TASK-CENTERED, COMPETENCY-BASED APPROACH TO TREATMENT

by Patrick J. Carnes, PhD

It started with lunch. I had been invited to join four couples in which one or both partners were recovering sex addicts. It was September of 1985, and we were attending the first national conference ever held on sex addiction. It was a time of great excitement and hope because of all the new knowledge and the clinical and personal sharing that had taken place at the gathering.

As the couples chatted, they eventually talked about their sexuality and how wonderful sex was for them. I remember thinking how useful it would have been to have a tape recording of that conversation. Especially for those new in recovery, and still filled with despair, to hear such experiences would be so helpful. Then it occurred to me that for all the progress we had made in understanding how sex addiction affects people, we had very little information about what made for successful recoveries and how recovery was best achieved.

We began a study of how recovery occurred. The study involved seven researchers and a thousand recovering people. The result was a book called, *Don't Call It Love* (Bantam, 1991). To piece together the recovery process, we asked recovering sex addicts and their partners to complete a number of instruments, including an extensive life status inventory and a month-by-month history of their recovery. We also interviewed people with extended recovery in a stage-by-stage fashion and analyzed their responses. We then adopted two strategies to obtain a pattern of recovery. We developed a pattern from the retrospective information proved by the surveys and interviews, and we asked people with different periods of recovery (six months, one year, eighteen months, etc.) how things were going for them now. The two strategies yielded the same pattern. The following overview of a five-year recovery process is based on changes in classic quality of life indicators.

The First Five Years of Recovery

The First Year: There was no measurable improvement, and yet most addicts reported that life was definitely better. This apparent contradiction might be explained by one respondent's comment that "when you are hitting your head against the wall, even stopping the hitting helps." In fact, according to our assessments, some things got worse. Most slips – if they occur – will occur in the second six months of recovery. Further, all health indicators – accidents, sickness, and visits to physicians – show the second six months to be the worst over the five years. The first year appears to be characterized by extraordinary turmoil, which really tests the recovering person's resolve to change. Some of the consequences of addiction continue, and the change itself is difficult.

The Second and Third Years: Once through the first year, significant rebuilding starts. There is measurable improvement occurring in many areas, including finances, ability to cope with stress, spirituality, self-image, career status, and friendships. Our survey documented improvement in finances, coping with stress, career status, and friendships continuing over the five-year period. These indicators reflect a period of intense personal work, which results in more productivity, stability, and a greater sense of well-being.

Three to Five Years: Once the personal base of recovery was established, healing occurred in the addict's key relationships. Improvements – often dramatic improvements – occurred in relationships with children, parents, siblings, and partners, but there were some exceptions. About 13% found that a breach with their family of origin could not be healed because the family was abusive or was threatening to recovery. Some marriages were casualties to the recovery process. Most importantly, sex addicts reported a significant shift toward more healthy and satisfying sexual expression. With the healing of relationships, overall life satisfaction improved dramatically. The below chart summarizes our findings.

Categories of Recovery Over Time

WORST SECOND 6 MONTHS	BETTER YEAR 2 AND 3	BETTER YEAR 3 PLUS
S A Relapse	Financial situations*	Healthy sexuality
Health Status	Coping with stress*	Primary relationships
	Spirituality	Life satisfaction
	Self-image	Relationship with family of origin
	Career status*	Relationship with children
	Friendships*	
* *Continued to improve three years plus*		

The question is asked, "Does it have to take three to five years to rebuild one's life?" Probably not, given current technology, because when the people in our survey went through recovery, the groups they joined were generally small and inexperienced. Treatment programs were few and therapists were learning as they went along. It is possible that, with more treatment options, concrete materials like *The 27 Tasks*, the greater experience of therapists, and the growing maturity of the fellowships, recovery can move faster. Nonetheless, some aspects of recovery address core developmental issues, which take time to heal. Our goal in these materials is to help you facilitate that healing process for your clients.

