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Overcoming the seduction of sexual addiction infidelity

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Abstract

Recovery from sexual addiction infidelity is painful and complex. Evidence suggests that there is an increased number of people who suffer from sexual addiction, specifically heterosexual males in a married and committed relationship. In response to the epidemic of sexual addiction, this paper presents some preliminary findings from a PhD study on sexual infidelity. Here I focus on a case study of the wife of a recovered sex addict. The data consists of an audio recording and transcription of an interview that was analysed using narrative inquiry. The story tells of the wife’s experience of hurt, betrayal and healing as well as her husband’s treatment and complete recovery from sexual addiction where he would behave sexually despite the likelihood of adverse consequences as a result of his behaviour. Only through an analysis of the couple’s experience of working with four different therapists both individually and as a couple, over the period of one year and self-help activities were we able to make sense of what aided in the husband’s recovery from sexual addiction and in the repair of their relationship. The findings support the importance of studying the experiences of those living with recovered sex addicts and have implications for the education of professionals with interest in sexual addiction infidelity.

Keywords: Sexual addiction, infidelity, therapy, treatment, recovery

Introduction

Sexual addiction infidelity has increased, especially with the advent of the Internet. In fact, as stated by Carnes and Carnes (2010), over seventy percent of sex addicts report cybersex as the beginning or as a catalyst to their sexual acting out. Researchers in all addictions report that availability is the key variable in addiction aetiology. For example, as outlined by Carnes and Carnes (2010), with sex addiction, “cybersex provides many venues for sexual access that are easy, affordable, and anonymous” (p. 10).

Owing to the increase of sexual addiction infidelity with its resulting heartache and damage, a case study is presented based on the approaches to recovery from sexual addiction infidelity. Not only was there sex addiction in this case study, but it was also compounded by the fact that while the sex addict was married, he was unfaithful to his
wife. While most research on infidelity and sex addiction has been conducted in the U.S. and Europe, there is a paucity of Australian research on sex addiction infidelity. Using narrative inquiry as part of a PhD study into infidelity counselling, the lived experience of the sex addict’s wife tells about her husband’s numerous infidelities. The arduous road to recovery from the seduction of sex addiction infidelity is outlined.

Sex Addiction

Sex Addiction is also known as compulsive sexual behaviour or hypersexuality (Kor, Fogel, Reid & Potenza, 2013). Criteria for hypersexual disorder were proposed for consideration for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), but ultimately rejected by the American Psychiatric Association despite a field trial suggesting the criteria were valid and reliable (Reid & Kafka, 2014). However, before defining hypersexual behaviour, it is important to consider “normal” sexual behaviour. As Frascella, Potenza, Brown & Childress (2010) point out, sex is fundamental to the survival of species, requiring an instinctual drive and reward-based reinforcement to ensure the perpetuation of the species. When this drive becomes intensive and leads to “out-of-control” sexual activity despite negative consequences and risk of harm to emotional and physical health, it has become negative and addictive.

Sex addiction involves compulsive behaviours such as constantly seeking new sexual partners, having frequent sexual encounters, engaging in compulsive masturbation and frequently using pornography, cybersex, strip club visitation, risky sexual activities, paying for sexual services and resisting behavioural changes to avert HIV risk (Carnes, 2010; Weinstein, Katz, Eberhardt, Cohen, Lejoyeux, 2015). According to Impett & Paplau (2003), males often engage in sexual activity for pleasure and esteem reasons. Furthermore, the pleasure related to sexual activity has been described to as basic as eating, fulfilling the basic drive of hunger (Codispoti, 2008). However, Carnes and Carnes (2010) state that sex addiction is steeped in secrecy and shame. As a result, when the sex addiction infidelity is exposed, the secrecy is lost and the attraction may subside for awhile.
According to Fong (2006), very little empirical data exists to explain the biological, psychological, and social risk factors that contribute to sex addiction. Also there is an absence of best practices on treating sexual addictions, despite the significant number of clients and communities requesting assistance with this problem (Carnes, 2010). Like other addictions, sex addiction can take over a person’s life with a cycle of self-destructive behaviour which is triggered through emotional discomfort such as fear, shame, and anger. In this way, Carnes (2010) argues that the person removes themselves from their emotions yielding a kind of numbing state, eliminating awareness of consequences, and leaving only awareness of pleasure. A recent study on pornography addiction (Voon, Mole, Banca, Porter, Morris, Mitchell, 2014) found that three brain regions mirror the neuronal excitation as seen in drug addiction. As the sex addiction progresses, the person needs more intense or bizarre sexual encounters or materials to get the same “rush” (Carnes & Carnes, 2010).

Karila, Wéry, Weinstein, Cottencin, Petit, Reynaud, Billieux (2014), point out that sexual addiction/hypersexuality, causes serious psychosocial problems for many people. Karila and associates (2014) have found that in recent years, research on sexual addiction has proliferated, and screening instruments have increasingly been developed to diagnose or quantify sexual addiction disorders (Karila et al., 2014). Other researchers, such as Reid, Carpenter, Gilliland and Karim (2012), question how to best classify hypersexuality as a psychiatric condition. At this point, the empirical science is not available to establish causality or pathogenesis for psychiatric disorders (Caine, 2003), including sexual disorders (Winters, Christoff & Gorzalka, 2010). Despite this limitation, data exist describing similarities between hypersexual behaviour and substance addictions (Garcia & Thibaut, 2010).

Ayres and Haddock (2009) report that internet pornography has become a huge industry. According to Zimbardo and Duncan, (2012), internet pornography offers portability, access, anonymity and visually explicit depictions of sexual acts that leave nothing to the imagination. The internet has created an information portal for these services through online dating services and classified advertisements for those in pursuit of sexual gratification (Carnes & Carnes, 2010). Although a range of individuals engage in online
sexual behaviour, the majority of people who identify as having a sexual addiction are heterosexual males in a married and/or committed relationship (Cooper, Delmonico, & Burg, 2000; Schiebener, Laier & Brand, 2015). Therefore the relational impact of sexual addiction is experienced largely by heterosexual women who go through the trauma and pain of infidelity.

**Infidelity**

One of the main problems associated with defining infidelity is that the categories of infidelity are not mutually exclusive. Infidelity can be emotional-only infidelity, or sexual-only infidelity as well as a combination of sexual and emotional combined types of infidelity on a continuum of sexual and emotional involvement (Glass & Wright, 1985; Tsapelas, Fisher & Aron, 2010; Wilson, Mattingly, Weidler, & Bequette, 2011). Within each of these general categories, there are different types. For example, emotional-only infidelity can include various types of activities in which the emotions are aroused such as secret rendezvous in online chatting rooms and real world venues (Vaughan, 2003). An emotional affair can be defined as “a relationship between a person and someone other than (their) spouse (or lover) that has an impact on the level of intimacy, emotional distance and overall dynamic balance in the marriage” (Moultrup, 1990, p. 34). In this view, neither sexual intercourse nor physical affection is necessary to affect the committed relationship(s) of those involved in the affair. An emotional affair can injure a committed relationship more than a one night stand or other casual sexual encounters (Blow & Hartnett, 2005). Sexual-only infidelity can consist of different types of sexual activities, such as flirting, sms-ing, oral sex, cyber-sex, one-night stands, sexual addiction or visits to sex workers or same-sex encounters (Blow & Hartnett, 2005), whereas sexual and emotional infidelity allows for any number of combinations of the above.

Infidelity is referred to as sex with someone other than one’s intimate partner without their permission or knowledge (Gordon, Baucom & Snyder, 2008; Janowiak, Nell & Buckmaster, 2002; Olson, Russell, Higgins-Kessler & Miller, 2002). The easy access to the Internet has contributed to an increase in the opportunity for infidelity, and has come to be referred to as “cyber-affairs” and “cyber-sex” (Atwood & McCullough, 2016), even
though they may never actually meet physically. The most distinguishing characteristic of all types of infidelity is secrecy, whether it is sexual or not. In other words, the violation of intimacy boundaries may be much more crucial than that of sexual boundaries and deceit is the most traumatic element of discovery to the faithful partner (Koocher, et al., 2005).

Infidelity may actually be a symptom of a sexual addiction which has been kept hidden from his or her spouse for months, or even years (Carnes & Carnes, 2010). Sexual addiction infidelity is believed to be a manifestation of a person’s deep emotional problems (Fisher, 2012). According to Carnes and Carnes (2010), it is linked to a root cause at the internal level, and the sexual acts become a way of coping with or escaping emotional pain. If someone who has committed infidelity has a sexual addiction, they may be unable to stop themselves from acting on compulsive thoughts about sex at such a level as to harm their careers, social lives and health (Fong, 2006; Karila et al., 2014). In each case, acting out sexual impulses becomes all-controlling and consumes a great deal of time. The person with sexual addiction will often feel strong levels of fear and shame following the acting out of their impulses, which can lead to depression and a preoccupation with keeping their actions secret (Carnes & Carnes, 2010). According to psychotherapist, Perel (2015), infidelity can also be “an expression of longing and loss ... a yearning for an emotional connection, for novelty, for freedom, for autonomy, for sexual intensity, a wish to recapture lost parts of ourselves or an attempt to bring back vitality in the face of loss and tragedy” (Ted Talk March10:27).

A striking paradox is that while studies of married people indicate that the vast majority disapprove of infidelity (Buunk & Dijkstra, 2006; Cherlin, 2009; Hertlein & Piercy, 2008), studies also show that that approximately 25 percent of wives and 50 percent of husbands had experienced extramarital intercourse (Glass, 2003). When emotional affairs and sexual intimacies without intercourse are included, the incidence of infidelity increases by approximately 15-20 percent for married people (Glass, 2003). Furthermore, when the higher levels of infidelity in cohabiting and other committed relationships are taken into consideration (Hertlein & Piercy, 2008), a conservative estimate is that approximately 75 percent of these couples will break their agreement for sexual or emotional exclusivity during the lifetime of their relationship. While statistics
about sexual infidelity are hard to prove because of the secrecy involved, studies suggest that about 20 percent of men and 15 percent of women will be sexually unfaithful at some point in life and that infidelity is widespread (Buunk & Dijkstra, 2006; Cherlin, 2009; Fisher, 2012). According to Allen and Baucom (2006), American dating couples report a 70 percent incidence of infidelity and in a survey of single American men and women, 60 percent of men and 53 percent of women admitted to “mate poaching,” trying to woo an individual away from a committed relationship to begin a relationship with them instead (Schmitt & Buss, 2001). Mate poaching is also common in 30 other cultures studied (Schmitt & Buss, 2001).

Because of the highly traumatic experience of infidelity, those involved often seek the help of a therapist (Abrahamson, 2008; Olson, et al., 2002; Scheinkman, 2005; Subotnik & Harris, 2005). Research shows that a large number of people who present for counselling have experienced infidelity (Carnes & Carnes, 2010). It is the most often cited reason that couples come for counselling (Abrahamson, Hussain, Khan & Schofield, 2012; Atkins, Baucom & Jacobson 2001; Peluso & Spina, 2008). Infidelity is considered one of the most damaging and one of the most difficult problems to treat (Atwood & Seifer, 2001; Olson, et al., 2002; Peluso & Spina, 2008). Though therapy has been found to be beneficial for some clients (Abrahamson, 2008; Atkins, et al., 2005; Gordon, Baucom & Snyder 2008), many therapists do not feel adequately prepared to treat the effects of infidelity (Peluso & Spina, 2008). Therefore more research needs to be undertaken to elicit from clients what they found helpful or unhelpful in their experience of infidelity counselling.

**Story of Sex Addict’s Wife**

Even though Shirley, the sex addict’s wife, wanted to tell me her infidelity counselling story, she was very concerned to keep her identity unknown as she was still married to the man who had been unfaithful to her several times. I assured her that using a pseudonym and not identifying any revealing features would protect her anonymity.

As we began the interview, Shirley told how she dreamt her husband was having an affair with a blonde woman and he was walking down the beach with her and “I saw them holding hands in the dream and I woke up in tears” (Para. 2). Obviously Shirley was upset.
and when she told her husband about the dream, he consoled her and then about a week later Shirley found out that it was actually true, “he was really having an affair and I was absolutely devastated” (Para. 2). Shirley revealed that eventually he disclosed to her that there were several infidelities. “He was in business and he travelled”. Shirley discovered later on that he had “women in different places where he used to go. However he was always unhappy. There was never enough sex” (Para 4)

In her quest to deal with his sexual addiction infidelities and realising there was never enough sex for him; Shirley told him that she was going to move out of their bedroom. “I cannot satisfy you and I never have been able to satisfy you, and I no longer want to live the lie that we have some kind of a good marriage” (Para. 6). Shirley said that when she moved into the spare room, “he went ballistic; he paced the passage at night, at 2 am and 3 am” (Para. 6). Shirley found she was quite frightened and would lock herself in her bedroom because she felt he might do something drastic; “he really tantrumed in a big way” (Para. 6). Shirley finally said to him “I am not moving back into the bedroom unless we have some counselling” (Para. 6).

