules make weekly attendance difficult, the intensive week model can be the solution. Two intensive weeks offered four weeks apart provide the flexibility patients need to get their work done. This also works for clinics that have special populations or have no local resources. They can travel and do the work a week at a time.

Study these arrangements and if they do not match what you need, create a scenario that does work for you. These are the ones that we have seen successfully implemented. Please contact us with questions or to let us know the arrangement you have used. We can only grow this program with the help of our participating therapists.
**Scenario I ~ The eight-week Integrated Practice Model**

This model utilizes existing rec addiction groups and combines them in the psychological sessions. This addict’s “schedule for the week” would include one psycho-educational group, individual session, twelve-step meetings, and group psychotherapy. During this time, a one-day (two-module) workshop on Saturday allows the opportunity to complete curriculum and to enrich community experience together. Week One is a start-up week. Weeks Two through Six is the Forty-Day Focus. Week Eight is transition to 90-Day Focus.

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td>Group Psychotherapy</td>
<td></td>
<td>Individual Session</td>
<td>Psycho-Education (8 Modules)</td>
<td>12-Step Meetings</td>
<td>Workshop (1 Day) 2 Modules (Suggest 6 &amp; 8)</td>
<td>12-Step Meetings</td>
</tr>
</tbody>
</table>
Scenario II ~ Consecutive Saturday Model

Five Saturday Workshops can be presented as a series. During the week, the patient can attend meetings and group therapy, as well as do individual therapy. The advantage here is concentrating the work within a five-week period. This model also works well for residential programming on weekends.

<table>
<thead>
<tr>
<th>1st Saturday</th>
<th>2nd Saturday</th>
<th>3rd Saturday</th>
<th>4th Saturday</th>
<th>5th Saturday</th>
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<tbody>
<tr>
<td>Module One</td>
<td>Module Three</td>
<td>Module Five</td>
<td>Module Seven</td>
<td>Module Nine</td>
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<td>Module Two</td>
<td>Module Four</td>
<td>Module Six</td>
<td>Module Eight</td>
<td>Module Ten</td>
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**Scenario III ~ Week-Long Intensives Model**

For patient populations whose travel or work schedules make weekly attendance difficult, the intensive week model can be the solution. Two intensive weeks offered four weeks apart provide the flexibility patients need to get their work done. This also works for clinics that have special populations or have no local resources. They can travel and do the work a week at a time.

<table>
<thead>
<tr>
<th>Week One</th>
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<tbody>
<tr>
<td><strong>Day 1</strong></td>
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<tr>
<td>Module One</td>
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<tr>
<td>Group &amp; Homework</td>
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<tr>
<th>Week Two</th>
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<tbody>
<tr>
<td><strong>Day 1</strong></td>
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<tr>
<td>Module Six</td>
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<tr>
<td>Group &amp; Homework</td>
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# Module Overview Chart

<table>
<thead>
<tr>
<th>Module</th>
<th>Psycho-educational Agenda</th>
<th>Task Performables</th>
<th>“90-Day Prep” Activities</th>
<th>Homework</th>
<th>Psychotherapy Group agenda</th>
<th>Additional Assignments</th>
</tr>
</thead>
</table>
| **ONE: WHAT IS REAL?** | • Welcome  
• Story of why we came  
• Problems & Secrets  
• Denial  
• Overview of Program  
• Information on Available 12-Step Groups | • Problem List  
• Secret List  
• Consequences Inventory | • Read chapters 1 & 2 of “Facing the Shadows”  
• Complete exercises in Chapter 2  
• Read Introduction to “Recovery Start”  
• Read Introduction to “40-Day Focus”  
• Read Introduction to “90-Day Prep” | • Examples of Denial  
• People Hurt  
• Consequences  
• Current Chaos  
• Expectations  
• How I got here  
• Problems list | • Examples of Denial  
• People Hurt  
• Consequences  
• Current Chaos  
• Expectations  
• How I got here  
• Problems list | • Listen to “40-Day Focus”  
• Cames-Bridgman DVD |
| **TWO: ADDICTIVE BEHAVIOR** | • 10 Criteria for Addiction  
• Addiction Cycle/System  
• Sexual Anorexia  
• Causes of Addiction  
• Addiction As A Brain Problem (NIH slides)  
• Intro to “40 Meditations”  
• Intro to “40 CDQs”  
• Intro to System Transformer / Recovery System | • Share Addiction System  
• Share System Transformer | • Complete System Transformer  
• Complete Cybersex Assessment | • Start “40 Meditations”  
• Start “CDQs”  
• Read Chapter 3 & complete Exercises | • Obstacles to Recovery (from System Transformer)  
• Addictive System Issues  
• Anorexia / Deprivation | |
| **THREE: COMPULSIVE SEX** | • The 10 Types  
• Courtship & the 10 Types  
• CyberSex Issues (info on CyberSex)  
• Meditation Principles | • Share 10 Types / Behaviors  
• Courtship Inventory  
• Share CyberSex Assessment (option)  
• Sexual Dependency Inventory (option) | • Continue “40 Meditations” & “CDQs”  
• Read Chapter 4  
• Completes Sex Addiction History | • Turn in 1st week progress sheets  
• CyberSex Timelines  
• SD1 Timeline  
• Task cards | | |
## Module Overview Chart

<table>
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<tr>
<th>Module</th>
<th>Psycho-Educational Agenda</th>
<th>Task Performables</th>
<th>&quot;90-Day Prep&quot; Activities</th>
<th>Homework</th>
<th>Psychotherapy Group Agenda</th>
<th>Additional Assignments</th>
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<tbody>
<tr>
<td><strong>Four: Accepting Illness</strong></td>
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<tr>
<td>WEEK 3</td>
<td>• First Step&lt;br&gt;• Powerlessness&lt;br&gt;• Unmanageability&lt;br&gt;• Steps as a grieving process&lt;br&gt;• Surrender&lt;br&gt;• Guidelines for Good 1st Step&lt;br&gt;• Meditation Principle II</td>
<td>• Share 1st Step&lt;br&gt;• Powerless&lt;br&gt;• Unmanageability&lt;br&gt;• Financial costs&lt;br&gt;• Worst moments&lt;br&gt;• Box Exercise (option)&lt;br&gt;• Death Factory (option)&lt;br&gt;• Gentle Path books&lt;br&gt;• Spiritual Skill Set</td>
<td>• Complete Positive Sexual Focus&lt;br&gt;• Complete 3 Circles</td>
<td>• Continue &quot;40 Meditations&quot; &amp; &quot;CDGs&quot;&lt;br&gt;• Read Chapter 5&lt;br&gt;• Current Problems List&lt;br&gt;• Complete Damage Control sheets as needed&lt;br&gt;• Create Disclosure Plan</td>
<td>• Turn in 2nd week progress charts&lt;br&gt;• First Steps&lt;br&gt;• Task cards</td>
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<td><strong>Five: Damage Control</strong></td>
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<tr>
<td>WEEK 4</td>
<td>• Damage Control&lt;br&gt;• Paradigm Shift&lt;br&gt;• Disclosure Issues&lt;br&gt;• Restoration of Trust&lt;br&gt;• Introduce Release Prevention Tools (list options)&lt;br&gt;• Meditation Principle III</td>
<td>• Share Damage Control Plan&lt;br&gt;• Share Disclosure Plan</td>
<td></td>
<td></td>
<td>• Turn in 3rd week progress charts&lt;br&gt;• First Steps (continued)&lt;br&gt;• Disclosure Issues&lt;br&gt;• Task cards</td>
<td>• &quot;90-Day Focus&quot;&lt;br&gt;• Positive Sexual Focus</td>
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<tr>
<td><strong>Six: Sexual Sobriety</strong></td>
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<tr>
<td>WEEK 5</td>
<td>• Sobriety Challenges (graphic)&lt;br&gt;• Release Scenarios&lt;br&gt;• 3 Circles (inner, middle)&lt;br&gt;• Meditation Principle IV</td>
<td>• Share Challenges&lt;br&gt;• Share Scenarios&lt;br&gt;• Positive Sexual Focus&lt;br&gt;• 3 Circles</td>
<td></td>
<td></td>
<td>• Turn in 4th week progress charts&lt;br&gt;• Sobriety Challenges&lt;br&gt;• Sobriety Definition Issues&lt;br&gt;• 3 Circles&lt;br&gt;• Task Cards</td>
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<tr>
<td><strong>Seven: Relapse Prevention</strong></td>
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<tr>
<td>WEEK 6</td>
<td>• Relapse Prevention&lt;br&gt;• Discovery Tools&lt;br&gt;• Use graphics in PowerPoint – Hill tools&lt;br&gt;• Introduce Soul Window &amp; Arousal Template book</td>
<td>• Share relapse contract&lt;br&gt;• Share relapse tools&lt;br&gt;• Relapse Abstinence Contract&lt;br&gt;• PCI</td>
<td>• Soul Window 1 &amp; 2&lt;br&gt;• Soul Window 3 &amp; 4 (optional)&lt;br&gt;• Soul Window 5</td>
<td>• Continue &quot;40 Meditations&quot; &amp; &quot;CDGs&quot;&lt;br&gt;• Read Chapter 7&lt;br&gt;• Complete exercises&lt;br&gt;• Fantasy Worksheets&lt;br&gt;• Arousal Template</td>
<td>• Relapse Issues&lt;br&gt;• Abstinence&lt;br&gt;• Lifestyle challenges&lt;br&gt;• 2nd &amp; 3rd Step issues</td>
<td></td>
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</tbody>
</table>
## Module Overview Chart