Stages of Recovery

In addition to our findings, we conducted a series of content analyses in which we were able to see six discernable phases or stages in which these changes occur. The states are summarized as follows:

The Developing Stage (lasts up to two years): During this period of time the addict's problems mount and create an awareness that something will have to be done. The addict may even seek therapy or attend a Twelve Step group, but then drop out. We also noted that many therapists would fail to see the problem of sexual acting out, or if they did see it, failed to follow through on it. Even knowledgeable therapists would

feel shame at this stage because the client dropped out of therapy. They would tell themselves that if they had been better therapists, the client might have gotten through.

Our research showed that no matter what therapists try at this stage, clients might not be ready. Addicts have a growing appreciation of the reality of the problem, but tend to counter this realization by minimizing the problem or thinking they can handle it by themselves, and some addicts temporarily curtail their behaviors or substitute other behaviors.

The Crisis/Decision Stage (one day to three months): At some point, the addict crosses over a line in which there is a fundamental commitment to change. Most often this is precipitated by a crisis, subterfuge and duplicity no longer covering the double life. This crisis may include all kinds of events like arrests, sexually-transmitted diseases, spouse or partner leaving, positive HIV tests, sexual harassment suites, loss of professional license, car accidents involving death or injury, and suicide attempts. Sometimes a crisis is precipitated by a therapist or employer who refuses to continue enabling destructive behaviors. For some of our respondents, the commitment to change was not about crisis, but rather about choice. They simply were not longer willing to exist in the old way. They reflected the old aphorism in Alcoholics Anonymous of being "sick and tired" and become willing to go to "any lengths" to get better.

The Shock Stage (first six to eight months): Once they admit the problem, addicts enter a stage that parallels what happens to anyone who has experienced deep loss and change. Disbelief and numbness alternate with anger and feelings of separation. Addicts describe physical symptoms of withdrawal that are at times agonizing. They also report disorientation, confusion, numbness, and the inability to focus or concentrate. Feelings of hopelessness and despair become more intense as their sense of reality grows. Addicts become reactive to limits set by therapists, sponsors, or family members. When they join a recovery group, they experience a sense of belonging, along with the realization that recovery was the right decision for them. The time-honored Twelve Step wisdom, distilled in slogans like "Keep it simple" and "A day at a time," appears to be very appropriate at this point. Addicts do report feelings of relief and acceptance once the double life is over.

The Grief Stage (six months): As they come out if shock, the addicts become aware of the pain. This suffering has several components that interact at the same time. First, there is awareness of all the losses due to addiction including jobs, relationships, children, time, money, and physical well-being. The wreckage is everywhere. Second, there is a sense of loss as the addiction ceases to serve as friend, comforter, and high. Third, the addiction has masked deeper hurts usually stemming from child abuse and family of origin events. Without the cover of the addictive process, memories return and clarity about those early wounds emerges. Understanding the level of suffering at this point helps to explain why the relapse rate was so high during this time period. Similarly, the decline in the level of health in the second half of the first year parallels this painful period. High emotional stress impairs the immunological system, making addicts more vulnerable to illness, and reduces the ability to function normally, thereby increasing the vulnerability to

accidents. These affects on health status prove a potent testimony to the power of pain.

The Repair Stage (eighteen to thirty-six months): Addicts who were successful in negotiating the rigors of the previous stage move from the pain into a deep, internal restructuring. Belief systems about self, sex, family, and values are overhauled, and new patterns of behavior develop. Systems theory would describe this phase as a "paradigm shift." It is a "second order" change in which the programming or internal rules are different versus "first order" change, which is characterized by using the old solutions with greater energy or trying harder. Said another way, by changing behavior one can make modest changes, but change the paradigm and the changes are dramatic. We were able to measure addicts taking responsibility for themselves in all areas of life, including career, finances and health. They reported a new ability to express their needs, to accept that they have needs, and to work to meet them. A common thread in our study was the deepening of new bonds with others. Addicts also reported efforts to complete things (degrees, projects, work, etc.) and to be dependable (being on time, following through, and responding to requests). In fact, addicts during this phase commented on learning not to live on the "edge," but rather choosing low-risk options over high-excitement options.