**Therapy**

In retelling her story, Shirley said that she attended four therapists. The first therapist she saw on her own and the other three therapists were seen by both her husband and herself.

**What was unhelpful?**

The first therapist was a pastor/counsellor and Shirley only went once. He told her “well if you were offering your husband steak at home, he wouldn’t go out for a hamburger” (Para. 2). Shirley’s reaction to the pastor/counsellor’s judgement was that she took that all on board and she started thinking “well I have to smarten up my act”. At first Shirley thought it was helpful advice from him because now she knew what to do,

At the time I thought it was helpful because I had the formula to make him stay. It never occurred to me that it’s something dysfunctional within him but I took the blame. (Para 26)

With this in mind Shirley, went overboard and came to the conclusion that,
If he has so much intercourse that he can’t possibly perform with her, then that’s what I am going to do; to keep him sexually impotent when he got with her. (Para 4)

So Shirley said that she “started behaving like a sex worker and he was insatiable; as much as I gave, it was never enough or it wasn’t quite what he wanted” (Para. 4).

After Shirley gave him the ultimatum that they needed to have therapy, they went as a couple to see a sex therapist. Shirley explained,

It was with a sex therapist and that was his choice and he researched this sex therapist person and we went there and we sat in her office and it had purple, airy fairy things hanging everywhere, fluff and boas and whatever. I don’t think she had any worthwhile credentials but he chose her and it seemed to me it was like a boudoir. I don’t know … it was just weird. (Para 8).

Shirley was not impressed with the sex therapist and said,

Well she actually asked us what sex we have and how often and all this kind of thing. Of course I didn’t tick any of the boxes in terms of what she thought was supposed to happen. So to me it felt like that she had empathy for him with his frustration with me so I said “I’m not going back there” (Para 10).

As a result of that experience with the sex therapist, Shirley commented, “Yes, we went once so was the end of that.”(Para 10).

The third therapist that they went to see was a psychologist and Shirley continued with her story,

Then we saw a psychologist – a man and this man just said nothing (laugh). We talked and he would just look and say “and so?” and we both got very frustrated with him. There was no dialogue. I have since found out that was a person-centred approach but without any engagement which I don’t think is true of person-centred but it didn’t really help. My husband became extremely frustrated with him. We went for about maybe five sessions and tolerated it and my husband was tearing his hair out and I felt guilty again because there was no feedback at all. (Para 12)

Having seen three therapists that were unhelpful, Shirley and her husband were struggling in their relationship because of his sexual addiction infidelity. However they persevered and saw a fourth therapist that proved to be helpful.

*What was helpful?*

With careful reflection, Shirley proceeded with her story as the wife of a sex addict,
So then we found a professional counsellor, a psychologist, and I think we saw her for a number of sessions. It must have been at least eight I think. She confronted him with his violence and she called it for what it was. She said “this is domestic violence” and I had never even thought of domestic violence. I had never considered what he was doing was domestic violence but I was frightened of him and intimidated but he’d never physically hit me or anything and I never knew that violence included verbal, and psychological or sexual abuse and I never actually knew that, you know (Para 4).

Expecting judgement and blame for her husband’s sex addiction infidelity, Shirley was amazed and pleasantly surprised,

In those sessions I expected because of my previous experience, that there were going to be more things found wrong with me. And I expected that now I will be beaten up by the counsellor for not being a good enough wife; for being too slack and I was very ashamed of the fact that my husband strayed. I felt like it was an indictment on me as a wife and she [the therapist] was the opposite. She didn’t take sides with me and I never felt that she was like particularly more sympathetic to me than to him. She was very objective but she would call him on the things he was doing and she would question my responses and I found that extremely challenging but very empowering. It made me think that maybe there was another option and maybe it’s not my fault, you know, so it really produced a lot of growth in me and I felt supported that maybe I have a right to say “no”. I’m not doing this anymore. Maybe it is okay for me to say no. I never thought I could ever say no to my husband. (Para 4)

Part of Shirley’s path to empowerment was way the psychologist worked with him,

Well it was quite surprising actually because he kind of … he would argue the point but the counsellor was so unaffected by his tantrums and his arguments and she was just cool, calm and collected and stuck to what she was saying, you know, and I really thought I want to be like that. (Para 6)

Shirley shared how the psychologist would challenge her husband,

She would explore that with him, “so on what basis do you say that?” and “what’s your belief that says your wife must be subservient to you and a slave to you as a wife and she has to do what you want?” And she would ask him things like “what does your wife enjoy?” And he couldn’t answer the question. “What are some things that she finds sexually satisfying?” And he couldn’t answer the question. So there were lots of things like that. (Para 8)

Another thing that Shirley found helpful from the psychologist was,

She gave us material to read which was good. I remember her giving us a book which was quite hard going at the beginning. It was called “Passionate Marriage” by David Schnarch and that helped a lot for me because I saw in there that I didn’t have to always please him. I could have desires of my own. The other thing … there was one thing she said that stands out. She said to me “don’t EVER do something you don’t want to do” and that really stood out for me because I did a lot of things that I didn’t want to do and it helped because the counsellor said “I don’t have to do it if I don’t want to” That was so enlightening for me but you see I had a very strict father who was very dominant and he absolutely ruled the house. I’m so happy to say that I now don’t do anything I don’t want to do, you know, not in a bitter way but I’m true to what I believe and I’m true to my heart and I’m liberated. (Para 16)
Shirley continued about another self-help book,

There was another book that the psychologist recommended which was “The Gift of Sex” by the Penners but to me I felt that everything I was doing to improve the sex was reinforcing the absence of emotion. It all became to do with the practice of the act of sex and to make it more stimulating or exciting but it didn’t seem to me that any of the therapists picked up on the lack of emotional connection and that to me was a huge thing missing. Without his emotional awareness or his ability to relate with me on an emotional level to the extent, for example, during sex I might be crying because I feel so used and like “this isn’t what I want to be doing” and he wouldn’t even notice that I’m crying. I would say to him just as he is getting ready to have intercourse with me “can we just have some cuddle time first?” and he would just throw me off and storm off to the bathroom in frustration. So there was no ability to connect with me on an emotional level or to read my needs or to even be interested in me having needs, you know. All he wanted to know was how to turn me on so if it wasn’t something practical or physical it was just me being neurotic. (Para 31)

Towards the end of the interview, Shirley summarised her experience of seeing four therapists in an attempt to rebuild her relationship after her husband’s infidelities. With wistful reflection, Shirley ended by saying:

I would say the therapy wasn’t what helped us, you know; that one psychologist was useful but I don’t think that was the thing helped me stay in the marriage or work through forgiveness or work though trust issues I had; that sort of came from my own research and reading and my faith journey. (Para. 38)

Instead Shirley shared how she was able to survive her husband’s sex addiction infidelity,

I think it was a great process for me in differentiating from him. I grew up. I found who I was and I found that I didn’t have to respond to his rubbish. I could be me and I could choose a different way and I had every right to divorce him but I wasn’t obligated to divorce him. I could if I wanted to and I didn’t have to and I chose not to. I chose to grow up and I chose not to end the relationship because there’s a lot that I value about him and there’s a lot that my children valued about him and there’s a lot that I hated about him but I weighed it up and I thought I didn’t want to start a relationship from scratch anymore. I started to be careful looking after me and protecting me and not doing anything that my heart didn’t want to do and so I was true to that and I learnt to tolerate his tantrums and his ups and downs and that’s just him and I’m not going to be budged. (Para 14)

Shirley concluded with her willingness to risk trusting her husband,

Well I came to a point to where I thought I needed to confront my fear of being hurt and I need to confront my fear of being disappointed and possibly being betrayed again, you know, and I knew that I couldn’t protect myself against hurt so I needed to deal with hurt and so I could shed my tears and I could be okay with grief and I could be okay with having hopes and dreams unfulfilled. I could be okay with that. When I started learning that I could trust … well trust came easier when I knew that I’d be okay and I would find comfort, not necessarily in the marriage, but I would find comfort somewhere if I got hurt again. So that then helped me to risk trusting. I could risk because I knew I would be comforted and I would find help somewhere through faith and friends. (Para 40)
Recovery from sex addiction infidelity

In summing up her recovery from being the wife of a sex addict, Shirley pointed out,

I was no longer ashamed. I was now willing to share my hurt. Before I kept everything very, very private because I didn't want him to be thought badly of and I felt like I was to blame which meant that I wasn’t accessing help, comfort and support. So when I overcame the shame that freed me. (Para 42)

Shirley said her husband’s recovery from sex addiction infidelity was remarkable as he changed direction, “He is just 180 degrees different from what he used to be” (Para 8). Shirley then described how he stopped his sex addiction,

He went on a spiritual retreat which was not what he wanted to do but he had a business associate who invited him to go on this retreat and because he was doing business with this man, he said “yes” but he totally didn’t want to go at all and he “tantrumed” all the way there. You were not supposed to wear your watch or have your phone from Thursday until Sunday and he was totally stressed out. On the Sunday night he came home from the retreat and he walked into the kitchen, I could see in his demeanour something had changed in him and he brought a jar of honey back from the retreat and put it on the kitchen bench and said “Look what the Lord has provided for us” and that was so unlike him. He never had gratitude and it turned out that he had some spiritual like a conversion experience. (Para 8)

As in Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous and Sexaholics Anonymous with their 12-step model, it seemed like Shirley’s husband went through a similar process. The 12 steps of AA (Alcoholics Anonymous) sprang from The Oxford Group, a non-denominational movement (Cheever, 2004) that was indirectly influenced by Jung who revealed to a client of his, Rowland Hazard, that the only way to recover from alcoholism would be a spiritual conversion (Addenbrooke, 2011). Rowland attended the Oxford Group and explained it to Bill Wilson who subsequently had a spiritual conversion and recovered from alcoholism. Wilson then explained it to Dr Bob Smith who also had a similar experience of becoming sober. As a result, in 1935 these two men formed AA (Addenbrooke, 2011). Thus AA’s set of principles and beliefs begin with a person admitting that he needs help to overcome a problem, and that he is “powerless” to control his behaviour on his own. In retelling her story about her husband’s recovery from sexual addiction infidelity, Shirley outlined Steps eight and nine that focus on making amends;

After my husband had this spiritual experience, he then decided to visit all the people that we had been to counselling with, to go and apologise and to tell them that he has now repented of
what he’s done and he can see the error of his ways. He made an appointment to see that frustrating psychologist and went and told him and he went and saw this other psychologist that was so helpful and told her. He confessed everything to me of all the people he had been involved in and asked for my forgiveness and said he would never do that again. (Para 12)

In describing her husband’s recovery from sex addiction infidelity, Shirley said;

He has completely changed. He is trustworthy and I’ve never again felt like questioning him or anything so he’s just completely 100 per cent trustworthy and that whole kind of sixth sense that I had about him of always being flirtatious and charming, and flitting about and, you know, all of that just went. It’s like he got grounded and he became sincere. (Para 12)

Conclusion

Even though sexual addiction infidelity causes so much damage to relationships and is difficult to treat, this case study gives insight and hope to those directly affected by it. These findings support the importance of studying the experiences of those living with recovered sex addicts and have enormous implications for the education of professionals with interest in sexual addiction infidelity who are reminded that “too often we map our clients’ prison, but not their escape” (Waters & Lawrence, 1993, p.53).
References


Outcome measurement:
Challenges for a small residential treatment provider

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Paper presented at the
4th Australian and New Zealand Addiction Conference
Gold Coast (QLD), 15 – 17 May 2017
Outcome measurement:
Challenges for a small residential treatment provider

ABSTRACT: Teen Challenge Victoria has been providing residential treatment for people with drug addiction/dependence at Kyabram since 1986. Treatment outcomes are unreported, something which the Board seeks to remedy. This paper explores the challenges of outcome measurement and reporting in a small, Christian faith-based, residential treatment program where poly-substance and/or alcohol use, sexual abuse and associated mental illness are the norm; and level of engagement with (and length of stay in) the program is volitional.

The paper characterizes the incoming student cohort; defines treatment aims; articulates the treatment model and provides an overview of program operation. It then frames a series of indicators which enable us to assess how well we deliver stated aims; reviews outcome measures recommended in the literature; selects those appropriate to our needs; considers available instruments; and identifies the Australian Treatment Outcomes Profile (ATOP) and the Substance Use Recovery Evaluator (SURE) as the most appropriate. It highlights indicators requiring additional measurement, largely in the domain of emotional health. It also identifies research questions related to understanding the factors which contribute to (or impede) recovery. These cluster around the influence of student history (substance-use; mental illness); aspects of treatment operation (willingness to engage; student-mentor relationship); and factors such as sense of self-worth, meaning and hope; non-enabling support networks. These questions extend well beyond what is routinely captured by ATOP and SURE, and segue into the generic question of: Having satisfied the basic reporting requirements of government and funders (change in substance-use; increase in public safety; contribution to society); how do we measure the importance of (non)treatment factors to sustainable recovery? The paper closes with implementation challenges and a plea for research collaboration.

