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2011 Winter Newsletter



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Gratefully Inspired on the Hill, Yet Again...

If you ask me, I'll tell you that I have one of the best jobs at Santé Center for Healing as the Aftercare and Alumni Coordinator. Namely because after all of the blood, sweat and tears are poured out by patients and staff alike, I come in and help plan a future. I continue the relationship with our alumni and I get to hear amazing stories like the one below, or like the one of a particular young man whose parents came and picked him up from Santé to take him out to dinner for his 19th birthday. His mother asked him what he wanted for his birthday, to which he replied, "My treatment at Santé is my birthday gift. Do not to get me anything more." This kind of refreshing gratitude from a young man who came into Santé a broken child is why we do what we do. The story below comes from a woman named Cindy who is currently in Santé's residential program. She has been gracious enough to share it with us and allow us to share it with you. Stories like this quite literally knock the breath out of me and remind me that *miracles really do happen on the hill...* I hope it inspires you as much as it did me.

It's a Wonderful Life at Santé

by Cindy A.

I have been a member of the Santé community since early September. I originally came here with the idea that my mere presence here would be enough to pacify my 'overly' concerned family; several spiritual awakenings later I became fully engaged in my recovery process. Our insurance company, on the other hand, thought my need to be here was premature and refused to pay. We were able to pay for the first 30 days, but took our financial options to the limit with that. On my 27th day of treatment I reluctantly filled out an AMA request form and was prepared to leave on a Sunday, 30 days after I had first arrived at Santé. Ron and Sam each spoke to me individually; they both voiced concern over my decision to leave. I explained to them that I was not willing to put more debt on my family, which would create yet another piece of the chaos my addiction had already let in its wake. They reassured me that if God wanted me here he would make a way. With much internal uncertainty and fear I rescinded my AMA request form, and had a conversation with my husband about my need and desire to finish my stay at Santé the right way. Within 72 hours, I received a check for \$10,000.00 from my high school alumni along with a letter expressing their desire to be a part of my recovery. My husband and I were overcome with emotion! I was amazed; not to mention extremely grateful!

My sister-in-law still lives in the town where my husband and I grew up and attended high school. She had recently asked my husband's permission to pray for me with her congregation at church. Little did she know that within her congregation was a member of my high school graduating class, and that soon our prayers were to be answered. Needless to say, I am glad I stayed at Santé.

It has been a long standing tradition in our family to watch, 'It's a Wonderful Life,' every Christmas Eve. Little did I know that I would experience the complete joy of truly knowing how much I am loved. I think an angel just got his wings.

- Cindy A.



Sex Addiction and Sex Offending: A Growing and Dangerous Relationship

by Samantha Smithstein, Psy.D.

Before the Internet, people were forced to great lengths to commit a sex offense. Sex offenders were typically either compelled by a paraphilia or didn't give a damn about the laws of society. People who suffered from a sexual addiction, on the other hand, typically acted-out through legal means, such as having affairs or casual sexual encounters; the most common illegal means being the hiring of prostitutes.

Subsequent to the Internet, there has been an explosion of out-of-control and illegal sexual behavior. Activities such as viewing child pornography, soliciting sex with minors through chat rooms, and others are much more common. Some of this has to do with the obvious fact that the Internet makes these activities much more available and easy. However, there are other factors as well, such as an illusion of privacy while doing it, lack of immediate consequences for these actions, an idea that others are doing it to (that makes it feel less taboo), and that the need for new simulation often leads to widening exploration.

Of course, some people committing sex offenses might have otherwise anyway, and there are still those driven by paraphilias or who are highly antisocial. But some sex offenders are more aroused to the *illicit and forbidden nature* of the material or acts than to the *actual* material or act – it is the taboo that is exciting. **Many people committing sex offenses today are otherwise law-abiding citizens who may not have ever crossed the line to commit illegal sexual acts if it weren't so easy and if they couldn't do it from the privacy of their own home, and are truly shocked when they are discovered and/or arrested.**

Does all of this make it okay or excusable to commit a sexual offense? Absolutely not. **A sex offense is a sex offense because there is a potential victim involved – and the possibility that someone is harmed.** However, it may be information that is important for us to think about when it comes to sentencing and (ideally) treating an individual who has committed a sexual offense. Now more than ever we should be thinking about the possibility of a sexual addiction as the driving force of a sex offense, and that the standard treatment models for sex offending may not be a complete model. Likewise, the sex addiction specialist who is working with a sex offender may not have all of the tools that he or she needs for a comprehensive treatment.