The Growth Stage (two years plus): As addicts achieve more balance in their lives and have a greater sense of themselves, they become more available to others. Relationships with partners, friends, children, and family go through a period of tremendous renewal. Here, too, is where life satisfaction measures really showed improvement. Addicts reported more compassion for themselves and others, and had a new trust for their own boundaries and integrity in relationships. A sense of achievement existed because of new milestones in love and sex. Addicts talked of a new ability to take care of and nurture relationships; Old relationships were transformed or ended.

Treatment Options

Participants in the study, who had achieved a significant amount of time in recovery (190), were presented with a list of treatment and support resources and asked to indicate whether they had used them and if they were helpful. Further, they were asked to indicate anything else they had tried and whether or not that was useful. The chart, which follows, summarizes the results of this part of our survey. Clearly a number of factors stood out as being helpful in recovery including:

- In-patient treatment experience
- A group experience
- Long-term individual therapy
- Twelve-step work
- An active and knowledgeable sponsor
- An ongoing spiritual life

- The support of friends
- A period of celibacy
- Regular exercise and balanced nutrition

Not everyone used all of these, but there emerged a pattern or recipe for success in recovery.

Treatment Choices

TYPE OF TREATMENT	HELPFUL	NOT HELPFUL
Inpatient treatment	35%	2%
Outpatient group	27%	7%
Aftercare (Hospital)	9%	5%
Individual therapy	65%	12%
Family therapy	11%	3%
Couples therapy	21%	11%
12-Step Group (SA-based)	85%	4%
12-Step Group (other)	55%	8%
Sponsor	61%	6%
Partner support	36%	6%
Higher power	87%	3%
Friends' support	69%	4%
Celibacy period	64%	10%
Exercise / Nutrition	58%	4%

Some principles also became clear. First, recovery is a long-term process. Brief interventions, including therapy, medication, or limited hospital stays, did not produce the desired results. This illness is the result of a combination of powerful family forces, neurochemical interactions, and trauma history which have impacted both developmental and internal processes. There is no quick fix, however there is a series of steps which, when taken over a period of time, can make for predictable success.

Secondly, it became clear that success was dependent on client follow-through and responsibility. If the client did not follow the recipe, success was marginal. This changes our perceptions of measuring outcomes. For example, completing steps 1 through 3 of a Twelve-Step Program in an in-patient facility, but never actively

completing further steps or attending further therapy, rapidly diminishes the changes of success – no matter how effective the program was. Similarly, individual therapy without the support of the client's partner or a Twelve-Step fellowship significantly reduces desired outcomes. Ultimately it was not one thing, but a series of interventions over time that maximized the best probabilities of success.

Changes in Health Care

As our research was being conducted, massive changes started to occur in the healthcare system. Despite the wealth of data which showed mental health treatment saved healthcare dollars, clinicians were being forced to justify their efforts at every turn.[1] Worse, it became clear that the fields of addiction and trauma treatment (both of which are involved and have proven records that they save dollars in the long run) were targete3d by many payers for cost-cutting. Sexual abuse victims, for example, are eight times more likely to have fatal cancer.[2] Alcohol and other drug addiction, when left untreated, create staggering healthcare costs. The American Society of Addiction Medicine fought back by developing Patient Placement Criteria for Treatment of Psychoactive Substance Use Disorders.[3] By establishing very concrete criteria, clinicians could argue more effectively for treatment resources. In fact, managed care is evolving from simply a stance of denial of everything possible, to searching for criteria that optimizes success.[4]