<table>
<thead>
<tr>
<th>MODULE</th>
<th>PSYCHO-EDUCATIONAL AGENDA</th>
<th>TASK PERFORMABLES</th>
<th>“90-DAY PREP” ACTIVITIES</th>
<th>HOMEWORK</th>
<th>PSYCHOTHERAPY GROUP AGENDA</th>
<th>ADDITIONAL ASSIGNMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>★ EIGHT: SEXUAL AWARENESS</td>
<td>• Arousal Template • Eroticized feelings • Soul Window process • Introduce • Emotional Restitution</td>
<td>• Fantasy worksheets • Arousal templates • Present Soul Window</td>
<td></td>
<td>• Continue “40 Meditations” &amp; “CDQs” • Emotional Restitution</td>
<td>• Turn in 5th week progress charts • Task Cards • Sexual Concerns • Arousal Patterns reflecting personality issues</td>
<td></td>
</tr>
<tr>
<td>★ NINE: RECOVERY PLANNING</td>
<td>• Emotional Restitution guidelines</td>
<td>• Read letter with group critique</td>
<td>• Complete “90-Day Focus” Planner</td>
<td>• Continue “40 Meditations” &amp; “CDQs” • Read Chapter 8 and complete exercises • Read “90-Day Focus Plan” • Read “90-Day Focus” Intro</td>
<td>• Turn in 8th week progress charts • Task Cards • Victim Sympathy • Offender Issues</td>
<td></td>
</tr>
<tr>
<td>TEN: RECOVERY PLAN</td>
<td>• 12-Step Groups • Sponsorship • Intro to “90-Day Focus” • Orientation to Monthly Monitor</td>
<td>• Present “90-Day/Planner”</td>
<td></td>
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<td>• Present Growth Goals • Feedback on Participation</td>
<td></td>
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</tbody>
</table>

*Recovery Module 6 & 8 in Saturday Workshop format*
RECOVERY START MODULE 1

What is Real

PURPOSE: To understand why denial is used to escape reality and feelings and therefore holds such a strong sway over addicts, and what to do to counter this denial. To understand the basic Recovery Start program.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Understand why denial is so powerful and what to do to counter this denial.
2. List the 14 Types of Denial.
3. Understand the basic 3-part Recovery Start program.

MATERIALS:

- PowerPoint presentation (Recovery Start Overview: Introduction to the Program)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue Queries-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on (1) how denial is used to escape reality and feelings, and provides suggestions regarding countering denial, and (2) the basic Recovery Start program and the Systems Transformer.

I. Welcome your group and provide an Overview of the Program.

This program is optimally facilitated via two groups per week. Individuals participate in a psychotherapy group during the week and then meet together at a psychoeducation group that is comprised of other psychotherapy groups that have also met during the week. In this way the psychoeducation group provides the agenda for the week, while individuals share their homework assignments in their independent psychotherapy group. The psychoeducation group is primarily for education, clarification and review of material, rather than presenting or processing homework.
Explain the rationale and advantages of using the 3-part Recovery Start program (The 40-Day Focus, The 90-Day Prep, and The 90-Day Focus); specifically how individual attendance at both a psychoeducation group and psychotherapy group work in tandem to compliment and strengthen individual commitment and positive outcome:

- Modify the brain
- Deeper learning
- Lay foundation
- Establish effective sobriety
- Clean out unmanageability
- Create recovery vision
- Typical amount of time spent completing homework assignments (2-3 hours per week)

Part 1: The 40-Day Focus
- 40 Meditations
- Core Dialogue Queries/Daily Monitoring
- Facing the Shadows book
- Steps 1 and 2
- Group/Workshop
- 90-Day Prep

Part 2: The 90-Day Prep
- Sexual Awareness Tools
  - Soul Window
  - Cybersex Assessment
  - Positive Sexual Focus
  - Arousal Template
- Recovery Planning Tools
  - Systems Transformer
  - Personal Craziness Index
  - Fire Drills
  - Three Circles
  - 90-Day Focus Planning
  - Facing the Shadow book
  - Emotional Restitution
Part 3: The 90-Day Focus: Creating Sobriety

- Meditation and Reading
- Affirmation/Daily Monitoring
- Recovery Plan
- Facing the Shadow book
- Steps 3, 4 and 5

II. Show PowerPoint presentation (Recovery Start Overview: Introduction to the Program).

III. Ask clients to briefly share their individual Story of Why We Came (“How I Got Here”) in small groups.

IV. Ask clients to discuss the concept of Denial and share their personal examples of denial in small groups.

- **Global Thinking:** Attempting to justify why something is not a problem using terms like “always,” “never,” “no problem whatsoever.”
- **Rationalization:** Justifying unacceptable behavior. “I don’t have a problem – I’m just sexually liberated.” “You people are such prudes!”
- **Minimizing:** Trying to make behavior or consequences seem smaller and less important than they are. “Only a little.” “It’s no big deal.”
- **Comparison:** Shifting the focus to someone else to justify behaviors. “I’m not as bad as __ .”
- **Uniqueness:** Thinking you are different or special. “My situation is different.” “I was hurt more.” “That’s fine for you, but I’m too busy to go to group right now.”
- **Avoiding by creating an uproar or distraction:** Being a clown and getting everyone laughing; angry outbursts meant to frighten; threats and posturing; shocking behavior that may be sexual.
- **Avoiding by omission:** Trying to change or ignore the subject, or manipulate the conversation to avoid talking about something. It is also leaving out important bits of information, like the fact that your lover is sixteen years old.
- **Blaming:** “Well, you would cruise all night too, if you had my job.” “If my partner weren’t so cold, I wouldn’t have to have an affair.”
- **Intellectualizing:** Avoiding feelings and responsibility by thinking or asking why. Explaining everything. Getting lost in detail and storytelling. Pretending superior intellect and using intelligence as a weapon.
- **Hopelessness/helplessness:** “I’m a victim, I can’t help it.” “There’s nothing I can do to get better.” “I’m the worst.”
- **Manipulative behavior:** Usually involves some distortion of reality including the use of power, lies, secrets, or guilt to exploit others.
- **Compartmentalizing:** Separating your life into compartments in which you do things that you keep separate from other parts of your life.
- **Crazy making:** When confronted by others who do have a correct perception, telling them that they are totally wrong. Acting indignantly toward them is an attempt to make them feel crazy by telling them, in a sense, that they cannot trust their own perceptions.
- **Seduction:** Using charm, humor, good looks, or helpfulness to cover up insincerity.
V. Discuss the importance of identifying Problems and Secrets (p. 4, “Facing the Shadow”).

VI. Introduce Systems Transformer / Recovery System that will help individuals sort out both long term and immediate goals of recovery (pp. 19-26, “The 90-Day Prep”).

VII. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:
   - Introduction and Preface to the Gentle Path Series (p. vii-xii, “Facing the Shadow”).
   - Chapter 1: What is Real – Recognizing Self-Delusion (pp. 1-26, “Facing the Shadow”).
   - Chapter 2: What is an Addiction – Understanding Addictive Behavior (pp. 27-48, “Facing the Shadow”).
   - Introduction to “Forty-Day Focus” (p. 17-23, “The 40-Day Focus”).
   - Introduction to “Ninety-Day Prep” (p. 9, “The 90-Day Prep”).

VIII. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:
   - Problems List (p. 4, “Facing the Shadow”).
   - Secret List (p. 9, “Facing the Shadow”).
   - Excuses (p. 12, “Facing the Shadow”).
   - Consequences Inventory (p. 14, “Facing the Shadow”).
   - Denial Worksheet (p. 18-21, “Facing the Shadow”).
   - Powerlessness (p. 22-23, “Facing the Shadow”).
   - Your Addictive Cycle (p. 33, “Facing the Shadow”).
   - Sexual Anorexia (p. 37, “Facing the Shadow”).
   - Sexual Addiction Criteria (p. 40-47, “Facing the Shadow”).
   - Systems Transformer (pp. 25, “The 90-Day Prep”).

IX. Assign additional homework if any:
   - The “40-Day Focus” audio CD.
   - Carnes/Bradshaw DVD.

X. Provide information on available and applicable 12-Step groups in your area.

XI. Give out the Task Sheets (pp. 25-37, “The 40-Day Focus”).

Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may present and process their homework in their separate psychotherapy groups or individual session(s).

- Denial
- People Hurt (emotionally, physically, sexually, financially)
- Consequences and Current Chaos
• Expectations for recovery (including finding a therapist and sponsor)
• Making full disclosure to a therapist, sponsor and possibly partner/family

XII. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start
Overview

Dr. Patrick Carnes &
Staff of Gentle Path Press

Module One:
What is Real?

Introduction to
The Program

Welcome

Story of
why we came

Problems & Secrets

Examples of Denial
Denial Types

- Global thinking: Attempting to justify why something is not a problem using terms like "always," "never," "no problem whatsoever."
- Rationalization: Justifying unacceptable behavior. "I don't have a problem — I'm just sexually liberated." "You people are such prudes!"

Denial Types

- Minimizing: Trying to make behavior or consequences seem smaller and less important than they are. "Only a little." "It's no big deal."
- Comparison: Shifting the focus to someone else to justify behaviors. "I'm not as bad as ______."
Denial Types

- Crazy making: When confronted by others who do have a correct perception, telling them that they are totally wrong. Acting indignantly toward them is an attempt to make them feel crazy by telling them, in a sense, that they cannot trust their own perceptions.
- Seduction: The use of charm, humor, good looks, or helpfulness to gain sexual access and cover up insincerity.

Recovery Start consists of three parts:

- 40-Day Focus
- 90-Day Prep
- 90-Day Focus

The 90-Day Prep

- Sexual awareness tools:
  - Soul Window
  - Cybersex Assessment
  - Positive Sexual Focus
  - Arousal Template
  - Emotional Restitution

The 40-Day Focus

- "Facing the Shadows"
- 1st & 2nd Step
- Group/Workshop
- 90-Day Prep
- Core Dialogues: Questions Daily Maintenance

The 90-Day Prep

- Recovery planning tools:
  - System Transformer
  - Personal Craziness Index
  - Fire Drills
  - Three Circles
  - 90-Day Focus Planning
  - Facing the Shadow
Advantages of Recovery Start

- Modify brain
- Deeper learning
- Lay foundation
- Establish effective sobriety
- Clean out unmanageability
- Create recovery vision

Why Therapy Works:

Homework:

Facing the Shadow:
- Read chapters 1 & 2 of Facing the Shadow
- Complete exercises in chapter 2

Recovery Start:
- Read introduction to Recovery Start
- Read introduction to The 40 Day Focus
- Read introduction to The 90 Day Prep
- Complete System Transformer exercise
- Listen to 40 Day Focus CD
- Watch Carnes/Bradshaw DVD
- Complete System Transformer

12 Step Groups
RECOVERY START MODULE 2:

Addictive Behavior

PURPOSE: To understand basic concepts of Addiction.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. List the 10 Criteria for Addiction
2. Understand the Addiction Cycle / System
3. Understand the Concept of Sexual Anorexia / Deprivation
4. Understand five specific Causes of Sex Addiction
5. Addiction as a Brain Problem
6. Understand how and why Meditations and Core Dialogues-CDQs are used

MATERIALS:

- PowerPoint presentation (Addictive Behavior)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series
- NIH Slides (“Addiction as a brain problem”)

LECTURE OUTLINE:

This lecture focuses on (1) concepts of addiction, and (2) using Meditation and Core Dialogue Queries-CDQs.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show the PowerPoint presentation (Addictive Behavior).