Key words: Outcome measurement; substance abuse; mental health; residential treatment; faith-based

Introduction
In 1974, a former drug addict turned pastor began working with street people in St Kilda, a red-light suburb of Melbourne. His aim was to rescue people from prostitution and drug addiction. He established Teen Challenge Victoria (TCV) with a counselling centre, coffee
shop, drug awareness and girls’ rehabilitation program. To facilitate treatment and recovery away from the drug-scene, TCV purchased a property at Kyabram in northern Victoria, and in 1986 started a Christian residential drug rehabilitation program for females aged 15-35. Demographic, staff and support changes mean that the program now caters for males only.

While TCV provides annual financial reports to relevant government authorities, it does not report treatment outcomes, something which the Board seeks to remedy. This paper outlines the Board’s plan to provide valid data on treatment outcomes which measure the degree to which we achieve stated aims; holds TCV accountable for use of supporter funding; and contributes to knowledge on substance abuse treatment at the (inter)national level.

Before exploring outcomes in substance abuse, it is worth reflecting briefly on some of the philosophical commitments and uncertainties embedded in the measurement process. At a systemic level, those entering treatment have significant variability in their history. This includes substance use (time, type, frequency, strength); physical, sexual and psychological abuse; family of origin (crime, family breakdown); mental illness (depression, PTSD); prison experience; neurobiological change and physical health (hep C, HIV). Treatment systems are not closed, ie the person is still dealing with unresolved legal, financial and family issues in parallel with treatment; and they choose their level of engagement with the program. Their exit environment is not controlled by treatment and may be unsupportive. Despite this range of uncontrolled factors, post-treatment change is largely attributed to the success or failure of the treatment program, an expectation which is unrealistic. In correcting this perspective, it may be worth reflecting on the degree to which the expectation stems from an unconscious commitment to a positivist philosophy of treatment (Casti, 1986, Morcol, 2001).

From a numerical perspective: Base-line data on substance-use (for instance) implicitly assumes that the aggregated 30 day sample is representative of the historical time-series. Do we have evidence for that? Not usually. We make that assumption as a pragmatic response to the fact that the data are unavailable. Data are aggregated for statistical purposes, which assumes that samples have been collected from a homogeneous population. Change results (outcomes) tend to be reified – ie they become ‘hard’ numbers rather than coarse indicators of change. This reification influences decisions on relative treatment effectiveness, policy and funding. Decision-makers are often remote from the research, unaware of the context-dependent nature of the outcomes, but confident that the numbers are ‘true’. It is worth reflecting on the subtle interaction between the way that we deal with uncertainty, and our desire for objectivity (van Asselt, 2005).
So, what is the point here? Quantitative outcome measurement remains an essential component of practice enhancement, policy formulation and financial accountability. However, it is also requires a clear-eyed understanding that human systems are complex rather than deterministic, and that the numbers produced are coarse indicators of change rather than ‘hard’ numbers. For those who interface with policy, it underscores the need for clear communication of the inherent complexity and uncertainty embedded in the evidence-base that we provide (Stirling, 2010).

With this framing, this paper explores the challenges of outcome measurement in a small, Christian faith-based residential treatment program for adult males with drug addiction or dependence. It articulates our treatment philosophy, aims, treatment model and how it is implemented; proposes outcome measures which allow us to report on achievement of our aims, are consistent with the literature, and for which valid instruments are available. It considers the gap between aims and what standard instruments deliver, and identifies areas where we need help from the research community.

Addiction, recovery and the TCV treatment model
Addiction and dependence are constructs used to describe substance abuse (Gawin, 1991). We use the term addiction as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences (NIDA, 2016); a compulsion to seek and take the drug; loss of control in limiting intake; and emergence of a negative emotional state reflecting a motivational withdrawal syndrome when access to the drug is prevented (Koob and Volkow, 2010); regarded as equivalent to a severe substance use disorder as defined by the American Psychiatric Association (American Psychiatric Association, 2013, NIDA, 2014). Understanding that addiction is an extreme form of the substance abuse spectrum, we use the term dependence to refer to a person who uses illicit substances regularly, is seeking (but currently unable) to stop, but has not yet progressed to the stage of uncontrolled-use/addiction (Serrano and Parsons, 2011, van Ree et al., 1999). We refer to a person engaged in treatment for addiction or dependence at TCV Kyabram as a ‘student’, because they are engaged in a prescribed study program for the duration of their stay. A person who completes the program is referred to as a ‘graduate’. Staff estimate that 50% or more of our students are in the category of addicts when they arrive in the program, and most have been physically, sexually and/or psychologically abused. Table 1 provides a brief overview of those seeking treatment at Kyabram.
### Table 1 Overview of those seeking treatment at TCV Kyabram

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>75 students seek treatment each year (28 beds)</td>
</tr>
<tr>
<td>Age range</td>
<td>16-60 (average age 30+)</td>
</tr>
<tr>
<td>Faith history</td>
<td>45% no faith, 5% Muslim, 50% some church background</td>
</tr>
<tr>
<td>Addiction history</td>
<td>50% polysubstance (ice, heroin, marijuana, alcohol)</td>
</tr>
<tr>
<td></td>
<td>45% either alcohol OR substance</td>
</tr>
<tr>
<td></td>
<td>5% prescription meds, gambling, porn</td>
</tr>
<tr>
<td>Abuse history</td>
<td>70%-100% abused (5% have a formal treatment plan at entry)</td>
</tr>
<tr>
<td>Completions</td>
<td>40% leave in first month (Phase 2)</td>
</tr>
<tr>
<td></td>
<td>32% leave in 2-4 months (Phase 3)</td>
</tr>
<tr>
<td></td>
<td>18% leave in 5-11 months (Phase 4)</td>
</tr>
<tr>
<td></td>
<td>10% complete program (12 months)</td>
</tr>
</tbody>
</table>

### Conceptualizing addiction and recovery

This section briefly introduces the complexity embedded in addiction and recovery, and seeks to illustrate the challenges involved in providing a comprehensive treatment program.

As mentioned, addiction is a construct, and therefore has no singularly ‘true’ definition (West and Hardy, 2005). It affects individuals, families and communities; is often associated with childhood abuse; may reflect a pain relief strategy; is characterized by compulsive behaviour despite awareness of negative effects (Beattie, 1992, Marsden et al., 2009, Laudet, 2007, West and Hardy, 2005, Khantzian, 1987). Addiction framing has moved from a moral failure to a chronic illness (Van den Brink et al., 2006) requiring continuing care and a long-term treatment perspective (McLellan et al., 2005, McLellan et al., 2000).

Addiction appears to be strongly associated with co-morbid psychiatric disorders (Gil-Rivas et al., 2009, Shields et al., 2014). There is growing consensus that concurrent treatment of substance abuse and mental health problems is appropriate (Davidson and White, 2007, Gil-Rivas et al., 2009, Simpson, 2004).

Recovery is also a contested concept (Neale et al., 2015). Perspectives include a process rather than an end-point (Laudet, 2007) where an individual achieves abstinence, improved health and quality of life (Sheedy and Whitter, 2009). Conceptualization of recovery is also moving from a symptomatic to a wellness focus, and from an acute to a continuing care model (Kaskutas et al., 2014). Those in recovery often frame it in terms of total abstinence from all drugs and alcohol, and a return to a quality of life that was lost (Laudet, 2007). It includes phases such as: ‘Essential recovery’ (being honest with myself;
being able to enjoy life without using); ‘Enriched recovery’ (a process of growth and development; taking responsibility for things); and ‘Spirituality of recovery’ encompassing notions of being grateful (Kaskutas et al., 2014).

Recovery in substance abuse is linked to mental health. Mueser (National Academies of Sciences, 2016) notes two perspectives of recovery in mental health: the traditional (symptomatic) medical perspective and the personal dimension. (Davidson and Roe, 2007) add recovery from, versus recovery in, mental illness. The Victorian Government’s Framework (unknown, 2011) views recovery in mental health as a personal journey of growth, self-determination and social engagement. (Leamy et al., 2011) identify recovery as: active; unique; a journey with phases, which may not involve cure. The Victorian Government’s view is that recovery-oriented practice in mental health should emphasise hope, social inclusion and self-management (unknown, 2011). This is echoed in (Leamy et al., 2011) who identify processes for recovery in mental health as: connectedness; hope and optimism; identity; meaning in life; and empowerment.

Research on the neurobiology of addiction has focused on the pharmacological and adaptive mechanisms within neurocircuits associated with change in brain reward system function and dysregulation of the inhibitory control system (Koob and Simon, 2009, Robinson and Berridge, 2000, Volkow and Li, 2004). These changes influence long-term memory such that when exposed to environmental cues associated with drug use, unconsciously activated circuits trigger arousal, dopamine release and the activation of craving, often leading to unexpected relapse (Volkow and Li, 2004, Hyman and Malenka, 2001, Noël et al., 2013, Kauer and Malenka, 2007). Other impacts include dysfunction in the interoceptive system, hampering self-awareness and metacognitive capacity (Noël et al., 2013). Research on the neurobiology of recovery is less well advanced (Erickson and White, 2009).

Philosophy and aims of treatment and recovery at TCV
Our philosophy is that each person is a tri-partite being (spirit, soul and body) created in the image of God. That framing underpins intrinsic worth, and suggests that treatment should address all dimensions of personhood. We seek to provide an environment where students can ‘discover’ that they are loved by God, and develop a personal relationship with Him through faith in Jesus. Our thesis is that the daily affirmation of being unconditionally loved and completely forgiven/accepted by God now, provides a deep sense of personal security, meaning and hope, enabling the intrinsic motivation and courage to persevere through the
pain of change required for recovery in both addiction and mental health. We view the autonomy and responsibility of the individual as fundamental, ie students are responsible for the level of engagement and length of stay in the program. We recognise that recovery is a journey, of which relapse is a part.

Our mission is to assist adults and families develop transformational solutions to life-controlling issues of drugs, alcohol, gambling, prescription medication and pornography. Our aim is that graduates develop the foundations and life-long tools to become mentally sound, emotionally balanced, socially adjusted, physically well, spiritually alive, productive members of society.

Treatment takes place in a relationally-based, supportive environment which seeks to enable a faith-based foundation for life; understanding of factors underlying addiction; and development of behaviours and skills which empower growth beyond treatment (a recovery-oriented focus (Davidson and White, 2007)).

_Treatment model_

Our treatment model employs interventions in four interconnected domains: spiritual, cognitive, affective and the program itself. The treatment model is illustrated in Figure 1.

- **Spiritual:** This is the foundation for all areas of treatment. We seek to foster a personal relationship with God; adoption of a Biblical framework for life; development of a stronger sense of self-worth, meaning and hope.

- **Cognitive:** Treatment uses cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) to restructure maladaptive thinking, overcome emotion dysregulation and develop healthier paradigms and behaviours. Students work through a program of structured reading¹, reflective questioning and journaling on topics such as the physiology/psychology of addiction; what recovery could look like; complemented by dialogue with mentors, peers and psychologists.

- **Affective:** We foster a therapeutic alliance between student and mentor within a supportive community environment (community as method (Brunette et al., 2004)). This has a modest impact on outcomes in mental illness, substance use and alcohol (Ackerman and Hilsenroth, 2003, Connors et al., 1997, Meier et al., 2005), and contributes to engagement and motivation (Meier et al., 2005).

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¹ Reading topics are outlined in Table 2
Program: The residential program provides shelter, food and a safe abstinent environment so that students can fully engage with the interventions.

The interventions are intended to be synergistic: the spiritual component provides the strength and intrinsic motivation to pursue change; the therapeutic community provides the relational support required during change; and the CBT/DBT provide cognitive restructuring and emotion regulation required for sustainable recovery. All interventions pass through the student’s volitional filter: students have to choose to engage for interventions to be effective.

Treatment comprises four phases (described in Table 2). These aim to assist students to:

- Feel safe; allow their system to return to a level which allows them to effectively engage; get used to functioning in community (Orientation).
- Understand the dimensions of addiction including thinking (self-talk, denial); behaviour (loss of integrity, responsibility); health and relational impacts; and develop motivation to change (Orientation, Phases 3 and 4);
- Renew their sense-of-self in the light of God’s love (Orientation, Phases 3 and 4).
- Deal with the pain, shame, anger etc stemming from events such as sexual abuse; the sense of not being loved by father or mother; forgiveness and possible reconciliation; identify triggers (stress, parties); develop strategies for sustainable recovery (Phase 4).
- Develop healthy foundations, frameworks and skills for life. This includes character, manhood, family responsibility, relationships, self-management (Phase 4).