These two areas – sex addiction and sex offending – are increasingly entwined in a growing and dangerous relationship. And yet the fields of sex offender treatment and sex addiction treatment remain fairly isolated from one another. Many sex addicts who get caught up in illegal activities and are prosecuted end up in sex offender treatment with their addiction untreated. And many sex offenders who have not yet been caught end up in sex addiction treatment with a provider who has little or no training regarding work with sex offenders. **It would behoove us to create as much dialogue as possible between these fields, so that we may grow to meet the needs of this ever-increasing population of people who need our help – within a society that needs us to help them.**

Pathways Institute for Impulse Control provides help for people suffering from the devastating effects of impulse disorders, "process addictions," and out-of-control behaviors; such as compulsive shoplifting, stealing, sex addiction and love addiction, and their partners and families. They provide a thorough assessment, as well as an investigation into the origins of and contributors to the behaviors, such as unmet needs, trauma, learning and attention differences, co-addictions, substance abuse, eating disorders, codependency, and/or mood disorders. They also provide psychotherapy, treatment groups, training and consultation, community education, interface with the legal system, and licensing and sale of our products. Through these means, Pathways offers practical tools and new pathways for people, and their partners and families, to gain control of their lives and become free to create a life of choice, and ultimately of deeper meaning.

Contact information:
www.pathwaysinstitute.net
415.267.6916
help@pathwaysinstitute.net

"Santé gave me the ultimate gift. Not only did they save my life, they showed me how to live."

~ Santé Alumni

Friendly Neighbors

by Ginger Coburn, LCDC

SAMHSA, or the Substance Abuse and Mental Health Services Administration, publishes numerous materials on substance abuse and mental health issues. One particular publication series is called TIPS, or Treatment Improvement Protocols. Not only are these publications extremely helpful resources and knowledge bases, but one I reviewed recently, TIP # 27, Comprehensive Case Management for Substance Abuse Treatment, reinforces our mission as Case Managers with the Texas Peer Assistance Program for Nurses (TPAPN) and our dependence on critical information that usually begins with treatment providers such as Santé and other treatment centers and mental health providers in Texas and beyond, particularly with regard to assessments and evaluations.

SAMHSA's publication defines Case Management as follows: *Case management has been variously classified as a skill group, a core function, service coordination, or a network of "friendly neighbors."* Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. Well put, I thought to myself, because this *IS what we (TPAPN Case Managers) do for our nurse participants!!*

So, who are the friendly neighbors? Without question, one very important neighbor is the substance abuse and mental health treatment provider. The information acquired, assimilated and disseminated from the substance abuse and/or mental health assessment is vital to creating the plan of recovery for the participating nurse who will hopefully engage in the process and reap the rewards of a substance free life: a return to safe nursing practice. Research has shown that case management leads to better outcomes.

With our high tech systems of communicating with "our friendly neighbors," TPAPN operates in a virtual world type setting. We don't see our participants face to face; therefore, we are even more dependent on these neighbors to provide comprehensive information in a way that connects all of the neighbors, and always in the best interest of the TPAPN participant. When the provider conducts a thorough assessment and conveys this information promptly to us, it can make all the difference as to whether or not the nurse is connected to appropriate and needed treatment.

Each participant enters TPAPN with a unique set of circumstances and needs. Having a provider who understands the TPAPN enrollment process, the policies and procedures of the program, the expectations of the licensing board and the particular nuances of certain work environments is invaluable. A provider who is willing and able to envision the larger picture of each entity's role with a nurse in early recovery is a valuable asset to all the neighbors, as a life, a license, and a career saved may allow another nurse to continue to be a vital part of healthcare.