IV. Discuss Addictive Systems Issues

A. Addiction basics
   - An Intimacy Disorder
   - A Relationship Disorder
   - A Family of Origin Disorder
• A Trauma Disorder

B. Criteria for Addiction
   • Loss of control - Clear behavior in which you do more than you intend or want.
   • Compulsive behavior - A pattern of out of control behavior over time.
   • Efforts to stop - Repeated specific attempts to stop the behavior which fail.
   • Loss of time - Significant amounts of time lost doing and/or recovering from the behavior.
   • Preoccupation - Obsessing about or because of the behavior.
   • Inability to fulfill obligations - The behavior interferes with work, school, family, and friends.
   • Continuation despite negative consequences - Failure to stop the behavior even though you have problems because of it (social, legal, financial, physical).
   • Escalation - Need to make behavior more intense, more frequent, or more risky.
   • Losses - Losing, limiting, or sacrificing valued parts of life such as hobbies, family, relationships, and work.
   • Withdrawal - Stopping behavior causes considerable distress, anxiety, restlessness, irritability, or physical discomfort.

D. Anorexia / Deprivation *optional* (pp. 34-36, “Facing the Shadow”).

E. Causes of Sex Addiction (“The Making of a Sex Addict” graphic):

F. The Brain Problem - addiction is a brain disease expressed in the form of compulsive behavior (Alan I. Leshner, MD, former director of the National Institute on Drug Abuse).

Key proven strategies to modify the brain and promote healing:

- Telling and hearing stories is the most complex activity the brain can do. Addicts telling and retelling their story significantly helps modify neuronal networks and promotes healing.

- Internal dialogue helps the brain make new connections and accelerates change. The Core Dialogues are designed to promote internal dialogue.

- Morning and evening focus helps the brain direct energy for problem solving, limit setting, and stimulating new growth.

- Break through "understanding" not only creates new options but promotes the brain to modify its circuitry. Having new understanding creates a "cascade" of new insights.

- Talking and sharing deeply with others is one of the most measurable ways to make brain change. It is absolutely critical to be part of a community working on the same issue.

- Anything that is good for your heart is good for your brain. This includes good nutrition, exercise, and rest.
V. Introduce “40 Meditations” (p. 41, “The 40-Day Focus”).

VI. Introduce “40 Core Dialogues-CDQs” (p. 85, “The 40-Day Focus”).

Sometimes individuals compartmentalize their thoughts and their lives. Trauma and shame play a role and lead to secrecy and denying parts of ourselves. In recovery it’s important that we integrate these disowned parts. The Core Dialogues, or CDQs, are a method to help you find your truth.

VII. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Chapter 3: What Are Your Behaviors – Understanding Compulsive Sex (pp. 49-90, “Facing the Shadows”).
- Cybersex Assessment (p. 27-45, “The 90-Day Prep”).

VIII. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- What are Your Behaviors (pp. 53-64, “Facing the Shadow”).
- Sexual History (pp. 65-66, “Facing the Shadow”).
- Courtship Inventory optional (pp. 72-77, “Facing the Shadow”).
- Start “40 Meditations” and read one meditation daily (p. 41, “The 40-Day Focus”).
- Start “CDQs” and complete Daily Progress Chart each day (p. 91, “The 40-Day Focus”).
- Task Cards

IX. Assign additional homework if any:

- Cybersex Use Inventory optional (pp. 81-90, “Facing the Shadow”).
- Cybersex Map Worksheet optional (p. 34, “The 90-Day Prep”).

X. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may present and process their homework in their separate psychotherapy groups or individual session(s).

- Obstacles to Recovery (from the System Transformer)
- Addictive System issues
- Anorexia / Deprivation

XI. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Dr. Patrick Carnes &
Staff of Gentle Path Press

Module Two: Addictive Behavior

Week One of The Program

10 Criteria for Addiction:

Loss of Control
Clear behavior in which you do more than you intend or want.

Compulsive Behavior
A pattern of out of control behavior over time.

Efforts to Stop
Repeated specific attempts to stop the behavior which fail.
Loss of Time
Significant amounts of time lost doing and/or recovering from the behavior.

Preoccupation
Obsessing about or because of the behavior.

Inability to Fulfill Obligations
The behavior interferes with work, school, family, and friends.

Continuation Despite Consequences
Failure to stop the behavior even though you have problems because of it (social, legal, financial, physical).

Escalation
Need to make behavior more intense, more frequent, or more risky.

Losses
Losing, limiting, or sacrificing valued parts of life such as hobbies, family, relationships, and work.
Withdrawal
Stopping behavior causes considerable distress, anxiety, restlessness, irritability, or physical discomfort.
Recovery Cycle
What is Sex Addiction?
A “pathological relationship with a mood-altering experience”

Sex Addiction is:
• An Intimacy Disorder
• A Relationship Disorder
• A Family of Origin Disorder
• A Trauma Disorder
Addiction as a Brain Problem:

Addiction is a brain disease expressed in the form of compulsive behavior.

Alan I. Leshner, MD
Former director of the National Institute on Drug Abuse

BRAIN ACTIVATION DURING FINGER TAPPING

Normal Volunteer  Alcoholic Patient

BRAIN ACTIVATION DURING SEXUAL AROUSAL

Normal Volunteer  Non activated region

Nucleus Accumbens—Brain’s Reward Center

Red indicates high number of receptors for dopamine

Normal  Obese

Alcoholic  Cocaine

People short of dopamine have difficulty feeling joy.

About the Homework:
**Forty Meditations**

**DAY ONE**

"Truth is but the end of vexation" – William Shakespeare

**Denying Our Own Experience**

After we act out, almost always we say it was not worth it. It was either a disappointment, a catastrophe, or a near disaster. Even when acting out is at its “best” – we are filled with visions of what will happen if someone finds out. Or we obsess with self-judgment and self-blaming. We calculate our losses in terms of time, money, and opportunity. We shoulder all the risks we took. We live in fear of discovery, consequences, or even arrest. Never do we say that it was worth every risk, cost, or consequence.

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**Core Dialogue Questions (CDQs)**

Core Dialogue Query Set No ___

**Topic:** DENIAL

**Date:** ___________  **Day:** _ _ of First Forty Days

**QUERIES:**

- How did you come to be? Why did you start? Who helped you? What have I not wanted to face about you being in my life?

**DIALOGUE:**

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**Systems Transformer Examples:**

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**Homework:**

**Recovery Start:**

- Start 40 Meditations – Recovery Start
- Start CDQs – Recovery Start
- Complete Cybersex Assessment

**Facing the Shadow:**

- Read chapter 3 and complete exercises in Facing the Shadow
RECOVERY START MODULE 3

Compulsive Sex

PURPOSE: To understand basic concepts of sex addiction, courtship and cybersex.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. List the 10 Types (categories) of sexual behaviors
2. Understand how Courtship relates to the 10 Types of sexual behaviors
3. Understand Cybersex Issues and Criterion
4. Understand Meditation Principles I: Key Skills

MATERIALS:

- PowerPoint presentation (Compulsive Sex)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses (1) concepts of sex addiction and cybersex, and (2) the relationship of courtship to types of sexual behaviors.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Compulsive Sex)

IV. Introduce basic information about sex addiction and The 10 Types of sexual behaviors (pp. 49-51, “Facing the Shadow”)

1. Fantasy - Sexually charged fantasies, relationships, and situations. Arousal depends on sexual possibility.
2. Seductive Role - Seduction of partners. Arousal is based on conquest and diminishes rapidly after initial contact.
4. Exhibitionistic - Attracting attention to body or sexual parts of the body. Sexual arousal stems from reaction of viewer whether shock or interest.
5. Paying - Purchasing of sexual services. Arousal is connected to payment for sex and with time the arousal actually becomes connected to the money itself.
6. Trading - Selling or bartering sex for power. Arousal is based on gaining control of others by using sex as leverage.
7. Intrusive - Boundary violation without discovery. Sexual arousal occurs by violating boundaries with no repercussions.
8. Anonymous - High-risk sex with unknown persons. Arousal involves no seduction or cost and is immediate.
9. Pain Exchange - Being humiliated or hurt as part of sexual arousal; or sadistic hurting or degrading another sexually, or both.
10. Exploitive - Exploitation of the vulnerable. Arousal patterns are based on target “types” of vulnerability.

V. Introduce the 12 components to Courtship (pp. 67-68, “Facing the Shadow”).

1. Noticing
2. Attraction
3. Flirtation
4. Demonstration
5. Romance
6. Individuation
7. Intimacy
8. Touching
9. Foreplay
10. Intercourse
11. Commitment
12. Renewal

Explain that courtship, when embarked upon in a healthy way, provides individuals an opportunity to learn how to handle getting to know others appropriately. When the 12 components of courtship go awry, an individual may become “stuck” and engage in compulsive behaviors that relate to an inability for developmental intimacy.

VI. Explain Courtship and its relationship to the 10 Types of Sex Addiction (pp. 67-71, “Facing the Shadow”).

VII. Introduce Cybersex issues (pp. 79-80, “Facing the Shadow”).

- Access to the unresolved
  - can see things sexually you have always wondered about and then get trapped.
  - unresolved things are of such potency that the images stick.
- Rapid escalation of amount and variety.
  - Being on the Net has a trance-like quality that has created a new technology for old obsessions.
  - Escalation becomes obsessional with new specific behaviors becoming quickly fixated.
  - Accelerates already addictive behavior.
  - Cybersex escalated to other behaviors (cybersex became catalyst or portal).
Suddenly Cybersex addicts are taking risks that they wouldn’t have before. The burned in images become problematic.