Figure 1 Treatment Model
## Table 2 Program structure

<table>
<thead>
<tr>
<th>Phase</th>
<th>Duration</th>
<th>Type of interventions</th>
<th>Target outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Admission</td>
<td>1 day</td>
<td><strong>Administrative:</strong> Interview; data collection; forms signed; moved into room; introduced to room-mate and student community.</td>
<td>Gather data on substance use, family, social history; medical conditions; pending court appearances etc. Provides data for treatment design.</td>
</tr>
<tr>
<td>Phase 2: Orientation</td>
<td>4 wks</td>
<td><strong>Settling in, system detox:</strong> Structured reading, reflective questions on impacts of substance use; discussion with mentor and peers. Group sessions with clinical psychologist. Adjust to program and community.</td>
<td>Students feel safe; system to stabilise (Marsden et al., 2009) so they can engage the program; reflect on choices; decide to get better; regain health; adjust to a daily routine, behavioural expectations and work requirements; build relationships.</td>
</tr>
<tr>
<td>Phase 3</td>
<td>18 wks</td>
<td><strong>Structured read (contracts 1-2)</strong> Understand who I am (loved by God, have intrinsic self-worth); journaling; discuss with mentor and P3 community; continue to practise living in community</td>
<td>Develop life foundations of a personal relationship with God; deepen desire to change; understand how God sees them; reprogram their self-image and behaviours and set directions for a different life.</td>
</tr>
<tr>
<td>Phase 4</td>
<td>30 wks</td>
<td><strong>Structured read (contracts 3-6)</strong> reflective journaling; discuss with mentor, P4 peers; group sessions with clinical psychologist (current &amp; alternative paradigms, behaviour, relapse prevention) (Simpson, 2004, Hendershot et al., 2011); adjust to community; practice new paradigms and behaviours on leave; develop new networks in their exit community.</td>
<td>Contracts 3-4: Understand emotions, defence mechanisms; develop character qualities; recover from shame; understand marriage, manhood, fatherhood; Contracts 5-6: Reflect on purpose; enjoyment apart from drugs; continue character qualities; relapse-prevention. Develop new networks. Complete Phase 4, remain clean and sober for 12 months = graduate.</td>
</tr>
<tr>
<td>Servant Leader Training (SLT)</td>
<td>12 months</td>
<td>Students take responsibility for part of program operation. PC acts as mentor.</td>
<td>Consolidate gains made during the program; learn to serve others; develop leadership and people management skills.</td>
</tr>
</tbody>
</table>
Implementation of the Treatment Model

Implementation of the Treatment Model is illustrated in Figure 2. Various operational components are described below:

Program supervision and monitoring of care:

- Overall program direction and operation is overseen by the Executive Director (ED). The ED is a former drug-user/dealer who has been abstinent for over 42 years; has a Dip Min, 12 months training at TC USA and 12 years’ experience in drug recovery.

- Day to day supervision of staff and program operation is provided by the Program Coordinator (PC). The PC reports to the ED; has a Cert IV in Ministry and over 20 years’ experience in working with TC. The PC is supported by a retired accountant (MBA, BPharm) with considerable management and pharmacological experience.

- An After-Hours Supervisor is rostered on each night. Any issues are logged and ways of managing the issue are discussed at the following morning’s staff meeting.

- Staff/student mentors are generally recovering addicts who have completed the program plus servant leader training (SLT) and remained abstinent for 2 or more years. Mentors have non-specialist qualifications (Dip Family Therapy) but considerable lived experience as recovering addicts who have taken up family responsibilities and re-engaged life. Specialist input by non-doctoral staff such as addiction counsellors is considered appropriate (McLellan et al., 2005, Moos, 2003).

Admission and continuation

- Admission is overseen by the Intake Co-ordinator who checks that an appropriate detox has occurred and whether the person has a diagnosed mental illness. If a medication regime is in-place, we administer the medication.

- Students are free to choose how long they stay in the program, provided they function within key rules: bullying is not tolerated and leads to suspension; getting out of bed (engaging the program – unless sick) and following staff directives.

Initial needs assessment

- Incoming students are put on a mental health plan. Students are also assessed by the clinical psychologist using the Depression, Anxiety, Stress Scale (DASS-21) (Henry and Crawford, 2005). Anxiety, depressive symptoms, stress or trauma impact a person’s capacity for recovery (Van den Brink et al., 2006, Gil-Rivas et al., 2009, Glasner-Edwards et al., 2010, Tyler Boden et al.).
Orientation

- The clinical psychologist uses motivational interviewing with the Orientation group to create a safe space for sharing of deep issues; the benefits of (and ambivalence to) change; the long-term nature of withdrawal, and development of coping strategies.

Integrated support

- The program engages with relevant government agencies (Centrelink, Australian Tax Office), and the legal system (Police, courts, Sheriff’s Office) to ensure that students receive welfare payments, negotiate payment of fines, satisfy parole requirements etc.

Family support

- Family support takes the form of weekly phone contact and weekend passes for those in Phase 3 and above. We provide some assistance to families in terms of dealing with the pain of having a loved one in addiction; or developing the understanding and skills required to stop enabling (Simpson, 2004, Beattie, 1992).

Exit environment and post program support

- Students who exit after Phase 3 are given help with new networks. Phase 4 students are given help to find work in the region, support networks etc, and receive fortnightly follow-up contact from their mentor for the first 3 months.

Figure 2 Implementation of the Treatment Model
Outcome domains and instruments for TCV

Selecting outcome domains
This section identifies appropriate outcome measures for TCV. It considers how we assess the degree to which we achieve stated aims; what the literature recommends that we should be monitoring; and how unique aspects of the program contribute to sustainable recovery.

TCVs aim is to adopt sound measurement and reporting practices so that we can be accountable for how we use people’s money; contribute to treatment practice and to (inter)national studies of treatment effectiveness. Our first responsibility is to measure the degree to which we deliver stated aims. Table 3 identifies a range of indicators of success in the domains specified in our aims (mentally sound, emotionally balanced etc). Indicators were developed by Board members and staff in recovery, and are sympathetic with other put forward in the literature (Kaskutas et al., 2014, Neale et al., 2016a). When describing success, the verbs should be taken as present continuous, indicating an on-going process. Table 3 also identifies instruments by which the outcome might be fully or partially measured. Numbers (eg ATOP 2 a-b OR SURE 7) refer to question numbers within the instrument. Discussion of instrument selection follows.

In regard to outcome measures recommended in the literature, the US National Institute on Drug Abuse (NIDA) convened a panel of 56 experts to define appropriate outcome measures for substance abuse treatment in clinical trials. The panel’s consensus was that (change in) drug taking behaviour, measured ideally by a combination of self-report and biological indicators, be seen as the appropriate primary outcome measure in most clinical trials (Donovan et al., 2012). They identified commonly used instruments for self-report of change in substance-use as the Addiction Severity Index (ASI) (McLellan et al., 1992), the Maudsley Addiction Profile (MAP) (Marsden et al., 1998) and Time Line Follow Back (TLFB) (Sobell and Sobell, 1992).
### Table 3 Domains and indicators of outcome measurement

<table>
<thead>
<tr>
<th>TCV aims</th>
<th>What does success look like?</th>
<th>How measured?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally sound</td>
<td>Adheres to prescribed medication regime</td>
<td>ATOP 2j, SURE 7</td>
</tr>
<tr>
<td></td>
<td>Makes sound decisions for himself and family</td>
<td>ATOP 2e</td>
</tr>
<tr>
<td></td>
<td>Learning to manage stress w/o gambling, porn</td>
<td>ATOP 1: mod? SURE 3-5</td>
</tr>
<tr>
<td></td>
<td>Learning to communicate, be transparent</td>
<td></td>
</tr>
<tr>
<td>Emotionally balanced</td>
<td>Developing a sense of self-worth, meaning, hope</td>
<td>ATOP 2k, SURE 6, 19-21</td>
</tr>
<tr>
<td></td>
<td>Learning to deal with shame, to love and forgive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developing character – integrity, perseverance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Can express feelings without inappropriate anger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respects and protects women</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Models fatherhood for his children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increasingly satisfied with life, grateful</td>
<td></td>
</tr>
<tr>
<td>Socially adjusted</td>
<td>Learning to develop intimacy</td>
<td>ATOP 2k? SURE 12, 14</td>
</tr>
<tr>
<td></td>
<td>Learning to set appropriate boundaries</td>
<td>SURE 13, 15</td>
</tr>
<tr>
<td></td>
<td>Functioning in healthy relationships</td>
<td></td>
</tr>
<tr>
<td>Physically well</td>
<td>Is not using illicit substances or alcohol</td>
<td>ATOP 1, SURE 1-2</td>
</tr>
<tr>
<td></td>
<td>Is developing a healthy diet and lifestyle</td>
<td>ATOP 2j? SURE 6, 8-11</td>
</tr>
<tr>
<td>Spiritually alive</td>
<td>Loves God, loves (serves) people, under authority</td>
<td></td>
</tr>
<tr>
<td>Productive members of society</td>
<td>Working or seeking work or in training</td>
<td>ATOP 2a-b</td>
</tr>
<tr>
<td></td>
<td>Is learning to manage his finances</td>
<td>SURE 18</td>
</tr>
<tr>
<td></td>
<td>Humble, can start @ bottom, delay gratification</td>
<td></td>
</tr>
</tbody>
</table>

### Outcomes from the literature

<table>
<thead>
<tr>
<th>Primary measure</th>
<th>Change in drug and alcohol behaviour</th>
<th>ATOP 1, SURE 1-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary measure</td>
<td>Engaged in criminal activity? (Threat to public safety)</td>
<td>ATOP 1 &amp; 2f-g</td>
</tr>
<tr>
<td></td>
<td>In prison? Hospital? (Ongoing cost: legal, health system)</td>
<td>ATOP 1 &amp; 2c-d, f-g</td>
</tr>
<tr>
<td></td>
<td>Capacity for substance refusal (self-efficacy)</td>
<td>SURE 4-6</td>
</tr>
<tr>
<td></td>
<td>Improvements in psychosocial functioning</td>
<td>ATOP 2, SURE</td>
</tr>
<tr>
<td></td>
<td>Improved satisfaction with quality of life (QOL)</td>
<td>ATOP 2, SURE</td>
</tr>
</tbody>
</table>
While change in drug taking behaviour was seen as the primary target for interventions, the NIDA panel recognised that other biopsychosocial domains are important. In a companion paper, a subgroup recommended five additional (secondary) domains, namely changes in: self-efficacy; psychosocial functioning; social networks and social support; craving; and quality of life (Tiffany et al., 2012).

In the UK, the National Treatment Agency for Substance Misuse (NTA) identified domains for outcome measurement and developed the Treatment Outcomes Profile (TOP) as the instrument to assess treatment effectiveness (Marsden et al., 2008). The TOP comprises 20 questions (Bradbury, 2007) covering substance use history; injection-related health-risk behaviour; the client’s ratings of physical/psychological health and quality of life; social functioning and criminal behaviour (Marsden et al., 2009). The Australian Treatment Outcomes Profile (ATOP) has adopted the same domains as TOP, and modified the questions for Australian conditions (Ryan et al., 2014).

In selecting outcomes for TCV from the NIDA recommendations, change in the domain of drug taking behaviour is seen as fundamental to addiction treatment. Change in criminal behaviour and reduction in treatment costs were included because public safety and expenditure are seen elements which are important to the community and government (McLellan et al., 2005). Given that our treatment aims are holistic, secondary outcome measures selected from the NIDA recommendations are: capacity for substance refusal (self-efficacy); ability to function in important relationships (psychosocial functioning) and overall satisfaction with life (quality of life (QOL)). These domains are also relevant to recovery in mental health (Leamy et al., 2011, unknown, 2011, Davidson and White, 2007). The fact that they were recommended for use in clinical studies does not appear to preclude their use in assessing treatment outcomes from a community-based residential program.

Unfortunately, the selected domains provide limited assessment of the degree to which we achieve our aims (Table 3). Nor do they assist us capture the importance of particular program features to achieving those aims, eg developing a personal relationship with God; feeling safe; fostering a therapeutic student-mentor alliance etc. One of the challenges for TCV is to initiate the additional research to capture these elements.

**Identifying appropriate instruments**

A review of the instruments available to measure the primary and secondary outcomes selected identified ATOP as the most suitable (Lintzeris et al., 2016, Ryan et al., 2014). The
ATOP questions on drug use appear to be modifiable to capture gambling or pornography (frequency, amount). However, ATOP captures only a small number of indicators relevant to our aims (Table 3). To remedy this situation, we explored the use of additional instruments and recommend use of the Substance Use Recovery Evaluator (SURE) (Neale et al., 2016b). SURE was developed with input from those in recovery, so it has some sympathy with indicators in Table 3. SURE (unknown, 2016) captures change in: coping and self-care; social functioning (Tyrer et al., 2005) and quality of life (Skevington et al., 2004, World Health Organization, 2004), enabling us to measure a greater number of indicators in Table 3. However, there remains a considerable gap in the area of ‘emotional health’, and there is still no measurement of the contribution of faith-based aspects of the program to sustainable recovery.