In the treatment of sex addiction, the problems were compounded by the fact that the diagnosis had not gained wide acceptance despite significant progress toward that end. The American Academy for Health Care Providers in the Addictive Disorders included sex addiction as one of the areas of addiction certification.[5] A new medical journal called *Sexual Addiction and Compulsivity, The Journal of Treatment and Prevention* began to be published.[6] Attendance at twelve step meetings for sex addiction increased by eighty percent from the year 1989 to 1994.[7] However, until there is a commonly accepted diagnosis, denial by some providers remains. Yet, societal costs are overwhelming. Sexual harassment suites, the AIDS epidemic, lost careers, suicide attempts, broken relationships – the list seems endless to those who work with addicts.

To summarize, we had been able to pinpoint factors in successful recovery; we knew that healthcare was moving quickly to kinds of treatment which could be concretely measured with predictable outcomes; we knew that patients needed a structure that

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[1] Cummings, Nicholas A., Arguments for the Financial Efficacy of Psychological Services in Health Care Settings," *Handbook of Clinical Psychology in Medical Settings,* Sweet J., Rozensky, R., and Tovian, S., eds. Plenum Publishing Co., 1991.

[2] Springs, MD, F. E., "Health Risk Behaviors and Medical Sequelae of Childhood Sexual Abuse." Mayo Clinic Porc. 1992: 67:527-532.

[3] "Hoffman, et. Al., "Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorder," American Society of Addiction Medicine, 1991.

[4] Wylie, M., Endangered Species, the Managed Care Revolution." The Family Networker, 18-2, March, 1994.

[5] For information write American Academy of Health Care Providers in the Addictive Disorders, 260 Beacon Street, Somerville, MA, 02143. (617) 924-3344.

[6] For information write Taylor & Francis.

[7] Salmon, Richard, National Council on Sexual Addiction, Boulder, Colorado.

could help them maximize success, create accountability, and emphasize self-responsibility; we knew that a shift in paradigm was critical; we understood that effective treatment requires an integration of resources including therapeutic and self-help. The challenge was to build an integrated set of interventions that were measurable, systemic in nature, built on the experiences of successful recovery, and managed-care friendly.

Competency-Based Recovery

By carefully studying our results along with several outcome studies, we have determined thirty areas of "competency" that make for successful recovery. These competencies are necessary to manage their illness. Failure to manage can result in relapse. The development of these competencies comes by accomplishing recovery "tasks." By doing these tasks, the skills or competencies are learned. We have further broken the tasks down into specific "performables" that a therapist can assign and outcome measures can track. The following chart details competencies, tasks and goals which can be the frame for a comprehensive treatment plan.

RECOVERY TASK	PERFORMABLES	LIFE COMPETENCY
1. Break through denial	• Make full disclosure to therapist of all forms of sexual acting out. • Share a list of examples of powerlessness and unmanageability.	• Recognize self-delusion.
2. Understand the nature of the illness	• Share the First step, a sexual history, and a consequences inventory.	• Have knowledge of addiction and recovery
3. Surrender to the process	• Complete a Second and Third Step.	• Know the personal human limits
4. Limit damage from behavior	• Share a damage control plan and implement it.	• Be expert in self-care, crisis avoidance, and crisis management
5. Establish sobriety	• Share a sobriety statement. • Complete a celibacy contract of eight weeks or more, and a relapse prevention plan. • Complete fantasy contamination exercise.	• Manage affairs without dysfunctional sexual behavior
6. Ensure physical integrity	• Review physical exam issues.	• Be expert in physical self-care