Just as in PTSD, the Internet image develops an importance, which is the strength of that image.

**Relational regression**
- People stop having relationships outside of the Cyber world. Real is replaced with digital. People start to lose the ability to make human connections.

**Relational expansion** – being closer to electron friends with high sexual intensity.

**Statistics**
- The average age for first-time contact with Internet pornography is approximately 11 years of age.
- The largest consumer of Internet pornography is the 12 to 17-year-old age group.
- The average age for seeking help is between 30 and 35.
- 80% of married sex addicts thought marriage was the answer to their addiction.
- The National Council on Sexual Addiction Compulsivity estimated that six to eight percent of Americans are sex addicts, which is 16 to 21.5 million people.
- 71% of those with sexual-acting-out problems also use the Internet as a venue.
- 70% of Internet porn traffic occurs during the 9 a.m. to 5 p.m. workday.
- US pornography revenue exceeds the combined revenues of ABC, CBS, and NBC ($6.2 billion).
- Extremely addictive because of the virtual anonymity and availability.
- Cybersex is the crack cocaine of sexual addiction; escalating extremely rapidly.

**Criteria**
- Preoccupation with sex on the Net – people become irritable because they can’t access the Net.
- Frequently engaging in sex to escape from problems.
- Repeated unsuccessful efforts to cutback or stop.
- Restlessness or irritability when attempting to stop.
- Escalating behaviors.
- Deceiving family members.
- Committing illegal acts – they think there is no risk. The ISP knows where you have been as well as the sites you have visited.
- Jeopardizing or losing relationships, job, education or career.
- Financial losses.

**VIII. Introduce Meditation Principles I: Key Skills.**
- Ability to recognize that our brain sends error signals we can recognize.
- Recovery requires our capacity to identify chaos & potential chaos as part of addictive process.
- Core is assembling memories, which create psychological distance necessary to avoid behavior.
- Successful recovery is built understanding sexual addiction and sexual health.
The path out of addiction requires efforts to be present vs. attempts to escape.
Addiction is about boundary collapse and recovery is about reclaiming personal boundaries.
Critical to recovery success is involving others as a reality check and in all of our choices.
The ability to act on our own behalf consistently, persistently, and thoroughly.

IX. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Chapter 4: What is a First Step – Accepting the Problem (pp. 91-108, “Facing the Shadow”).

X. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
- Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
- Courtship Inventory (pp. 72-77, “Facing the Shadow”).
- Cybersex Use Inventory (pp. 81-90, “Facing the Shadow”).
- Cybersex Map Worksheet (p. 34, “The 90-Day Prep”).
- Cybersex and Eroticized Rage (p. 43, “The 90-Day Prep”).
- Sexual Addiction History (pp. 93-95, “Facing The Shadow”).
- Powerlessness Inventory (p. 95, “Facing the Shadow”).
- Unmanageability Inventory (p. 98, “Facing the Shadow”).
- Financial Costs Worksheet (pp. 100-101, “Facing the Shadow”).
- Ten Worst Moments (p. 103, “Facing the Shadow”).

XI. Assign additional homework if any:

- Sexual Dependency Inventory-SDI (online)

XII. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

- Cybersex Timelines
- Sexual Dependency Inventory-SDI
- Individual sexual behaviors that fit in to “The 10 Types”

XIII. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Module Three: Compulsive sex

The Ten Types of Sex Addiction

Research of the 10 Types

- In the original research conducted for Don’t Call It Love, a series of 114 sexual behaviors was statistically analyzed.
- A total of 10 “types” of sexually compulsive behavior emerged in the sex addicts surveyed.

Fantasy Sex

- Sexually charged fantasies, relationships, and situations. Arousal depends on sexual possibility.

Seductive Role Sex

- Seduction of partners. Arousal is based on conquest and diminishes rapidly after initial contact.
Voyeuristic Sex

- Visual arousal. The use of visual stimulation to escape into obsessive trance.

Exhibitionistic Sex

- Attracting attention to body or sexual parts of the body. Sexual arousal stems from reaction of viewer whether shock or interest.

Paying for Sex

- Purchasing of sexual services. Arousal is connected to payment for sex and with time the arousal actually becomes connected to the money itself.

Trading Sex

- Selling or bartering sex for power. Arousal is based on gaining control of others by using sex as leverage.

Intrusive Sex

- Boundary violation without discovery. Sexual arousal occurs by violating boundaries with no repercussions.

Anonymous Sex

- High-risk sex with unknown persons. Arousal involves no seduction or cost and is immediate.
Pain Exchange Sex

- Being humiliated or hurt as part of sexual arousal; or sadistic hurting or degrading another sexually, or both.

Exploitive Sex

- Exploitation of the vulnerable. Arousal patterns are based on target “types” of vulnerability.

Courtship and the Ten Types

What is courtship?
A capacity to have a relationship ....

The capacity to have a relationship that is:

- Sexual and mutual
- Sexually explicit
- Sexually expressed
- Sexually meaningful
- Sexually real

Noticing
**What are your memories of early courtship?**

Did anyone teach you about courtship?

---

**Dysfunctional Courtship Beliefs**

- Women are capricious.
- Women tease.
- Men only want sex.
- No man can be trusted.
- No means yes.

---

**Sex Addiction, Courtship Failure, and Eroticized Feelings**

- Sex addicts notice sex but not feelings
- Erotic anger does not have to be pleasurable
- Check if other addictions trigger scenario
- Make arousal template explicit
- Identify ideal
- Look for distortions of courtship

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**Cybersex Issues**

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**Cybersex**

- Chat rooms – fuel fantasy.
- Online affairs.
- Exhibitionism; Voyeurism.
- Fetishism.
- Swapping.

---

**Cybersex**

- Access to the unresolved – can see things sexually you have always wondered about and then get trapped.
- These unresolved things are of such potency that the images stick.
- Being on the Net has a trance-like quality that has created a new technology for old obsessions.
**Cybersex Template**

- **Rapid escalation** of amount and variety.
- **Escalation becomes obsessional with new specific behaviors** becoming quickly fixated.
- **Accelerates already addictive behavior.**
- **Became addicted because cybersex escalated to other behaviors (cybersex became catalyst or portal).**

**Cybersex**

- **Relational regression** - People stop having relationships outside of the Cyber world. Real is replaced with digital. People start to lose the ability to make human connections.
- **Relational regression** - Suddenly Cybersex addicts are taking risks that they wouldn’t have before. The burned in images become problematic.

**Cybersex**

- Just as in PTSD, the Internet image develops an importance, which is the strength of that image.
- **Relational expansion** - results in being closer to electron friends with high sexual intensity.

**Cybersex Addiction Criterion**

- **Preoccupation with sex on the Net** – people become irritable because they can’t access the Net.
- **Frequently engaging in sex to escape from problems.**
- **Repeated unsuccessful efforts to cutback or stop.**
- **Restlessness or irritability when attempting to stop.**

**Cybersex Addiction Criterion**

- **Escalating behaviors.**
- **Deceiving family members.**
- **Committing illegal acts** - they think there is no risk. The ISP knows where you have been as well as the sites you have visited.
- **Jeopardizing or losing relationships, job, education or career.**
- **Financial losses.**

**Cybersex Issues:**

- The average age for first-time contact with Internet pornography is approximately 11 years of age.
- The largest consumer of Internet pornography is the 12 to 17-year-old age group.
- The average age for seeking help is between 30 and 35.
- 80% of married sex addicts thought marriage was the answer to their addiction.
- The National Council on Sexual Addiction. Compulsivity estimated that six to eight percent of Americans are sex addicts, which is 16 to 21.5 million people.
Cybersex Issues:

- 71% of those with sexual acting-out problems also use the Internet as a venue.
- 70% of Internet porn traffic occurs during the 9 a.m. to 5 p.m. workday.
- US pornography revenue exceeds the combined revenues of ABC, CBS, and NBC ($62 billion).
- Extremely addictive because of the virtual anonymity and availability.
- Cybersex is the crack cocaine of sexual addiction; addiction escalates extremely rapidly.

Meditation Principles I: Key Skills

Key Skill

Ability to recognize that our brain sends error signals we can recognize

Key Skill

Recovery requires our capacity to identify chaos & potential chaos as part of addictive process

Key Skill

Core to 1st step is assembling memories which create psychological distance necessary to avoid behavior

Key Skill

Capacity to identify what contributes to the addiction
Key Skill

Successful recovery is built on knowing what sexual health is and what sex addiction is.

Key Skill

Ability to recognize that our brain sends error signals we can recognize.

Key Skill

The path out of addiction requires efforts to be present vs. attempts to escape.

Key Skill

Addiction is about boundary collapse & recovery is about reclaiming personal boundaries.

Key Skill

Critical to recovery success is involving others as a reality check and in all of our choices.

Key Skill

The ability to act on our own behalf consistently, persistently, and thoroughly.
Homework:

_Recovery Start:_
* Continue Meditations and CDQs

_Facing the Shadow:_
* Read chapter 4 of _Facing the Shadow_
* Complete Sex Addiction History
RECOVERY START MODULE 4

Accepting Illness

PURPOSE: To understand the guidelines for a good Step 1.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Present a comprehensive Step 1
2. Understand Grieving as a process toward healing
3. Understand the concepts of Powerless and Unmanageability
4. Understand the concept of Surrender
5. Understand Meditation Principles II: Key Concepts

MATERIALS:
- PowerPoint presentation (Accepting Illness)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on (1) Step 1 issues related to grieving and surrender, and (2) Meditation Principles II.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Accepting Illness)

IV. Discuss First Step Guidelines of Presenting a Good First Step – powerlessness, unmanageability, financial costs, worst moments, surrender.