Implementing outcome measurement

Post-treatment assessment will be based on self-report (Del Boca et al., 2014). While we understand the significant potential for bias, the use of toxicological testing is not workable. Where possible, assessment will seek to engage significant others to provide a more balanced view of progress. We will also test ATOP and SURE with students and graduates to ensure that language is unambiguous (Neale et al., 2015). Such road-testing is recommended (Del Boca et al., 2014).

Assessment will be limited to students completing Phase 3 and above. Our rationale is that they have developed some awareness of issues underlying their addiction, ownership of choices and engaged these issues sufficiently to impact decision-making. For completeness, we will collect and report overall numbers of students entering and leaving, and where possible, explore (with early leavers) what influenced their decision, with a view to removing obstacles which negatively impact retention (Van den Brink et al., 2006).

In terms of monitoring frequency, the Australian Treatment Outcomes Study (ATOS) (Darke et al., 2015), measured substance use among heroin users at intervals of 3 months; 1 year, 2 years, 3 years and 11 years after baseline interview. In seeking to provide comparable data, monitoring time-steps of 3 months, 6 months, 1 year, 3 years and 5 years post-treatment appear more suitable to our needs. In selecting the 5 year limit, we note that a minimum abstinence of 5 years for heroin users considerably reduced the likelihood of relapse (Hser et al., 2001, Laudet, 2007, National Academies of Sciences, 2016).
In summary, ATOP and SURE provide TCV with a vehicle for capturing treatment outcomes in domains which are consistent with international practice. However, they do not provide specific feedback on the effectiveness with which we achieve some of our aims, nor feedback on the importance of some of our processes to achieving those aims.

Implementation challenges and research needs
To fully implement an effective program of outcome measurement, TCV will need assistance from the research community to develop a valid instrument(s) which:

- Enables us to measure those indicators unaddressed in Table 3;
- Allows us to measure the importance of unique elements of our program such as faith; intrinsic self-worth; meaning and hope to sustainable recovery;
- Allows us to capture the views of significant others in the student’s life;
- Allows us to monitor and understand the motivation for, and impacts of, engaging in this type of treatment on staff and their families.

To facilitate treatment improvements, TCV requires assistance with fundamental research directed at better understanding the mechanisms linking treatment, sustained recovery and:

- The influence of incoming characteristics (substance-use history; mental illness etc);
- Aspects of treatment operation (engagement; student-mentor relations; community);
- The unique aspects of our program: faith, intrinsic self-worth; meaning/hope;
- Post-treatment support for graduating students.

Other challenges include establishing a searchable database; staff training; monitoring for up to 5 years; handling repeat students; data aggregation processes; data extraction/reporting.

Summary and conclusions
TCV aims to provide a Christian faith-based, residential, substance abuse treatment program which assists graduates to develop the foundations and tools to become mentally sound, emotionally balanced, socially adjusted, physically well, spiritually alive, productive members of society. Our treatment model employs interventions in four interconnected domains: spiritual, cognitive, affective and the program itself. The spiritual domain fosters a personal relationship with God, development of self-worth, meaning and hope, which are relevant to recovery in substance abuse and mental health. The cognitive domain uses CBT and DBT to develop healthier paradigms and behaviours. It employs a program of structured reading, reflective questioning and journaling on topics such as the physiology and
psychology of addiction; what recovery could look like; complemented by dialogue with mentors, peers and psychologists. The affective domain fosters a therapeutic alliance between student and mentor within a supportive community environment. The residential program provides shelter, food and a safe abstinent environment so students can effectively engage with these interventions.

The non-standard nature of our program presents the challenge of identifying outcome measures which allow us to assess how well we achieve our stated aims, and which are consistent with the literature. ATOP and SURE provide a means of capturing treatment outcomes in relation to some of our aims; and are consistent with international practice. However, they do not provide feedback on aims such as emotional health, or the importance of some of our processes to achieving those aims. Close collaboration with the research community is required if we are to address these issues in a sound manner.
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Betrayal Trauma:
Working With Partners of Sex Addicts

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BETRAYAL TRAUMA – Working with Partners of Sex Addicts

ABSTRACT
Imagine being in a car accident. Out of the blue someone smashes into you. You didn’t see it coming and you were not to blame yet you are trapped, helpless, not sure who to turn to or what to do next to save yourself. The struggle to make sense of what just happened is overwhelming.

This is exactly what it feels like for partners of sex addicts when they discover that the person they love and are in relationship with has been acting out with pornography, sex workers or other people. Unlike a car accident, for the partner of a sex addict the trauma is just beginning. Further disclosures around behaviours, finances, people and places continues to increase the level of confusion, fear, pain and grief.

Partners seek help when they can no longer manage feelings of pain and isolation. They seek to understand what has happened, for their spouse and for themselves. They want to know how to help their loved one and themselves. They want to be able to protect and support their family and the relationship. None of this is possible without appropriate support from a therapist who understands the impact of betrayal trauma which is unique to the partners of sex addicts. Unlike other addictions sex addiction is personal because it undermines everything that was believed about or contracted to in the relationship. Indeed the very person that should be offering support is the greatest trigger!

However with the right support partners can find ways to break free of the fog of confusion, fear and denial and, in many cases the relationship can not only be repaired but strengthened as each party learns to take responsibility for themselves and their own recovery.

Key Words: betrayal, trauma, sex addiction, partners

Introduction
“’There are days when you may want to give up and leave. There are nights where you may cry yourself to sleep or stare at the ceiling feeling hopeless and more alone than you can ever remember...There are weeks where you may feel like your life has been shattered into a million little pieces and you want to wake up from this nightmare. There are moments where you may blame yourself, your family, and God, wanting to scream, WHY ME?’”

Facing Heartbreak p1

I’m sure you all know from your own experiences that when something big happens – something unexpected – shocking - that takes us by surprise such as the terrorist attacks on the US on 9/11 or the death of Princess Diana for example, that you are able to recall in great clarity exactly where you were and what you were doing when you heard of those events. Some of you may even remember these events (or other traumatic moments) with such clarity that you will be able to remember what you were wearing, still hear certain sounds or smell certain smells.
The brain is often able to recall in pretty much vivid detail, almost like looking at a photo, exactly what was happening when events shake us because they are so shocking in there impossibility. It's as if the moment is frozen in time with all its sensations attached. This is the experience of partners of sex addicts who call this moment of discovery of their spouses betrayal their personal 'D Day' and they recount it in vivid detail and re-experience it with each intrusive memory, thought, experience and anniversary.

(And just as a point of clarity, this paper refers to the addict as ‘him’ and the partner as ‘her’. This is not to suggest that all sex addicts are male and the partners female, which is definitely not the case. I use this solely for the sake of simplicity for the purposes of this paper.)

What Is Betrayal Trauma?

“It creeps through the door like a thief in the night & puts all my senses asunder. The shock's a surprise when with eyes open wide I'm sent reeling and fall to the floor. Then slowly the dawning of reality, yawning, its great gaping mouth open wide and I find that my heart is a smoking divide and my brain is a land mine of warning. And I rant and I rage, broken, unmade, left panting and ravaged and raw.”

Poem written by the partner of a sex addict

Betrayal trauma refers to a social dimension of psychological trauma, independent of post traumatic stress reactions, Freyd (1996) in The Encyclopedia of Psychological Trauma (2008), which goes on to say that “Betrayal trauma occurs when the people or institutions on which a person depends for survival significantly violate that person's trust or well-being”(p76). In her book Blind to Betrayal (2013) Freyd adds that “betrayal violates us. It can destroy relationships and the very trust we need to be intimate in our relationships”. She adds that betrayal trauma “can and does damage the social fabric that creates the bonds for a healthy society” (p ix). Levine and Kline (2010) write that

“...a dilemma of profound consequences is set up if the people who are supposed to love and protect us are also the ones that have hurt, humiliated, and violated us. This 'double-bind' undermines a basic sense of self and trust in ones instincts. In this way ones whole sense of safety and stability becomes weakened”.

Partners of sex addicts experience this double bind as the person they have loved and trusted enough to build their lives with has betrayed them at such a fundamental level their sense of self, safety and stability is completely shattered.
Partners of sex addicts experience levels of trauma unique amongst addictions. Stephanie Carnes states that “finding out the person you love is a sex addict is one of the most painful experiences a spouse or partner will ever go through”. (Facing Heartbreak. 2012) and Claudia Black says that partners are “devastated and overwhelmed and seeking answers for what to do next” (Intimate Treason. 2012). So it's not hard to imagine how impossible it seems for partners who are trying to function in their day to day life when it feels that their world has so utterly disintegrated. What's more, they are also overwhelmed by their own sense of powerlessness being caught up in something beyond their understanding, that they didn't sign up for and that they can't really talk to anyone about. For a partner discovering that they are in relationship with a sex addict the trauma, pain and confusion experienced results in a huge struggle to function in a way that enables them to continue to care for themselves, their relationships and their families. The consequences for all involved can feel overwhelming and insurmountable.

Research carried out by Steffens and Rennies (2006), Omar Minwalla (2009), and Stephanie Carnes (2016), among others, all build on each other to reinforce that partners of sex addicts experience significant trauma responses as a result of discovering their spouses addiction and acting out behaviours. (Confirmatory Analysis of the Partners Sexuality Survey, Carnes, S. & O'Connor, S. Sexual Addiction and Compulsivity Journal of Treatment and Prevention, Vol 23, Number 1, 2016)

Dr Christine Courtois writes about complex betrayal trauma which she describes as “multiple and repeated experiences of interpersonal trauma” Courtois, C.A. (2014). Partners of sex addicts experience both relational and repeated trauma as they are betrayed by someone they have committed to spend their future with. Michelle Mays, Director of the Centre for Relational Recovery and author of the blog PartnerHope says that this complex betrayal trauma weaves together three types of trauma – attachment, emotional and psychological, and sexual. (PartnerHope blog/2017/4/27)

Most people associate trauma with life threatening events and we are more likely to associate the word 'trauma' with an act of violence such as war, sexual assault, motor vehicle accident etc. Therefore partners also often tend to minimise their traumatic responses to their spouses betrayal, and they find enormous relief when they come into therapy with someone
who understands sex addiction and its impact on partners, and finally start to see that they are not crazy but experiencing what is a normal response to a highly traumatic event.

Indeed to help highlight just how complex and significant this trauma is, Dr Omar Minwalla from the Institute for Sexual Health developed the ‘Thirteen Dimensions of Sex Addiction Induced Trauma (SAIT) among Intimate Partners and Spouses Impacted by Sex Addiction-Compulsivity.’

These 13 dimensions are:
1. Discovery Trauma
2. Disclosure Trauma
3. Reality-Ego Fragmentation
4. Impact to Body and Medical intersection
5. External Crisis and Destabilisation
6. SAIT Hyper-vigilance and Re-experiencing
7. Dynamics of Perpetration, Violation and Abuse
8. Sexual Trauma
9. Gender Wounds and Gender-Based Trauma
10. Relational Trauma and Attachment Injuries
11. Family, Communal and Social Injuries
12. Treatment-Induced Trauma
13. Existential and Spiritual Trauma

Add to this some of the comments from partners of sex addicts as they seek to describe their experience which include:

- I can't seem to stop crying. Nothing seems to make sense. I even forget where I am sometimes.
- I feel like a zombie – it's like a big part of me has died, and yet I'm still alive.
- Sometimes, when the pain hits me – it's like a wave that is so powerful it knocks me off my feet.
- I wish he was dead, then at least this nightmare might finally be over.
• It's like I have nothing any more – no future, no dreams – my past has all been a lie and my hope has been shattered.

• I wish he had cancer, at least then I could expect some support from others.

• How do I trust and who? I can't even trust myself – how did I not pick this?

and you can see that the betrayal trauma experienced by partners is not just about finding out that her partner has been unfaithful...it is so much more. The trauma is then compounded by the secrecy and shame which go hand in hand with this addiction, and for many there is no one who is safe to talk to or to seek help and support from.

Steffens and Means (2009) state that “Many partners of sex addicts demonstrate such intense and enduring response [to their spouses sexual acting out] that they meet the diagnostic criteria for PTSD” (p 17). Although there have been some changes to this diagnostic criteria in the DSMV, Minwallas' research shows that:

“when you understand the sexual symptoms experienced by partners of sex addicts, it becomes apparent that the symptoms are strikingly similar to those known to occur from sexual trauma, such as rape, sexual assault, sexual abuse and molestation. When we look at well-established symptoms of sexual trauma and abuse, partners of sex addicts can identify with many or all of them.”

(Mending a shattered heart – p 94)

So although a strict diagnosis of PTSD may not be applicable given Criterion A in DSMV, it is imperative to note that partners of sex addicts often experience the same symptoms as sexual assault survivors. Other grief criteria also apply to some partners who can struggle for years to come to terms with their experience.