RECOVERY TASK	PERFORMABLES	LIFE COMPETENCY
7. Participate in a culture of support	• Attend twelve step sex addiction meetings regularly. • Attend other twelve step meetings as appropriate.	• Build a functional health support system
8. Reduce shame	• Complete steps Four and Five.	• Recognize and manage toxic shame
9. Grieve losses	• Define clear grieving strategies and use them.	• Recognize grief and have skills for grieving
10. Understand multiple addictions and sobriety	• Share Addiction Interaction Disorder screen and multiple addiction relapse prevention plan.	• Remain relapse free from all concurrent addictions.
11. Acknowledge cycles of abuse	• Share results of survivors week and abuse inventory.	• Identify abuse and exploitation
12. Bring closure and resolution to addictive shame	• Complete steps Eight and Nine.	• Keep current on shame, resentment and relationship issues
13. Restore financial viability	• Live within financial means (spend less than earned). • Work recovery financial plan.	• Maintain financial viability
14. Restore meaningful work	• Establish a meaningful career path.	• Have meaningful work
15. Create lifestyle balance	• Use a Personal Craziness Index for 8 weeks.	• Live in balance/harmony
16. Build supportive personal relationships	• Find and use a sponsor. • Attend a therapy group for 175 hours. • Be a sponsor to others.	• Initiate and sustain enduring life relationships.
17. Establish healthy exercise and nutrition patterns	• Have a weekly aerobic exercise pattern. • Remain in appropriate weight range and height.	• Stay physically fit
18. Restructure relationship with self	• Complete eighteen months of individual therapy.	• Be authentic
19. Resolve original conflicts-wounds	• Do therapy specific to family of origin or trauma issues.	• Identify and manage recurring dysfunctional patterns

RECOVERY TASK	PERFORMABLES	LIFE COMPETENCY
20. Restore healthy sexuality	• Write a sex plan and keep it updated.	• Have sexual health
21. Involve family members in therapy	• Family members attend family week. • Family members attend therapy sessions.	• Capacity to ask for help from immediate family
22. Alter dysfunctional family relationships	• Full disclosure to primary partner and immediate family as appropriate.	• Remain true to self in the presence of dysfunction
23. Commit to recovery for each family member	• Family members enter a recovery program for themselves.	• Take responsibility for self
24. Resolve issues with children	• Share secrets and make amends to children when appropriate.	• Resolve conflict in dependent relationships
25. Resolve issues with extended family	• Share secrets and make amends to extended family when appropriate.	• Resolve conflict in interdependent relationships
26. Work through differentiation	• Write a "Fair Fight" contract.	• Sustain intimacy without loss of self
27. Recommit/commit to primary relationship	• Commit to a primary relationship, or recommit to a primary relationship.	• Capacity to maintain a committed relationship
28. Commit to coupleship	• Attend twelve step meeting for couples regularly.	• Participate in a community of couples
29. Succeed in primary intimacy	• Have a primary relationship which is satisfying.	• Be vulnerable and intimate
30. Develop a spiritual life	• Find and use a spiritual director or mentor. Join a spiritual community.	• Be spiritually conscious

In conclusion, we identified activities recovering people used to accomplish these tasks, and then developed this training series which has been built around those activities. This manual and its activities are organized according to the stages of recovery identified in our original research. Our goal is to help establish essential life competencies which would sustain recovery.

The actual tasks and activities for each task are presented in summary form in each section of this manual. They are designed to be used in conjunction with those processes described previously: in-patient and/or out-patient treatment, twelve-step participation; the involvement of friends, partner, and sponsor, the development of a

spiritual life; and a commitment to personal health, including sexual health. The advantage of a common process is that an addict can move across levels of care as needed. Through in-patient, extended residential, out-patient, or private individual care, the task work can transfer as the patient's needs require.

Expert System

To use the language of computer systems, we have done our best to capture an "expert system" – the experts in this case being those people who have put together successful recoveries. By doing so, we are able to document the progress of addicts through a common process, with common measures, and common follow-up. In years to come, we will be able to document for providers in concrete terms what is needed for recovery on the basis of patient reality and real costs. Any expert system will go through evaluations, and we are sure our learning curve will be high. Your participation however, will bring us closer to the recognition of this illness as treatable and treatment of it as cost-effective.