- No excuses or explanations (you acted out because you acted out.)
- Clear understanding of powerlessness, with good examples.
- Clear understanding of unmanageability, with good examples.
- Knowledge of your own addictive system.
• Knowledge of how your behavior fit the criteria for addiction.
• The worst expressed and the secrets exposed.
• Taking full responsibility for actions.
• A range of feelings expressed.
• Feelings are appropriate for the events reported.
• Suffering including grief, pain, sorrow, and remorse.
• Ownership of loneliness.
• A commitment to do whatever it takes to change.

V. Provide information on Grieving as a process toward healing.

Grief is inevitable, because change and the experience of loss is inevitable - Unforeseen, unanticipated and uncontrollable circumstances that have little to do with effort or merit, often play a much greater role in whether or not we get what we want (all of the time, some of the time or never).

Addicts have typically experienced a lot of loss in their lives related to childhood or adolescent situations, and also due to the experiences of being in their disease. When an individual does not successfully navigate a resolution process to resolve the grief, unresolved feelings may continue to sabotage successful recovery. It is not unusual for addicts to struggle with anger, pain and resentment toward losses. A typical grieving process usually consists of stages or phases, although not everyone goes through all. It’s important to remember that the process is not an event and it is more like spokes of a wheel (versus being linear) and may be repeated over time. Eventually the intensity of the experiences (and emotions) decrease, as well as the duration and the frequency. When an addict does not move through the process and does not address the feelings that arise by running or denying, then often addiction and compulsive behaviors become the maladaptive tool for coping.
Going through the fires of life, however, like the Phoenix bird, gives individuals an inner strength. Roberto Assagioli developed a method of psychosynthesis, which rests on the belief that we are each capable of reaching beyond our personalities to grasp transcendent wisdom after we go within and into our own self-defeating thoughts. In psychotherapy, whatever method used, individuals are asked to change a “style” of sorts, which alters thinking, believing and then acting. Moreover, suffering can be transformed (Viktor Emil Frankl) into meaningful experiences when the opportunity for growth is acknowledged, even though sometimes the potential of positive possibilities is difficult to imagine.

- **Denial and Shock** - At first, it may be difficult the individual to accept loss and change. As denial gradually diminishes the addict begins to express and share feelings with others.
- **Anger** - During this stage the most common question asked is "why me?" The addict is angry at what he/she perceives to be the unfairness of life and may project and displace anger onto others. When given some social support and respect, eventually she/he will become less angry and able to move into the next stage of grieving.
- **Bargaining** - Many try to bargain; with others and often with some sort of deity.
- **Guilt** – The addict may feel guilty for things done or not done, prior to the loss. He/she needs help in accepting his/her humanness and learning to forgive.
- **Depression** – The addict may at first experience a sense of great loss. Mood fluctuations and feelings of isolation and withdrawal may follow. It takes time to
gradually return to a stable state and become more socially involved in what's going on. Encouragement and reassurance will not necessarily be helpful in this stage.

- **Loneliness** - As the addict goes through changes because of loss, he/she may feel lonely and afraid. The more the addict is able to reach out to others and make new friends, the more this feeling lessens.

- **Acceptance** - Acceptance does not mean happiness. Instead the addict accepts and deals with the reality of the situation.

- **Hope** - Eventually the addict will reach a point where remembering the past will seem less painful and will begin to look ahead to the future and more good times.

VI. Introduce Meditation Principles II: Key Concepts

- Addiction was a way to cope at one time, which does not serve any longer
- Addicts believe in secrecy, which almost always is illusory
- Maintaining addictive behavior and its secrecy absorbs much energy and abilities
- Addiction thrives on fantasy, possibility, and future thinking, which undermines the ability to be present
- Recovery requires being present to oneself, which has been lost in the addiction process
- Addiction is an ally who protects the addict from essential truths about himself/herself
- Addiction relies on extending beyond human limits and the belief that the addict is inherently different from others
- The brain requires challenge and benchmarks of success in order for recovery to work
- Addiction has momentum which makes it hard to stop… yet, recovery can also have momentum which creates success
- Deprivation is the silent partner of addiction… wherever one is, we find the other

VII. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:


VIII. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
- Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
- Change exercise (p. 112, “Facing the Shadow”).

IX. Assign additional homework:

- Box Exercise *optional*
- Death Fantasy *optional* (included in “A Gentle Path Through the Twelve Steps” by Hazelden and “Spiritual Skill Set – Part 1” by Gentle Path Press.)
X. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

  • First Steps

XI. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Dr. Patrick Carnes &
Staff of Gentle Path Press

Module Four:
Accepting Illness

Week Three of
The Program

First Step:
We admitted we were powerless over our sexual addiction – that our lives had become unmanageable

Powerlessness:
Being unable to stop behavior despite obvious consequences.
List examples of powerlessness in your life and discuss them.

Unmanageability:
Means that your addiction created chaos and damage in your life.
List examples of unmanageability in your life and discuss them.

Steps as Grieving Process
The Loss of the Addictive Relationship

Guidelines for Good 1st Step:

- No excuses or explanations (you acted out because you acted out).
- Clear understanding of powerlessness, with good examples.
- Clear understanding of unmanageability, with good examples.
- Knowledge of your own addictive system.
- Knowledge of how your behavior fit the criteria for addiction.
- The worst expressed and the secrets exposed.

Guidelines for Good 1st Step:

- Taking full responsibility for actions.
- A range of feelings expressed.
- Feelings are appropriate for the events reported.
- Suffering including grief, pain, sorrow, and remorse.
- Ownership of loneliness.
- A commitment to do whatever it takes to change.

Meditation Principles II: Key Concepts
Key Concepts

Addiction was a way to cope at one time, which does not serve us any longer.

Key Concepts

Addicts believe in secrecy, which almost always is illusory.

Key Concepts

Maintaining addictive behavior and its secrecy after time absorbs much of our energy and abilities.

Key Concepts

Addiction thrives on fantasy, possibility, and future thinking, which undermines our ability to be present.

Key Concepts

Recovery requires that we be present to ourselves, which we have lost in the addiction process.

Key Concepts

Addiction is an ally who protects us from essential truths about ourselves we are not ready to have.
Key Concepts

Addiction relies on extending ourselves beyond human limits and our belief that we are different from others.

Key Concepts

The brain requires challenge and benchmarks of success in order for recovery to work.

Key Concepts

Addiction has momentum which makes it hard to stop... yet, recovery can also have momentum which creates success.

Key Concepts

Deprivation is the silent partner of addiction... wherever one is, we find the other.

Homework:

- Continue Meditations & CDQs
  - Recovery Start
- Complete Damage Control Sheets as needed
- Create Disclosure Plan
RECOVERY START MODULE 5

Damage Control

PURPOSE: To limit damage resulting from behaviors.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Write out a Damage Control Plan if necessary
2. Understand the concept of Paradigm Shift
3. Understand Disclosure Issues
4. Write out a Disclosure Plan if necessary
5. Understand the concept of Restoration of Trust
6. Understand Meditation Principles III: Reality Factors

MATERIALS:

- PowerPoint presentation (Damage Control)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on (1) limiting damage from acting out behaviors, (2) understanding issues related to restoring trust, and (3) understanding Meditation Principles III.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Damage Control)
IV. Discuss the concept of Paradigm Shift

Paradigm – a term that is typically used to mean how an individual “views” the world. His/her set of assumptions, concepts, values, and practices that constitute a way of viewing reality. Individuals, communities, societies and cultures possess individual and collective paradigms.

Paradigm Shift – generally used when one’s world view is changed. In the case of recovery it occurs when “Dysfunctional beliefs are discarded and replaced with a firm grip on the obvious.”

V. Provide information on the process of Change.

Change is inevitable - Unforeseen, unanticipated and uncontrollable circumstances that have little to do with effort or merit, often play a much greater role in whether or not we get what we want (all of the time, some of the time or never). Changing a pattern or habit is difficult because the addict is losing a familiar way of perceiving, thinking, feeling or acting.

The Six (6) Stages of Recovery:

1. The Developing Stage
   - My isolation and inability to believe I could get help kept me stuck.
   - Confronted in a supportive way, I went to a twelve step group, but then left it.
   - Two DUI’s caused me to stop drinking and I ended all relationships for four to five months. Started a new relationship, drinking returned, and things got crazy again.
   - Unconsciously sought help – suicidal at times.

2. The Crisis/Decision Stage
   - Got arrested: October 1983.
   - Wife took off wedding ring (after 35 years) and said, “You can’t come home.”
   - Couldn’t deny it after apartment supervisor ordered me to move within 24 hours.

3. The Shock Stage
   - Felt gradually like I was coming to.
   - The program was disorienting, painful, scary, and relieving, but I knew I belonged.
   - Numbness and grief over loss of my job. Despaired and felt no hope.
   - Felt physically as if hit on head with a two-by-four.

4. The Grief Stage
   - Tears about loneliness, about the loss of my life to addiction. Tears seemed endless.
   - Incredible sense of loss over addiction. I had to learn about nurturing myself.
   - I was in mourning, crying all the time, afraid of my own shadow, angry at God, angry at having to stop, and had very little energy.
   - Cried a lot with new kinds of tears that felt like I was getting bad stuff out of me.
5. The Repair Stage
   • Started self-care: health, meditating, went back to school. Worked on boundaries.
   • Could wake up without feeling afraid: could laugh with people.
   • Began to do writing, got in touch with talents, went back to school, got in graduate program in addictionology, and accomplished things for myself.
   • For the first time in my life I got to finish projects, like on my house and my master’s thesis. Own a store I love.

6. The Growth Stage
   • Feel connected to self and others; a new compassion for people with problems.
   • Peace of mind. Finish my degree. Holding a good job. I’m a father to a new baby.
   • Relationship rebuilt by taking ownership of my role. I make amends to my kids when I make mistakes. I feel close to my kids and husband.

VI. Introduce the concept of Damage Control (beginning to create a new order to one’s life).

1. List Current Problems (e.g., divorce, disease, unemployment, arrest)
2. Complete Damage Control Worksheet (pp. 136-138, “Facing the Shadow”).
   • Problem
   • Best Possible Outcome
   • Minimal Acceptable Outcome
   • Possible Solution
   • Best Solution
   • Action Steps
VII. Introduce Disclosure Issues.