“Post Traumatic Stress Disorder (PTSD), Complicated Grief (CG) and even Disorders of Extreme Stress Not Otherwise Specified (DESNOS) are all issues which may need to be addressed in partners, particularly over the longer term. Indeed many of the symptoms described in the proposed Diagnostic Criteria for Complicated Grief Disorder apply to partners of sex addicts which "includes symptoms of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased (or....sex addict), unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities lasting longer than 12 months.”

S. Drayton (2015)

It's also important to note that these systems do generally 'last longer that 12 months' for many partners of sex addicts. Whether they were aware of some of the acting out behaviours,
or have received some level of disclosure, many are already experiencing trauma symptoms long before they come for help.

Gaslighting

An insidious form of psychological abuse, gaslighting is the favoured weapon of the addict, particularly the sex addict. I use the word insidious which the dictionary describes as “stealthily treacherous or deceitful” and “operating or proceeding in an inconspicuous or seemingly harmless way but actually with grave effect” (Dictionary.com). Both these explanations describe perfectly the impact of gaslighting. Taken from a 1940s movie about a man who emotionally manipulates his wife into believing she is insane so that he can commandeer her fortune, it enables the addict to stay in active addiction while the partner begins to doubt her intuition (which is one of her best sources of information) and doubt her thoughts and feelings as the incoming data is manipulated to maintain the addicts innocence.

Patrick Carnes states that addicts use gaslighting in an attempt to “make their partners feel like an accomplice to [their] abusive behaviour. And that this “...is a common manipulative ploy used to promote guilt and blame within [the partners] life for [the addicts] abusive behaviour.” (90 Day Prep workbook 2 Facing the Shadows 2009)

One of the main reasons gaslighting is such an effective tool for the addict is that it generally contains a kernel of truth. The partner will focus on this small truth and even though she knows at a deeper level that what was upsetting her seemed bigger than this, she will ultimately give up her deeper sense of something being wrong and give the addict the benefit of the doubt, knowing that what he has said in his defence holds some truth.

This results in partners feeling that they really are going crazy. This in turn can increase their sense of isolation as it feels harder to tell others or seek support from family and friends.

Is it Sex Addiction?

“Sex addiction is not the same thing as infidelity...Sex addiction progresses, gets out of control, becomes a compulsive pattern, and takes over the addicts life. The illness escalates, and most addicts have a profound shame and despair around their behaviour.”

Mending a Shattered Heart p9
Is it really an addiction or is it just an excuse for bad behaviour or mismatched libido?”

Many of you will no doubt be aware of the ongoing debate regarding the classification of sexual addiction-compulsivity in the DSM. Some argue that it should not be classified as an addiction and others argue that it does in fact meet all the criteria for being classified as an addiction.

Following is part of a statement recently released by IITAP (International Institute for Trauma Addiction Professionals) regarding the validity of sex addiction as a diagnosis.

“the American Society for Addiction Medicine has declared that sex, eating, and other similar reward producing behaviours can all be classified as addictions. In ASAM’s 2011 definition of addiction they write:
Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioural engagement in addictive behaviours.”

Add to this the statement released by APSATS – the Association Partners Sex Addiction Trauma Specialists) which states that:

“To date, over two dozen empirically valid and reliable neurological studies and reviews establish the legitimacy of sexual addiction as a serious problem and public health issue. More than thirty studies reveal decreased relationship and sexual satisfaction when pornography use or sexual compulsivity are present, and seventeen studies associate pornography use and sex addiction with a variety of sexual issues. Additionally, several studies specifically highlight the experience of partners of sex addicts as traumatic, negative and multi-faceted”.

and it is evident that there is a lot of research in this growing area, all of which point to the fact that sex addiction cannot be easily dismissed as anything other than an addiction.

Paula Hall, in her book Sex Addiction: The Partners Perspective sums it up nicely when she says that “while the Professionals decide what to call it, it undoubtedly continues to be a growing problem”(p 8). She goes on to say that “what defines addiction is the dependency on something as a mood regulator, the exact nature of that substance or behaviour is not relevant to the definition” (p10).
What is relevant however, is that for partners, discovering that the person they believed they knew and trusted implicitly has been living a secret life is beyond shocking. It is shattering at such a fundamental level that many struggle to continue to operate in their daily lives in any way which is remotely functional. Struggling to understand what and why is fraught with challenges, particularly when also confronted with the debate about whether the behaviour exhibited by the spouse is in fact an addiction – and although there will be times when the behaviour does not meet the criteria for sex addiction, for those it does it enables the partner to start to understand that the addiction is something outside of themselves. In other words with education about the nature of addiction and sex addiction in particular, both the partner and the addict, seeking help from appropriately trained professionals, can embark on the long and often arduous path to recovery which begins with understanding what addiction is, how it developed and how it has impacted the addict and their partner.

**Helping Partners**

“The discovery...that your partner has betrayed you and your relationship in the most intimate way possible – the sexual bond – is devastating. It turns your world upside down and makes you doubt everything you thought you knew about your partner, your relationship and even yourself.... To choose to stay in a relationship crippled by sexual betrayal and to work through the pain, loss, and uncertainty is no less than heroic, for both the partner and the sex addict.”

*Moving Beyond Betrayal* p xvii

Patrick Carnes identifies six stages of recovery for partners of sex addicts:

**The developing stage/pre discovery**

partners see that there is a serious problem

**Crisis/Decision/Information gathering**

partners realise that they can no longer tolerate the problem and seek to understand exactly what has been going on

**Shock**

partners see how bad things actually are and seek help

**Grief/Ambivalence**

partners start to connect with the depth of their loss and pain

**Repair**

partners start to reconstruct how they interact with themselves and others

**Growth**

partners experience a new depth in their relationships

*Mending a Shattered Heart* – pg242,243
So when partners come for help they are generally in the very early stages of understanding the significance of what has been going on with the person they believed they knew intimately and could trust implicitly. They are confused, often very angry, and in enormous pain. They don't really know the full extent of what is (or has been) going on and they don't understand how they could not have known. They may have reached out to friends or family for support and been told that they should just leave, or kick him out, so they are often also filled with shame at their own indecision and confusion, and they don't know who to turn to or who to trust....and they certainly don't trust themselves.

So how do we help partners?

Stabalising the Trauma and Managing the Crisis

Sex addiction is unique amongst addictions in terms of the impact it has on partners and families because it is personal in a way that no other addiction is. It violates everything that has been contracted to in the relationship (both implicitly and explicitly) and turns the world of the partner upside down. Everything that the partner thought they knew, believed in or understood is called into question as they start to unravel the secret life their spouse has been living.

Awareness is growing of this traumatic impact on partners and it is being recognised that the way partners respond to the discovery that their spouse is a sex addict is similar to those who have experienced a significant trauma such as a sudden bereavement or assault. (Paula Hall, 2016).

Steffens and Rennie point out that the way partners respond to this trauma will depend on the length of time in the relationship and previous traumas experienced, and indeed it can generally be seen by the level of distress that the partner presents with whether or not there have been previous traumas. Connecting with these earlier traumas can also help partners to understand their current level of distress which in itself can help the partner feel more stable.

Developing the therapeutic alliance with a therapist and normalising the trauma response is the first step toward stabilising the partner. Feeling that they are finally being heard, validated and held will go a long way towards helping the traumatised partner start to settle.
Sex addiction is about secrecy, lies, manipulation and isolation and as such creates an attachment rupture at a core level. The consequences of the resulting trauma in partners is profound and clients can even present with similar symptoms to Borderline Personality Disorder, so recognising the profound nature of trauma in the partner is essential to ensure that the client receives the correct treatment.

Johnson sums it up when she says

“For traumatised couples, the therapist’s goal must be not just to lessen the distress in a survivor’s relationship, but to create the secure attachment that promotes active and optimal adaptation to a world that contains danger and terror... Trauma intensifies the need for protective attachments and often, simultaneously, destroys the ability to trust that is the basis of such attachments.” Johnson, S.M. (2005) p 10

Recognising this for partners ensures that the therapists office becomes the safe place where the partner will eventually learn to reconnect to themselves and their world. This ultimately helps not just the partner, but the addict and wider family. In fact Jennifer Schnieder's research suggests that if partners receive the right support most relationships will survive the trauma of sex addiction. (Schneider, J. (1998) Surviving Disclosure of Infidelity: Results of an International Survey of 164 Recovering Sex Addicts and Partners)

Helping traumatised partners through the healing process, looking at the traumatic impact of discovery and providing tools to help manage emotional disregulation resulting from this trauma, along with developing a support network and strategies for self care will all help to provide a more stable platform from which the partner can start to function.

**Therapeutic Disclosure**

One of the biggest challenges partner and addict alike experience is that of disclosure. It is a pivotal part of the recovery process for both parties. Disclosure can make or break the relationship and is something which requires the utmost sensitivity and preparation. Although this is something often approached with reluctance by the addict and with a sense of desperation by the partner, the research carried out by Corley & Schneider (2002) revealed that post disclosure 96% of both addicts and partners felt that the disclosure process was the right thing to do. Many addicts fear the consequences of disclosing their behaviours to their partners and that it will have a negative impact, while partners feel that they need to know
about all the acting out behaviours as soon as possible. Schneider’s research also points out that if handled correctly the disclosure process can be one of healing and in the majority of cases the marriage is able to survive.

Disclosure is a 3 fold process which involves the addict reading a written statement to the partner where they are completely honest about their acting out behaviours, listing times, places, people etc., and also answering any questions the partner has about these behaviours. This statement is written by the addict with support and guidance from their therapist.

The partner is able to then read their own letter to the addict in which they outline the impact this behaviour has had on them. This often includes those things which have been lost or destroyed as a result of the addiction. This statement is something which will be have been worked on by the partner and her therapist for some time. Some recommend that the impact statement is read to the addict prior to disclosure. Others prefer to read it after the disclosure has taken place giving the partner time to incorporate any new information from the disclosure into her impact statement.

In the final step the addict reads a letter of emotional restitution written to the partner in which they demonstrate understanding of how their acting out behaviours have impacted the partner, and in which they also demonstrate empathy and remorse. This can help to validate the partners experience, particularly the pain and trauma which has ensued as a result of the addiction.

Disclosure is a complex process, requiring time, compassion and support for both parties. It is imperative that the process is not rushed but given as much time and space as is needed. It is also helpful if there is a common desire on the part of both therapists to facilitate the best outcome for their clients which will enable a dialogue that ensures the needs of all parties are respected and met.

While this 3 fold process is designed to start the healing process, it will take time for the addict to really understand the impact of their sex addiction on their partner and it will take time for the partner to really understand the nature of addiction and learn tolerance and compassion. However it is possible, with good communication and boundaries for both
parties to understand the experience of the other, and learn how to support each other in the recovery process.

Key points for disclosure:

- Disclosure begins the healing process.
- Disclosure should be guided by the partner and what they need to know (they should be given the facts without the gory details)
- Disclosure should be a contained experience facilitated by both the addicts therapist and the partners therapist, or a good couples therapist who understands sex addiction and the impact on partners
- The disclosure process should be well planned and discussed in detail with all parties before the event
- The partner should have a good self care plan following disclosure which includes time with therapist and any support people

**Empowering partners**

Working with partners I know that it is possible to heal from the trauma of discovery that your spouse is a sex addict, and while some couples do indeed separate (and this is the right choice for them), others who are fully committed to recovery and making the relationship work go on to experience post traumatic growth.

In my partners healing and support groups (PHASE) I have seen that the best way forward is by empowering partners to own their own stories, experiences and needs. The groups are a particularly powerful way of helping partners connect to others with the same (or similar) experiences. They provide an opportunity for connection where they are safe and able to share their story and experiences free from the fear of judgement and blame. They are very nurturing and respectful of each other and give each other feedback which helps normalise their experiences and also keeps them accountable. They also learn from each others successes (and failures) and come to understanding the nature of sex addiction and that it is not really even about sex, and it is certainly not about them. As Paula Hall explains “sex addiction is not about fulfilling a sexual need, in the same way that chronic overeating is not about fulfilling hunger” (2016 p10). Addiction is an intimacy disorder and for sex addicts sex
is used to disconnect, creating intensity rather than intimacy. Recovery is therefore about connection and learning to be known at a deep and personal level. This is often a new experience for both the addict and their partners and although often challenging at first, this new intimacy can ultimately become the mainstay of the relationship.

In my groups we use the 3 C’s borrowed from Al anon which teaches partners that they didn't cause it, they can't cure it and they can't control it. This can be very liberating for partners who feel somehow responsible for their spouses betrayal, and gives them permission to start to explore their own histories, needs and desires.

Learning about, and starting to practice healthy boundaries is vital for both parties to begin to feel safe in the relationship. Positive communication which is not about shaming and blaming the addict but about appropriately expressing needs and wants, and developing a recovery relationship with the addict which involves mutual commitment and respect for each others healing and recovery will enable both parties to start to experience themselves, their spouses and their relationship in a whole new way.