- Be careful. Tell only those you trust.
- Wait. Even after deciding to tell someone, take time to think over your decision before actually going through with it.
- Know your motives. What payoffs do you seek? Do you want to support or are you seeking approval?
- Do it if you can help others with the same problem. Sharing with people who need to be in a 12-Step program, or who already are, helps you, those people, and the group.
- Remember, it is not necessary to tell many people at all. You do not have to tell even when people ask or pry.
- When in doubt, talk with your sponsor and your group. They can provide the support you need to make safe decisions.
- Mistakes will happen. All addicts tell someone they later wish they had not told. It is okay to make mistakes.

VIII. Introduce the concepts of Restoration of Trust.

The most important step to reduce damage is to be truthful and listen. Although acknowledging your remorse is appropriate, now is not necessarily the time for promises and “I love yous”. Being defensive is like pouring gasoline on the fire. Really understand how deeply you have hurt people. The goal is not to fill yourself with shame, but rather to develop resolve for change.

- Give it a lot of time.
- Be willing to lose it in order to get it.
- Restore self first.
- Accept the illness in the other.
- Admit mistakes promptly.
- Share spirituality.
- Use the amends steps.
- It’s never going to be perfect.
- Be with other recovering couples.
- Have fun together.

IX. Introduce Meditation Principles III: Reality Factors

- Addiction fosters loss of contact with reality, which is true insanity
- Addicts go beyond denial into magical thinking that something extraordinary will happen to save us.
- Addicts find that much of their time and energy is focused on proving what is not true
- The compulsion to protect ourselves from the truth is so strong it is hard to acknowledge our dark sides
- Recovery starts when we acknowledge to others the contradictions in our lives
- Overcoming contradictions and matching truth with reality will raise in us the desire to escape
- The life of Jekyll & Hyde always means the destruction of both
- Toxic talk about others or ourselves supports the addictive process by creating distraction and turmoil
• It takes time to reclaim our reality, so it is best to wait on major decisions

X. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

• Begin Chapter 6: What is Sobriety – Managing Life without Dysfunctional Sexual Behavior (pp. 149-182, “Facing the Shadow”).

XI. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

• Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
• Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
• Damage Control Worksheet as needed (p. 115, “Facing the Shadow”).
• Disclosure Plan if necessary (p. 142, “Facing the Shadow”).
• Reflections on the Recovery Essentials (pp. 160-163, “Facing the Shadow”).

XII. Assign additional homework if any:

• The 90-Day Focus audio CD
• Positive Sexual Focus audio CD
• Relapse Scenarios worksheet optional (p. 169, “Facing the Shadow”).
• Fire Drill Planning Sheet optional (p. 173, “Facing the Shadow”).
• Resisting Relapse Reflection optional (p. 101, “Facing the Shadow”).

XIII. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

• First Steps if needed (until all have shared)
• Disclosure issues

XIV. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Dr. Patrick Carnes &
Staff of Gentle Path Press

Module Five: Damage Control

Week Four of The Program

Paradigm Shift:
Dysfunctional beliefs are discarded and replaced with a “firm grip on the obvious.”

The Six Stages of Recovery

Recovery Over Time

<table>
<thead>
<tr>
<th>WORSE</th>
<th>BETTER</th>
<th>BETTER</th>
<th>THREE YEARS PLUS</th>
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<tbody>
<tr>
<td>Sex addiction relapse</td>
<td>Financial situation</td>
<td>Healthy sexuality</td>
<td>Developing parenting skills 2 years</td>
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<tr>
<td>Health status</td>
<td>Coping with stress</td>
<td>Primary relationships with Family of origin</td>
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<td>Self-image</td>
<td>Spirituality</td>
<td>Relationship with Children</td>
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<tr>
<td>Career status</td>
<td>Friendships</td>
<td>Life satisfaction</td>
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* Continue to improve three years plus.

Course of Recovery Over Time

<table>
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<tr>
<th>PRERECOVERY</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
<th>YEAR 4</th>
<th>YEAR 5</th>
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<table>
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<tr>
<th>DEVELOPING PARENTING SKILLS 2 years</th>
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THE DEVELOPING STAGE

- My isolation and inability to believe I could get help kept me stuck.
- Confronted by a colleague in a supportive way, I went to a twelve step group, but then left it.
- Two DUI's caused me to stop drinking and I ended all relationships for four to five months. Then I fell into a new relationship, drinking returned, and things got crazy again.
- Unconsciously sought help – suicidal at times.

THE CRISIS/DECISION STAGE

- Got arrested; October 1983
- Wife took off wedding ring (after thirty-five years) and said, "You can't come home."
- Couldn't deny it after apartment supervisor ordered me to move within twenty-four hours.

THE SHOCK STAGE

- Felt gradually like I was coming to.
- The program was disorienting, painful, scary, and relieving, but I knew I belonged.
- Numbness and grief over loss of my job. Despaired and felt no hope.
- Felt physically as if hit on head with a two-by-four.
THE GRIEF STAGE

• Tears about loneliness, about the loss of my life to addiction. Tears seemed endless.
• Incredible sense of loss over addiction. I had to learn about nurturing myself.
• I was in mourning, crying all the time, afraid of my own shadow, angry at God, angry at having to stop, and had very little energy.
• Cried a lot with a new kind of tears. These tears felt like I was getting bad stuff out of me.

THE REPAIR STAGE

• Started taking care of my health, meditating, went back to school. Worked on boundaries.
• Could wake up without feeling afraid: could laugh with people.
• Began to do writing, got in touch with talents, went back to school, got in graduate program in addictionology, and accomplished things for myself.
• For the first time in my life I got to finish projects, like on my house and my master’s thesis. Own a store I love.

THE GROWTH STAGE

• Feel connected to self and others. A totally new compassion for people with problems.
• Peace of mind. Finish my master’s in full. Holding a good job. I’m a father to a new baby.
• Relationship rebuilt by taking ownership of my role. I make amends to my kids when I make mistakes. I feel close to my kids and husband.
Damage Control
Create a new “order” to your life, begin a damage control plan.

Current Problem List

Examples:
• Divorce
• Disease
• Unemployment
• An arrest

Disclosure Issues
• Be careful. Tell only those you trust.
• Wait. Even after deciding to tell someone, take time to think over your decision before actually going through with it.
• Know your motives. What payoffs do you seek? Do you want to support or are you seeking approval?

Disclosure Issues cont.
• Do it if you can help others with the same problem. Sharing with people who need to be in a 12-Step program, or who already are, helps you, those people, and the group.
• Remember, it is not necessary to tell many people at all. You do not have to tell even when people ask or pry.

Disclosure Issues cont.
• When in doubt, talk with your sponsor and your group. They can provide the support you need to make safe decisions.
• Mistakes will happen. All addicts tell someone they later wish they had not told. It is okay to make mistakes.
Restoration of Trust
The most important step you can take right now is to be truthful and listen. Promises and “I love you” can in fact bring shame and ridicule. Acknowledging how sorry you are is appropriate. Being defensive or blaming is like pouring gasoline on the fire. It works better to really understand how deeply you have hurt people. The goal is not to fill yourself with shame, but rather to develop resolve for change.

Restoration of Trust
• Give it a lot of time.
• Be willing to lose it in order to get it.
• Restore self first.
• Accept the illness in the other.
• Admit mistakes promptly.
• Share spirituality.
• Use the amends steps (eight and nine).
• Remember, it’s never going to be perfect.
• Be with other recovering couples.
• Have fun together.

Introduce Relapse Prevention Tools

Meditation Principles III: Reality Factors

Reality Factors
Addiction fosters loss of contact with reality, which is true insanity

Reality Factors
Addicts go beyond denial into magical thinking that something extraordinary will happen to save us.
Reality Factors

Addicts find that much of their time and energy is focused on proving what is not true.

Reality Factors

The compulsion to protect ourselves from the truth is so strong it is hard to acknowledge our dark sides.

Reality Factors

Recovery starts when we acknowledge to others the contradictions in our lives.

Reality Factors

Overcoming contradictions and matching truth with reality will raise in us the desire to escape.

Reality Factors

The life of Jekyll & Hyde always means the destruction of both.

Reality Factors

Toxic talk about others or ourselves supports the addictive process by creating distraction and turmoil.
Reality Factors

It takes time to reclaim our reality, so it is best to wait on major decisions.

Homework:

- Continue Meditations & CDQs - Recovery Start
- Read chapter 6 and complete exercises in Facing the Shadow
- Complete all exercises pgs. 149 – 182; Facing the Shadow
- Listen to 90 Day Focus & Positive Sexual Focus CDs
RECOVERY START MODULE 6

Sexual Sobriety
(Presented in a Saturday workshop format)

PURPOSE: To understand sobriety challenges and relapse prevention.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Understand Sobriety Challenges
2. Write out Relapse Scenarios
3. Draw a Three Circle recovery plan (inner, middle, outer)
4. Understand concept of Positive Sexual Focus
5. Understand Meditation Principles IV: Surviving Bottom Principles

MATERIALS:
- PowerPoint presentation (Sexual Sobriety)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on (1) developing increased awareness of sobriety challenges in order to realistically evaluate relapse prevention tools, and (2) to understand the Meditation Principles IV.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Sexual Sobriety)
IV. Discuss Sobriety Challenges (graphic)

<table>
<thead>
<tr>
<th>Underachieving despair</th>
<th>Distorted Achievement</th>
<th>Overachieving depletion and chaos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-defeating shame</td>
<td>Compromised Self-Image</td>
<td>Self-absorbed obsession</td>
</tr>
<tr>
<td>Not accountable</td>
<td>Lack of Accountability</td>
<td>Secret life</td>
</tr>
<tr>
<td>Profound self-neglect</td>
<td>Problematic Self-Care</td>
<td>Grandiose entitlement</td>
</tr>
<tr>
<td>No remorse</td>
<td>Impaired Conscience</td>
<td>Guilt driven</td>
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<tr>
<td>No common sense</td>
<td>Faulty Realism</td>
<td>Common sense ignored</td>
</tr>
<tr>
<td>Avoidance/procrastination</td>
<td>Limited Self-Awareness</td>
<td>Compulsive busyness</td>
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<tr>
<td>Isolation</td>
<td>Incomplete Relationships</td>
<td>Hidden parts of self</td>
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<tr>
<td>Shutdown feelings/numbness</td>
<td>Disordered Affect Feelings</td>
<td>Indulgent rage, drama, intensity</td>
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</tbody>
</table>

V. Relapse Scenarios (graphic)
VI. Three Circles (graphic)

- **Abstinence List** - “Abstinence” means concretely defining behaviors that you will abstain from as part of your recovery. To use one of these behaviors again means to slip; to continue it over a period of time means a relapse.

- **Boundaries List** - Boundaries are self-imposed limits that promote health or safety. They may involve situations, circumstances, people, and/or behavior that you avoid because they are dangerous, jeopardize your abstinence, or do not add to your recovery or your spirituality.

- **Healthy Sexuality** – List ten sexual and relationship goals you have. Then list specific steps you can take and resources you might use. These are uncharted waters for many. If you do not have a partner, you can still work on various dimensions of your sexuality.

VII. Understand Positive Sexual Focus and Sobriety Definition (pp. 63-67, “The 90-Day Prep”).

VIII. Introduce Meditation Principles IV: Surviving Bottom Principles

- Recovery starts when you accept that our lives had become unmanageable
- We examine the worst episodes of our addiction to grasp the patterns in our disease
- Severe hardship teaches us to reclaim a better life vision while facing today
- Bad experiences become mentors teaching us important lessons we needed to learn
- We must train our brain to change well-worn paths of addiction in order to survive
- Those who do survive have the capacity to transform suffering into meaning
- Feelings avoided for years will help us in knowing what we have to do
- Recovery demands that we change faster than we understand, so we have to accept confusion for a while
- Gratitude is the critical to appreciate what we have gotten from our experience with loss
- Surviving crisis always brings the temptation to do just enough… Recovery teaches that “half measures availed is nothing.”
IX. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Chapter 6: What is Sobriety – Managing Life without Dysfunctional Sexual Behavior (pp. 182-203, “Facing the Shadow”).

X. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
- Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
- Sobriety Challenges Worksheet (pp. 158-159, “Facing the Shadow”).
- Relapse Scenarios worksheet (p. 169, “Facing the Shadow”).
- Fire Drill (pp. 172-173, “Facing the Shadow”).
- Three Circle Method (p. 175-179, “Facing the Shadow”).
- Positive Sexual Focus (pp. 179-182, “Facing the Shadow”).
- Positive Sexual Focus (pp. 64-65, “The 90-Day Prep”).
- Letter to Yourself (p. 196-197, “Facing the Shadow”).
- Emergency First Aid Kit (p. 198, “Facing the Shadow”).

XI. Assign additional homework if any.

- Step 2 reading materials \textit{optional}
- Step 3 reading materials \textit{optional}

XII. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

- Individual sobriety definitions
- Details about relapse scenarios

XIII. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

* Module Six: Sexual Sobriety

Dr. Patrick Carnes & Staff of Gentle Path Press

Week Five of The Program

Sobriety Challenges

<table>
<thead>
<tr>
<th>The Sobriety Challenges</th>
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<tbody>
<tr>
<td>Overcoming Impulsivity</td>
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<td>Adjusting Achievements</td>
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<td>Overcoming Depression andシェア</td>
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<td>Self-defining shame</td>
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<td>Overcoming Impulsivity</td>
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3 Circle Worksheet

Abstinence List:
“Abstinence” means concretely defining behaviors that you will abstain from as part of your recovery. To use one of these behaviors again means to slip; to continue it over a period of time means a relapse.

Boundaries List:
Boundaries are self-imposed limits that promote health or safety. They may involve situations, circumstances, people, and/or behavior that you avoid because they are dangerous, jeopardize your abstinence, or do not add to your recovery or your spirituality.

Healthy Sexuality:
Start by listing ten sexual and relationship goals you have. Then list specific steps you can take and resources you might use. These are uncharted waters for many. If you do not have a partner, you can still work on various dimensions of your sexuality.
Meditation Principles IV: Surviving Bottom Principles

Surviving Bottom

Recovery starts when you accept that our lives had become unmanageable

Surviving Bottom

We must examine the very worst episodes of our addiction to grasp the patterns in our disease

Surviving Bottom

Severe hardship teaches that we must reclaim a vision of a better life while facing how bad it is today

Surviving Bottom

Our bad experiences become like mentors teaching us important lessons we needed to learn

Surviving Bottom

We must train our brain to break out of the well-worn paths of addiction in order to survive
Surviving Bottom

Those who do survive have the capacity to transform suffering into meaning

Surviving Bottom

While we have run from feelings for years, they in fact will help us in knowing what we have to do

Surviving Bottom

Recovery demands that we change faster than we understand, so we have to accept confusion for a while

Surviving Bottom

Gratitude is the critical ability to appreciate what we have gotten from our experience with loss

Surviving Bottom

Surviving crisis always brings the temptation to do just enough... Recovery teaches that “half measures availed is nothing.”

Homework:

- Continue Meditations & CDQs - Recovery Start
- Chapter 6, Facing the Shadow, pgs. 182 - 203
- Letter to Self
- Emergency Kit
- Fire Drills
- Assigned readings and 3rd Step optional
RECOVERY START MODULE 7

Relapse Prevention

PURPOSE: To understand the utility of Relapse Prevention tools.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Understand Abstinence and Relapse issues
2. List Relapse Prevention Tools
3. Write out his/her Soul Window
4. Understand Lifestyle Challenges
5. Complete a Personal Craziness Index-PCI
6. Understand Step 2 and Step 3 issues

MATERIALS:
- PowerPoint presentation (Relapse Prevention)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on using various relapse prevention tools to maintain sobriety.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Relapse Prevention)
IV. Discuss briefly Abstinence, Relapse and Prevention Issues. Introduce Relapse Prevention Tools and list of options (pp. 182-202, “Facing the Shadow”).

**Relapse Prevention: Recovery Tools**

**Resisting Addictive Cravings**

- Develop spiritual strategies
- Decode feelings
- Avoid trigger situations
- Forgive yourself for slips
- Work on nurturing yourself
- Avoid keeping cravings secret
- Find alternative passions
- Acknowledge your choices

**Creating your Recovery Zone**

- PCI - Personal Craziness Index
- Letter to Yourself
- Emergency First Aid Kit
- Relapse Contract
V. Discuss Resisting Relapse Reflection (p. 101, “Facing the Shadow”).

VI. Introduce the concept of Soul Window 1 & 2 (pp. 47-52, “The 90-Day Prep”).

**Soul Window Part 1**

When matches occur, they often reveal deeper patterns in your life.

<table>
<thead>
<tr>
<th>Sexual Behavior That Harmed Others:</th>
<th>Descriptions of This Behavior:</th>
<th>Non-Sexual Behaviors That Fit Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Column A record sexual behavior that hurt others. Include “victimless” behaviors in which you rationalized your behavior (e.g., “they got paid”), even though you were exploiting someone who was vulnerable.</td>
<td>In Column B list words and phrases that would characterize your sexual behavior (e.g., dishonest, seductive, exploitive, opportunistic, willful, rule-breaking).</td>
<td>In Column C review the descriptions in column A and determine if any of those words describe non-sexual behavior (e.g., deceptive fits for sexual behavior and may also relate to occasions when you have been deceptive in non-sexual situations such as with finances, work, school, friends or family).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Behavior That Harmed Others:</th>
<th>Descriptions of This Behavior:</th>
<th>Non-Sexual Behaviors That Fit Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced my partner into unwelcome acts</td>
<td>Made my wife do things she did not want to do.</td>
<td>Humiliated a co-worker by telling an embarrassing story about him</td>
</tr>
</tbody>
</table>

People Harmed: I lied to my children about my husband to make myself look better

What Would They Say? “We believed something that’s not true, and you probably lied to us about yourself”

What of What They Would Say is True? All of it!

VII. Introduce the concept of Soul Window 3 & 4 optional (pp. 53-60, “The 90-Day Prep”).

VIII. Introduce the concept of Soul Window 5 (p. 61, “The 90-Day Prep”).

IX. Provide information on Lifestyle Challenges

X. Introduce the PCI - Personal Craziness Index (pp. 99-108, “The 90-Day Prep”).
XI. Provide information on Step 2 and Step 3 Issues

Step 2 – Came to believe that a Power greater than ourselves could restore us to sanity. This step is about Faith and believing that a higher power can begin to operate in the addict’s life. Sometimes addicts run in to anger and a sense of hopelessness when they do not believe that it can (of even exists).

Step 3 – Made a decision to turn our will and our lives over to the care of God as we understood Him. This step is about Surrender. Addicts find that real recovery begins when a decision is made to "let go" of living in old ways and trust that they do not know / have not known the better way.

XII. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:


XIII. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

- Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
- Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
- Fire Drill Planning Sheet (p. 173, “Facing the Shadow”).
- Relapse Contract (p. 198, “Facing the Shadow”).
- Write out Celibacy / Abstinence Contract
- Soul Window 1 & 2 (pp. 47-52, “The 90-Day Prep”).
- Soul Window 5 (p. 61, “The 90-Day Prep”).
- PCI - Personal Craziness Index (pp. 186-195, “Facing the Shadow”).

XIV. Assign additional homework if any.

- Soul Window 3 & 4 optional (pp. 53-60, “The 90-Day Prep”).

XV. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

- Abstinence and Relapse issues
- Lifestyle Challenges
- Step 2 and Step 3 issues

XVI. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
**Module Seven: Relapse Prevention**

Week Six of The Program

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**Relapse Prevention**

Imagine a boulder on top of a hill. You have been given the job of keeping that boulder there. If it rolls down the hill, it will cause all kinds of damage. At the bottom of the hill is a large lake. If the boulder hits the water, it will be much more difficult to retrieve. The boulder serves as an important stabilizer for all that is around it, so it would be important to keep it up there. And if it were to fall, it is your job to return it.