**Conclusion**

“...both the addict and partner need their own recovery before there is any hope for recovery as a couple... Sex addiction exceeds behavioural problems. Addiction is a brain disease. Recovery means healing the brain, healing core wounds, and changing behaviour. Partners need to heal their own wounds of betrayal. They have their own symptoms and core issues.”

Mending a Shattered Heart p 245

Recovery involves restoring trust in self as well as in the addict. Both take time and require good support from others who understand the relational shattering and betrayal trauma which is created by sex addiction. Partners come for help angry and distraught that they find themselves in this distressing situation and that they are having to embrace the awareness of something they never believed was possible. The come angry, confused and heartbroken not knowing how to make sense of the nightmare that has become their life. They have zero tolerance with lies, and secrecy (real or perceived) which trigger trauma responses. Creating safety, stabilising the trauma and building the therapeutic alliance goes as long way toward helping the partner of a sex addict start to manage that which has felt absolutely unmanagable.
For those couples who are going to stay in relationship and make it on the recovery journey they will need 100% commitment, 100% honesty and 100% transparency. The nature and impact of sex addiction is such that for post traumatic growth to occur and the relationship to survive (and ultimately thrive) nothing less will do. (Both parties need to embrace this 100% rule by the way). Most partners start from a position of believing that all that is necessary for their emotional well-being is for the addict to stop acting out and all will be right again. However as they gain awareness around the addiction and their own powerlessness over their spouses behaviour and recovery, they also learn that as they didn't cause the addiction, they are also not dependent on the addicts recovery for their future happiness and well-being. With good therapy and support they eventually come to learn that they are responsible for their own safety and growth, and learn to trust that regardless of what happens with the addict they will be able to heal, grow and eventually flourish as they connect with their inner strength and integrity.
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An evaluation of the therapeutic potential of a creative writing program in residential drug and alcohol rehabilitation.

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An evaluation of the therapeutic potential of a creative writing program in residential drug and alcohol rehabilitation.

ABSTRACT: This is an evaluation of the potential therapeutic benefit offered by a creative writing program designed specifically for use in residential drug and alcohol rehabilitation services. Participants were recruited through snowballing email invitations to take part in the anonymous online questionnaire, housed on a dedicated website. There were eight responses. The research approach was qualitative, with open ended questions. All participants had to have taken part in the creative writing program, whilst they were residents of a drug and alcohol rehabilitation program. The final evaluation was based on what emerged from the data. A variety of responses to the program were found. All responses indicated that participants believed the program to be a valuable experience as part of their drug and alcohol rehabilitation program. The data indicates that this particular creative writing program holds therapeutic benefits for residents within a drug and alcohol rehabilitation service.

Keywords: Drug and alcohol, therapeutic program, addiction, trauma, creative writing, humour, group work, evaluation.

Introduction

An innovative alternative to existing approaches utilising a therapeutic creative writing program was developed by the author. It is the result of ongoing collaboration between residents of drug and alcohol rehabilitation services and the author, a professional writer. It draws from a mix of creative writing techniques, psychological perspectives, participant suggestion and facilitator invention. It is a group program in which a combination of psychotherapy, psychoeducation, games and creative writing exercises provide an opportunity for experiential learning and consequent therapeutic change.

This program began as volunteer literacy support conducted in a residential drug and alcohol rehabilitation service. The literacy tutor’s initial theoretical influence began with Friere (1972), who is concerned about the dehumanisation of disempowered individuals. While the participants perceived that they had literacy difficulties, the tutor found that they had greater literacy than she had been trained to deal with, such as teaching people how to write their own name or read a bus timetable.

As a professional writer, the literacy tutor drew on her Communications degree, and created writing exercises with the collaboration of the program participants, in a process of trial and error. She also incorporated exercise suggestions from the participants. This promoted both engagement and a sense of ownership amongst the participants (Baldwin & Fleming, 2003). The participants’ literacy skills increased rapidly. As a creative writing process was used, others in the rehabilitation facility, with high levels of literacy, joined the
The program then developed so that all could participate equally, without shame (Bartlett, 2007).

An unexpected outcome was that the program appeared to be therapeutic. One participant reported that it saved him from suicide. Consequently, the tutor studied to better inform her work with the participants. Her studies thus far have included Drug and Alcohol work, Youth at Risk, a Masters of Language and Literacy, and a Masters of Counselling and Psychotherapy.

The program also expanded its scope. Target groups included homeless adults, youth at risk, sex workers, men in jail, adolescent girls in jail, and residents of drug and alcohol rehabilitation centres. Over twenty-one years the facilitator witnessed the program produce significant therapeutic change in some people’s lives.

This therapeutic aspect of the program has never been investigated, or reported, until now, and as far as the author is aware, is unique. This paper presents a rigorous evaluation of the program. The contribution of the paper is that it provides validation of an alternative option to foster therapeutic change in a major area of need.

**Literature Review**

It must be acknowledged that addiction is difficult to treat. Currently, more than 300,000 Australians are affected by substance use disorders (Australian National Health and Medical Research Council, 2016). The search for more effective treatment options is ongoing. Butler et al (2015) argue that even understanding the neurological processes of addiction does not lead to effective treatment. They propose an educational model anchored in the neurobiological understanding of the human brain’s dynamic plasticity. Such an intervention approach ‘requires that we deconstruct its mechanisms in everyday terms’ (Butler et al, 2015, p.28). This echoes the approach of the therapeutic creative writing program being evaluated. Other writing approaches are examined in this literature review, along with themes generated by evaluation participants’ responses, such as change occurring because of the group interaction.

It is pertinent that this was an evaluation of a group program. Yalom (2005, p.1) promotes the power of group work to create therapeutic transformation, stating ‘A persuasive body of outcome research has demonstrated unequivocally that group therapy is a highly effective form of psychotherapy’. He proposes that eleven factors comprise the complex therapeutic experience of group work. These include the instillation of hope, interpersonal learning, group cohesiveness, and catharsis. Yalom (2005) regards cohesiveness as a significant factor in successful group therapy outcomes. He suggests that the safety provided
by cohesiveness promotes acceptance and understanding, both for the client themselves and their interaction with others. Group work can also create the space for cathartic, emotional expression, building hope and a sense of self efficacy, according to Yalom (2005). The group cohesion described by Yalom (2005) can foster humour and laughter, which Walter (2006) believes to be an elemental human communication, promoting trust. Further to this, a scientific, quantitative study found that laughter increased pain tolerance, due to the release of endorphins (Dunbar et al, 2011). This is a factor that may be worth considering when working with clients who are in the process of reducing their substance use. All of these elements can be found reflected in the evaluation results of this therapeutic creative writing program.

It has been difficult to find similar published results that are focussed specifically on the therapeutic value of creative writing for treating addiction, thus the scope of this literacy review has been broadened to include mental health. Mental health and addiction are often closely linked, according to the 2013 National Mental Health Commission project (Deady, et al 2013). The project found that ‘Comorbid mental health and substance use problems (MHSUP) occur in up to 71% of people in mental health services, and 90% of people in substance use treatment settings’ (Deady, et al 2013).

Works linking creative writing and addiction can be found. However, some works are not robust in terms of academic evidence. ‘Spaces of possibility: The place of writing in urban drug treatment’ (Evans, 2004) is such an example. Evans (2004) endorses the use of creative writing for women in substance abuse treatment. The article is not current. It is also a personal reflection on the author’s experience of facilitating these groups, thus it is not an academic evaluation. The focus of the article is on education rather than therapy. There are other weaknesses in the article such as the emphatic, emotive style of writing, for example, ‘…importantly, I have also witnessed poor and working-class women create spaces of refutation, moments of challenge, and words of strength and will’ (Evans, 2004).

The author finds the value of this work in some positive elements of offering creative writing during treatment for addiction. These elements can be seen reflected in the author’s philosophical approach, the findings of this evaluation, and the perspective of Evans (2004). The discourse of power inequity is seen as a pivotal underpinning. Both Evans (2004) and the author argue against imposing a controlled narrative. Evans (2004, p.125) states that ‘Women in substance abuse treatment use a variety of voices and create a plethora of texts to make sense of their lives’, which is again a commonality. Further, both the author and Evans (2004) are concerned with the vulnerability of those who are ashamed of their perceived lack of literacy ability, and consequently the imperative to provide the opportunity for everyone ‘to
write without fear or censure’ (Evans, 2004, p.117). As enticing as these insights may be, they do not constitute academic veracity.

Another work deliberately sidesteps any process of validation. A United Kingdom paper, ‘Writing for recovery: a practice development project for mental health service users, carers and survivors’, by Taylor et al (2013), rejects the concept of providing evidence through research. The aim of the project was a recovery approach, where participants could gain meaning through creative writing. While the exercises described, such as ‘Self-Portrait as Metaphor’ and ‘Nonsense Poetry’, appear to be truly creative, lack of validation may inhibit further replication in other settings.

In contrast, a 2012 Australian study by King et al (2012), ‘Creative writing in severe mental illness’ offers three theoretical frameworks and explanatory models underpinning their project. The first focuses on narrative and the strengthening of personal identity. The second explains how writing can repair a symbolic internal void, and they propose the third, which is ‘writing as a form of cognitive remediation’ (King et al, 2012, p. 445). This was a pilot project investigating how useful creative writing might be for clients of a non-government agency in Brisbane, Queensland, Australia. It was a qualitative study utilizing observation, participant interviews, and informal reports. The creative writing itself could be prose or poetry, fiction or non-fiction. There was no focus on psychotherapy. It was hoped that the creative writing itself would perform a cognitive remediation (CR) function.

While King et al (2012) suggest that short, free, spontaneous bursts of writing may be beneficial, allowing participants to by-pass their inner critic, in practice their work seems to be both didactic and prescriptive. They focused on ‘the processes and techniques of writing, and not just on self-expression’ (King et al, 2012, p. 450). Participants were told to write about their life, with a positive view. They were also given worksheets explaining ‘sentence structure, descriptive language, sequencing and other technical issues affecting the quality of the writing’ (King et al, 2012, p. 448). The author believes that a greater therapeutic benefit arises from cases where the previously voiceless client discovers their own, hither-to hidden power of imagination and self-expression, which a focus on technique would inhibit.

King et al (2012) recommend more research to develop evidence-based support for this kind of workshop. They propose that there should be an active control group. They do not go so far as to suggest what form of activity the control group would engage in. They want to introduce measurement of cognitive change, of functioning, and of personal recovery.

Measurement is employed in Expressive Writing (Pennebaker & Smyth, 2016). Expressive Writing is a form of therapy where participants write about an event that has
distressed them. The procedure involves writing about the event for fifteen to twenty minutes, once a day, for three to four days. The first research conducted by Pennebaker and Beall in 1986 indicated that this had a positive physiological and psychological impact. Since then, the scope of problems treated with Expressive Writing has broadened to include physical ailments and mental health issues, including depression and anxiety (Pennebaker & Smyth, 2016). The University of Texas libraries hold 220 works of research into Expressive Writing, covering a broad spectrum of enquiry; from the effects of Expressive Writing on military staff with Post Traumatic Stress Disorder, to the health effects for people with type 1 diabetes.

It could be argued that Expressive Writing has become widely known because it has measurable effects. Meshburg-Cohen et al’s 2014 study of ‘Expressive Writing as a therapeutic process for drug dependent women,’ employed vigorous measurement; the Post-Traumatic Stress Diagnostic Scale, the Pennebaker Inventory of Limbic Languidness, the Brief Symptom Inventory, the Positive and Negative Affect Scale, the Essay Evaluation Measure, and a follow-up questionnaire. ‘In order to reduce unintentional expectancy effects and investigator bias, one experimenter administered baseline assessments and all writing instructions, while a different experimenter, blind to study condition, administered…follow-up assessments’ (Meshburg-Cohen et al, 2014, pp. 4-5).

This impersonal evaluation approach appears to be somewhat harsh, considering that these women are reported to have high rates of trauma and post-traumatic stress. It also appears to be at odds with the concept that the therapeutic alliance is ‘one of the major determinants of therapeutic success’ (Prochaska & Norcross, 2014, p. 6). Even though no group differences were discerned in the one-month follow up, Expressive Writing was advocated as a low-cost therapy to be used along with substance use disorder treatment. There seemed to be no justification for this recommendation.

Pennebaker and Smyth (2016) warn that Expressive Writing is not for everyone, a warning which was borne out in an Australian study. Baikie et al (2006) conducted a study investigating the effectiveness of Expressive Writing as a brief intervention for high-risk, drug-dependent patients in a primary care clinic. Out of fifty-three initial participants, only fourteen completed all measures. These measures included the Depression Anxiety Stress Scale, a 12-item Short Form Health Survey, and a demographic survey. These were administered to create a baseline, and again at a two-week follow up. No ‘statistically significant benefits’ were found (Baikie et al, p. 5, 2006). Interestingly, the report refers to anecdotal evidence; ‘many participants were enthusiastic about Expressive Writing and felt that it was helpful’ (Baikie et al, p. 4, 2006). It seems that in this research there was no mechanism for translating this feedback into useful evidence.
It is argued here, that the Expressive Writing tasks asked of participants in Baikie et al’s (2006) research, were prescriptive, as opposed to creative. This may account for why ‘Although participants were instructed to ‘really let go and explore their very deepest emotions and thoughts’, the results were inhibited (Baikie et al, 2006).