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**Relapse Prevention**

As this big rock rests here, it takes little or no effort on your part to keep things in balance. But let us say that the land becomes unstable and the boulder starts to roll down hill. Where is the best place for you to intervene? At the top it might take only 20% of your strength to stop the boulder’s momentum. By the time it is halfway the hill, it might take 100% of your ability to stop it. At the bottom of the hill, it may have so much speed and power, you may not be able to stop it.

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**Relapse Prevention: Loss of Control**

Diagram showing the decrease in ability to control the boulder as it rolls down the hill.
Relapse Prevention

Obviously, it is best to keep the rock stable in the first place. But if you have to intervene, it is far better to do it at the top of the hill, than “last ditch” efforts at the bottom. So it is with recovery. It is better to keep stable or intervene early. Using the rolling-boulder analogy, let us construct how the addictive cycle can reassert itself in your life. A very predictable sequence of events occurs in relapse.

Recovery Tools

Introduce Soul Window & Arousal Template
Soul Window Part 1 Example:

- **Social Behavior That Arose Values:**
  - Forced my partner into monogamous acts

- **Description of the Behavior:**
  - Made my partner do things she did not want to do

- **Non-Social Behavior that FB Describes:**
  - Humiliated a co-worker by taking an embarrassing story about him

Soul Window Part 2 Example:

<table>
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<tr>
<th>People Involved</th>
<th>What Would They Say?</th>
<th>What or What They Would Do If They Were You?</th>
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<tbody>
<tr>
<td>I told my children about my husband's use</td>
<td>“We believed something that’s not true, and you probably lied to us about yourself.”</td>
<td>All of it!</td>
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Homework:

- Continue Meditations & CDQs
  - Recovery Start
- Read chapter 7, *Facing the Shadow*, & complete exercises
- Fantasy worksheets
- Arousal Templates
RECOVERY START MODULE 8

Sexual Awareness
(presented in a Saturday workshop format)

PURPOSE: To understand one’s own Arousal Template.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Write out his/her own Arousal Template.
2. Understand the concept of Eroticized feelings.

MATERIALS:
- PowerPoint presentation (Sexual Awareness)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogues-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Sexual Awareness)

IV. Introduce concepts of the Arousal Template
   - Our Arousal Template is a mix of physiology and learning, based on Relational or Sexual Experiences.
   - It is a primarily unconscious decision tree or map of how we have become “wired” sexually, built on preferences already somewhat determined by our survival instincts and genetic code (whether we like tall or short, blondes or redheads).
   - It is a guide we use to determine (subconsciously) what is erotic or arousing.
   - It determines decisions in its own right and becomes a template for action.
   - It organizes what we have learned about: consent, equality, respect, trust, safety, dishonesty, domination, objectification, power, control … What is valuable, worthwhile, exciting, desired, helpful, and also what is to be avoided.
   - Thoughts, ideas, behaviors and responses become associated with the triggering stimuli (cues for arousal).
V. Introduce the concept of Eroticized Feelings
   • Just as objects, situations, or scenarios become eroticized so do feelings. Remember in your basic psychology courses reading of experiments that showed people were more attractive when the subject perceived fear or risk either to themselves or that person. (e.g., Taking a date to a scary movie). Almost any feeling can become an arousing “trigger” that is associated with behavior.

   • Pain, Fear and Risk – Fear is a well-documented neurochemical escalator of the sexual experience. Many trauma victims of violent sexual abuse as children report that as adults they are unable to be orgasmic without some form of pain.

VI. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

   • Arousal Template sample (attached handout)
   • Emotional Restitution (pp. 69-97, “The 90-Day Prep”).

VII. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

   • Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
   • Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
   • Matrix Reflection Questions (p. 226, “Facing the Shadow”).
   • Fantasy Worksheets (p. 237, “Facing the Shadow”).
   • Arousal Template (pp. 248-255, “Facing the Shadow”).
   • Mirror of Desire (pp. 259-262, “Facing the Shadow”).

VIII. Assign additional homework if any.

IX. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

   • Sexual Concerns
   • Arousal Patterns reflecting personality issues

X. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Dr. Patrick Ceresa &
Staff of Gentle Path Press

* Module Eight:
Sexual Awareness

Week Five of
The Program

Relapse Prevention

Homework:

- Continue Meditations & CDQs
  - Recovery Start
RECOVERY START MODULE 9

Recovery Planning

PURPOSE: To begin the process of Emotional Restitution.

OBJECTIVES: By the end of this module (attending psychoeducation and psychotherapy groups) the individual will:

1. Understand Emotional Restitution.
2. Increase accountability and empathy for self and other(s)

MATERIALS:
- PowerPoint presentation (Recovery Planning)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on tasks to begin Emotional Restitution and repair interpersonal relationship(s)

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Recovery Planning)

IV. Introduce concept of Emotional Restitution (pp. 71-97, “The 90-Day Prep”).
- Clearly explaining how your partner (and others) were innocent regarding your offending destructive behavior – Victim Identification
- Raising awareness and empathy – Victim Self-Introspection Letter
- Identifying special qualities that your partner (and others) possessed that were used against him/her – Partner Positive Trait Card
- Becoming more aware of interpersonal interactions and thought processes that lead to victim posturing – Addict’s Frame by Frame Analysis
- Identifying dishonesty, manipulation and controlling behaviors – Letter of Clarification
- Becoming more aware of relationship dynamics contributing to intimacy distance and disability – Co-Addict Emotional Restitution Exercise
• Becoming more aware of interpersonal interactions and thought processes in order to increase understanding – Diary exercises

V. Assign Reading Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

• Chapter 8: Where is Your Support – Creating Your Support Systems (pp. 265-283, “Facing the Shadow”).
• Emotional Restitution (pp. 71-97, “The 90-Day Prep”).

VI. Assign Written Homework (recovery tasks) to be completed and presented prior to the next psychoeducation group:

• Continue “40 Meditations” and read one meditation daily (“The 40-Day Focus”).
• Continue “CDQs” and complete the Daily Progress Chart daily (“The 40-Day Focus”).
• Important People Inventory and Reflection (pp. 276-279, “Facing the Shadow”).
• Victim Identification (p. 71, “The 90-Day Prep”).
• Victim Self-Introspection Letter (p. 72, “The 90-Day Prep”).
• Partner Positive Trait Card (p. 74, “The 90-Day Prep”).
• Addict’s Frame by Frame Analysis (p. 76-77, “The 90-Day Prep”).
• Letter of Clarification (pp. 86-89, “The 90-Day Prep”).
• Partner Diary (p. 96, “The 90-Day Prep”).

VII. Assign additional homework if any.

• Co-Addict Victim Identification optional (p. 95, “The 90-Day Prep”).
• Co-Addict Partner Diary optional (p. 97, “The 90-Day Prep”).

VIII. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. For instance, individuals may turn in their weekly progress charts and Task Cards (sheets), and present and process their homework in their separate psychotherapy groups or individual session(s).

• Victim Empathy/Sympathy
• Offender Issues
• Intimacy Issues

Improving Group Focus: A very useful process for reading letters in group for feedback begins with each member being assigned specific criteria to listen for in the letter (these criteria can be found in the Emotional Restitution instructions). After the reading of the individual letter, each group member provides feedback referencing the criteria observed.
IX. Invite individuals to close their eyes, relax and breathe deeply. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Dr. Patrick Carnes &
Staff of Gentle Path Press

** Module Nine: Recovery Planning

Week Six of
The Program

Homework:

• Emotional Restitution Guidelines

• Continue Meditations & CDQs
  - Recovery Start
RECOVERY START MODULE 10

Recovery Plan

PURPOSE: To understand the importance of a Recovery Plan and follow-through.

OBJECTIVES: By the end of this module the individual will:

1. Complete a “90 Day Focus” Planner.
2. Write out and present a list of Growth Goals
3. Receive feedback on participation and suggestions for continued recovery.

MATERIALS:

- PowerPoint presentation (Recovery Plan)
- Facing the Shadow, 2nd ed. workbook
- The 40-Day Focus, Book One of the Recovery Start series (includes Task Cards, Meditations, Core Dialogue Queries-CDQs)
- The 90-Day Prep, Book Two of the Recovery Start series
- The 90-Day Focus, Book Three of the Recovery Start series

LECTURE OUTLINE:

This lecture focuses on (1) using the “90-Day Focus Planner”, and (2) identifying individual goals for continued growth in recovery.

I. Welcome your group and ask if anyone needs clarification on concepts, topics or homework.

II. Ask your clients to share insights related to their homework assignments (already presented in their individual psychotherapy group during the past week) in small groups:

III. Show PowerPoint presentation (Recovery Planning)

IV. Discuss importance of:

- Creating a list of Goals in Recovery
- Feedback from others
- Participation in 12-Step Groups
- Service
- Sponsorship

V. Introduce “The 90-Day Focus”

VI. Provide orientation to Monthly Monitor
VII. Assign Reading Homework to be completed and presented at the next psychotherapy group:

- The Next 90 Days – Introduction (“The 90-Day Focus”).

VIII. Assign Written Homework to be completed and presented at the next psychotherapy group:

- 90-Day Focus Planner (pull-out section, “The 90-Day Prep”).

IX. Assign additional homework.

List of Growth Goals – The Growth Goals are key to implementing a contract for treatment objective for the 90 Day Focus. Individual therapy sessions are highly encouraged to focus the work of therapy for the three month period.

X. Because individuals in the psychoeducation group will each meet with their separate psychotherapy group, clarify which homework assignments will be shared prior to the next psychoeducation group. Clients will present and process their homework during individual therapy session(s).

XI. Invite individuals to close their eyes, relax and breathe deeply.

XII. Provide time for individuals to share feedback regarding their own, and others’, participation and growth in the psychotherapy group.

XIII. Close the session with either a recovery reading or The Serenity Prayer.
Recovery Start Overview

Dr. Patrick Cames &
Staff of Gentle Path Press

Module Ten: Recovery Plan

Week Seven of
The Program

Twelve Step Groups

Sponsorship

Intro to 90 Day Focus
Orientation to Monthly Monitor

Monthly Recovery Examples:

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