It appears that there is a significant gap in this literature. Nothing was found about the power of the group in creative writing therapy. There is an abundance of literature on Expressive Writing, however it is a solitary pursuit, based in reality rather than the imagination. Nothing was found about self-discovery through creative writing, or the healing effect of humour within creative writing groups. Perhaps this gap is created by our understanding of what constitutes evidence. Prochaska and Norcross (2014, p. 418) argue that ‘The research definition of evidence relies on objectification of experiences, and privileges one conception of evidence over others.’ It is hoped that the words of the participants themselves in this evaluation may trigger further research to fill this gap.

**Aim**

The aim of this research was the evaluation of the therapeutic potential of a creative writing program in residential drug and alcohol rehabilitation, from the perspective of the participants.

**Methodology**

This evaluation employed a qualitative approach (Fossey, 2014), within a relativist ontology (Dudovskiy, 2011). Arguing against quantitative approaches, Critcher et al, (2005, p.87) states ‘the belief that answers given to questions with predetermined categories … are necessarily true or valid seems at best optimistic and at worst naïve’. A concern with power invited the incorporation of feminist research philosophy, where there is an attempt to share power between participants and the researcher (Coddington, 2015). Those invited were free to choose not to participate, and anonymity compounded this power.

**Method**

The demographics for this research were ex-residents of drug and alcohol rehabilitation facilities who participated in this therapeutic creative writing program. An anonymous, online questionnaire comprised of the following nine open ended questions was used to gather data;

1. Can you please describe how you felt when you knew that you had to take part in a creative writing program? 2. What did you expect the creative writing program to be like? Can you please describe this? 3. If the creative writing was different from what you expected, can you please write about why it was different? 4. Can you please discuss whether there was any short or long term benefit from participating in this program? 5. What impact, if any, did you notice the program have on others? 6. Do you still have any of your writing from the group? If no, can you talk about why not? If yes, can you talk about why you kept it? 7. What changes would you
recommend for the creative writing program? 8. What qualities do you think the facilitator of this group should have? 9. Do you think this program is appropriate for a residential drug and alcohol recovery facility? Can you please describe why or why not?

An ethical complication shaped the method of this research. The author is known by the participants and was also evaluating the program that she devised. To avert contamination of the results as a consequence of this dual relationship, great effort was made to provide anonymity to the participants. A website was created specifically for the purpose. This website held all information pertinent to the research, and a link to the anonymous SurveyMonkey Questionnaire. A snowballing method of invitation via email was utilized. Eight participants responded to this invitation. The results are anonymous. Pseudonyms have been used in place of participant numbers.

**Data Analysis**

Evaluation differs from other forms of social research in that it is a systematic process seeking feedback in order to assess value (Trochim, 2006). This evaluation incorporates elements from both qualitative and participant-oriented models. The results are the participants’ reported experience of the program. This is a summative evaluation, examining the effects of the program. Using open-ended questions was a qualitative approach that allowed the formation of rich responses. The areas of enquiry came from the researcher’s curiosity and concerns based on over two decades of experience of running the creative writing program in residential drug and alcohol rehabilitation facilities.

The data analysis involved sifting the responses to these areas of enquiry into categories, illustrated in the following table:

<table>
<thead>
<tr>
<th>Areas of enquiry</th>
<th>Response categories</th>
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<tr>
<td>Reaction to mandatory attendance</td>
<td>Scared</td>
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<td></td>
<td>Excited</td>
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<td>Shy</td>
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<td>Angry</td>
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<tr>
<td>Expectations</td>
<td>No expectations</td>
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<td></td>
<td>Definite expectations - Opposite occurred</td>
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<td></td>
<td>Hope</td>
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<tr>
<td>Outcome – Short Term</td>
<td>Increased understanding of cognitive processing</td>
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<td></td>
<td>The value of privacy</td>
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<td></td>
<td>Mood and self-esteem enhancement</td>
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### Results

The participants’ words speak profoundly, giving rich data beyond the capacity of a quantitative study.

*Reaction to mandatory attendance*

The first area of responses concerned feelings regarding the mandatory attendance of the creative writing group, as required by the rehabilitation facility. There were mixed results. Three people reported feelings of fear: Troy said he was ‘Nervous and anxious’; Conversely, three people reported feelings of excitement. Ben wrote, ‘In truth, I was a bit excited and hopeful. I had loved writing at school and hadn’t done any since’. A contrasting response came from Mark, who was ‘Angry at being forced to do something I didn’t want to do’.

It appears that anticipation of being forced to attend this program elicited a variety of responses, encompassing fear, excitement and anger.

*Expectations*
The next grouping of responses centres on Expectations. Three participants had no expectations. Two described having hope. Bruce reported ‘I was hoping it would be inspiring. I was surprised by how easily I was able to participate’.

Other people had negative expectations that were overturned. Mark dreaded it. He explained that he expected it to be;

‘Like school. I hated school. I hated writing. I hated poetry. The introduction put me at ease. I didn't have to show my writing to anyone so I wasn't going to be judged and shamed. The teacher told us about how the brain works and things started to make sense for me. We played games and had fun, which wasn't what I expected. I wrote stuff that surprised me. I wrote a letter to my girlfriend. I've never written a letter before. It blew her away’.

Luke was apprehensive, ‘Maybe they'd make me write about my issues and problems. I wasn't looking forward to it. It was fun and everyone seemed to like it. It showed me not to be frightened of writing’.

**Outcomes: Short-Term Benefits**

The responses indicate that all participants found some short-term benefit in the program. These include the relief of privacy, the value of this specific psychoeducation model, mood and self-esteem enhancement, processing fear and worries, group connection, fun and humour. There are elements of these in the following excerpts; Ben found learning about the underpinning of the course to be useful: ‘I wasn't expecting the introduction to be like it was. It was really helpful, explaining why we get blocked and what to do about it.’ Maria also valued the strengthening connection she gained with others in the group. ‘I think it brought us closer. I felt different from everyone else. Participating in the group gave me lots of surprises. We also laughed a lot, because of the games. I think that was bonding’. Julia found the program useful for processing emotions: ‘I felt I had an outlet for my fears and worries but also to be able to let go of them and just enjoy fun exercises’.

**Outcomes – Long Term Benefits**

It appears that the benefits from participating in the group carried on into the future. Participants reported an increase sense of self-confidence and self-esteem. One person explained that it enhanced their ability to function at work. Two others went on to study at a tertiary level as a result of participating in the program. One now has a career working to help others. These benefits may be noticed in the following responses; Julia said ‘it fuelled
my desire to pursue writing at a higher level. I went on to do my masters in creative writing at UTS and it was one of the best experiences in my life’.

Maria offered this rich response;

I used to dread having to write reports. I had so much fear around it, I would drink just so I could function. This is not a great long-term strategy, which is why I ended up in rehab. Doing this program completely eliminated my fear of writing. This made it so much easier to go back to work, after I had finished rehab’.

Effect on Others in the Group

Not all participants remembered or perhaps noticed what effect the group had on others. Those that did, stated that it had a positive effect, such as Mark’s response;

‘What other people wrote blew me away. You’d see a side to someone you had no idea about. We all had a laugh together as well. So we might have had a bad couple of days and we’d come out of the group happy’.

Recommended Changes

When asked about recommended changes to be made to the program, participants offered some creative responses, such as the inclusion of drawing. Other comments reveal that participants found the program valuable just as it is and recommended no changes.

Recommended Qualities in Group Leader

The recommended qualities for a group leader of this program are as individual as those who participated in the program. These could be consolidated into respect, empathy, passion for the program, and a sense of humour. Bruce recommended ‘A love of writing and a respect for the power it has to transform, a love of the students and a respect of their transformations’.

 Appropriateness for Rehabilitation Facilities

All participants gave a positive response to the question of whether the program is appropriate for inclusion in drug and alcohol rehabilitation facilities. Troy’s enthusiastic response encompasses them all;

‘Yes I do! It gave me a sense of self-worth. I wrote things I didn’t know I could from fiction to personal accounts. At first it was hard but I’m glad I did. Writing was a chore when I was younger. When I read back through the pages from rehab, I’m stunned and shocked at what I wrote. Some of it was pretty good. I found it brought the residents closer as we had similar stories but some were unable to express it. It was a great part of being at rehab’.

Discussion
The aim of this research to evaluate the therapeutic potential of a creative writing program in residential drug and alcohol rehabilitation, from the perspective of the participants. Whilst rich data was obtained, it is suggested that the process by which this data was obtained was not the strongest research approach, hampered as it was by ethical constraints. Nevertheless, the data which was received, was encouraging. The participants’ responses were unanimous. All stated that they believed the creative writing program in question offered value to their rehabilitation experience. Further research needs to be undertaken to explore possible contributing factors to this response.

The initial negative reactions some participants expressed appear to have arisen from past experiences associated with school. There was fear associated with vulnerability to exposure. The issue of privacy and the lack of it in the context of a rehabilitation facility also arose. There were changes of self-perception, and unique outcomes, such as pride in writing a letter for the first time. It appears that positive change occurred as a consequence of the structured introduction, and the freedom to keep writing private if so desired.

Elements of power and empowerment are evident in the participants’ responses. This is the core principle of the program. It is imperative that the facilitator represents the value of the program as inducement enough to participate, with respect and consideration given to any who may choose not to. That this works is indicated by Troy’s response, where he thought ‘I’d be forced to write about things that I had no interest in. It was very different to what I thought it was going to be’.

One of the program’s aims is to give people the opportunity to experience writing freely. The effect can be seen in Mark’s response, ‘I wrote stuff that surprised me. I wrote a letter to my girlfriend. I’ve never written a letter before’.

The program appears to allow people to play and have fun with their imagination. The majority of participants mentioned ‘laughter’, ‘enjoyment’, and ‘fun’ in their responses. The laughter is shared within the group. Bruce describes ‘feeling the lift in my mood and self-esteem from taking the chance and participating, and from the connections that happened in the group’.

While Pennebaker’s (1986; 2016) Expressive Writing therapy is a solitary pursuit, the same goals of processing trauma are available to participants of this group creative writing
program. Nicole and Luke both referred to the short and long-term benefits of participating in the program in terms of being able to self-soothe with writing. Nicole said ‘It helped to put feelings down on paper, to get them out of my head’.

Finally, revisiting Butler et al’s (2015) position on empowering those in addiction through education, it is worth noticing that this program can change lives. Ben said;

‘It gave me the chance to see that I could do more with my life…In the long term, it gave me confidence in myself. I thought ‘If I can write, I can study’. I hadn't thought this before. I was just a homeless drug addict before, hating myself, totally focussed on how I was going to get my next hit. From rehab, I went on to do a tertiary preparation course and matriculated into education at Sydney Uni. I got a teaching degree, which blows my mind when I think of where I was. Now I work with young people, trying to help them not fall into the hell that is addiction’.

**Limitations**

A limitation to this research evaluation is the lack of immediacy regarding participant feedback. The program itself had not been in operation for three years at the time of researching, therefore all opinion was retrospective, and, one could argue, clouded by the passing of time. Conversely, this may be a benefit, as time may be needed to notice and contemplate change. Considering that the program began in 1992, some of these reminiscences could belong to participants of a class that took place many years ago. It will never be known who responded, due to the ethical safeguards of the research. Another limitation is the sample size. While the eight participants provided rich data, well over one thousand people have taken part in the program during the twenty-one years of its operation. It could be argued that the responses are skewed favourably toward the program, as those who did respond did so out of their own positive experience, which does not necessarily represent the views of others. Further to this was the difficulty in gaining any responses at all, given that program facilitator had maintained strict boundaries and had no contact with any of her past participants. Those few that the author was able to contact by email were working now in the welfare field.

**Research Recommendations**

It is suggested that one alternative approach to future research could involve case studies. Another approach could be a before-and-after type evaluation, where participants are interviewed before, and immediately after, participating in the program, by an outside researcher, to avert the ethical constraints faced by the author. It is also possible that this
interviewing could be done by staff of the rehabilitation service. These both could be valuable methods of capturing the therapeutic change that occurs as a result of participation.

**Research Implications**

It is significant that all eight people responded so favourably to a program that they remembered participating in whilst in a residential drug and alcohol rehabilitation service. While it is not suggested that this program is a cure for addiction, results indicate that this creative writing program should be strongly considered for inclusion amongst the current tools of therapy provided in residential drug and alcohol rehabilitation facilities. Finally, the results indicate that further research into the value of this program as a drug and alcohol group therapy may be beneficial.
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