There are numerous professionals that make up the neighborhood: the nurse, addiction specialists, mental health professionals, employers, supervisors, peer nurses, support groups, TPAPN nurse advocates, supportive family members, TPAPN staff and others along the way. One thing is true; asking for help is not always an easy task for most of us, at times. In all walks of life and in all professions, successful people have had help along the way. Asking for help isn't always comfortable, but with knowledgeable and friendly neighbors close by, a cup of sugar is never out of reach. When nurses have received good treatment as the foundation to their recovery all of the neighbors involved are rewarded in their efforts to pay it forward: We realize healthier and safer nurses for the next patient who may just be one of us.

***"I attribute my success to this – I never gave or took any excuse."
- Florence Nightingale***

Ginger Coburn, LCDC is a case manager for TPAPN. When not flying airplanes for fun, Ginger remains very grounded in both her work and play. TPAPN is the approved peer assistance program for nurses, RNs and LVNs, licensed in Texas providing monitoring and assistance services to nurses whose practice is impaired by substance use disorder or certain psychiatric disorders. TPAPN is administered by the Texas Nurses Foundation. TPAPN and the other professional peer assistance programs of Texas held their 3rd annual workshop for treatment providers, counselors, EAPs and HR representatives, on June 24, 2011 at Memorial Hermann's Prevention and Recovery Center in Houston. Contact TPAPN's program operations coordinator, Leah Lambricht at llambricht@texasnurses.org or 512-467-7027 ext. 105 for registration or exhibition information about next year.

Shame is 'King' in Sexual Compulsivity

by Helen Friedman, PhD

Picture the 40-year-old man whose wife sends him out on an errand to pick up pizza, but who cannot resist turning into a mall to cruise in the parking lot and expose himself. He returns home to his wife and their guests 4 hours later!

Or picture the individual who masturbates to the point of permanent genital injury, despite having been forewarned by the physician that the next time repair would be impossible.

Think of the character played by Diane Keaton in "Looking for Mr. GoodBar".

Approximately 3-6% of Americans are sexually compulsive. Of all the compulsive behaviors, it can be the most embarrassing, so people often don't seek help. Sexually compulsive individuals frequently express the feeling that it would be more acceptable to be alcoholic than sexually compulsive. While shame fuels all compulsive behavior, it is especially in the area of sexuality that shame is king. In our culture, most of our secrets are sexual in nature. It is something we still don't talk about much.

To the uninitiated, sexual compulsivity is hard to comprehend. Most people confuse it with a high sex drive. The two are very different. Sexual compulsivity isn't about enjoyment of sex as a way to be intimate with self or another. Instead, it is about disconnecting from inner sensibilities and anesthetizing emotional pain.

There are three criteria to tell if sexual compulsivity is present. The first is preoccupation with sex to the exclusion or neglect of work, health, family, and/or social relationships. Second, there is a loss of control. The individual vows, "I will never do this again," but does. Third, there are negative consequences, such as loss of marriage, job, health, financial stability, and standing in the community but the individual engages in the sexual behavior anyway.

Sexual compulsivity can take many forms. It can range from repetitive masturbation, marital sex in which the partner is objectified (a commodity), multiple affairs, pornography, and prostitution; to voyeurism, exhibitionism, obscene phone calls, and indecent liberties; to rape and child sexual abuse.

One of the newest forms is engaging in cybersex for extended periods of time. Cybersex includes online viewing and exchange of pornography, watching or engaging in live caller ID, and arranging online for sexual services or meetings offline. Cybersex is affordable, anonymous, and easily accessible. It is considered to be the crack cocaine of sexual compulsivity, because it can quickly escalate the progression of the disorder.

What causes sexual compulsivity? The answer is complex. Put simply, one doesn't develop sexual compulsivity without emotional pain. The purpose of any compulsive behavior is to relieve or anesthetize emotional pain, to induce a trance state, where the individual disconnects from painful realities and mood is altered. Individuals who become sexually compulsive typically have childhood histories of lack of nurturing and other forms of emotional, physical, or sexual trauma. The child finds sexual behavior to be a source of comfort, but also shame. Shame fuels compulsive behavior. That is, it results in negative feelings, and all the more need for the "fix." Ultimately this process becomes a cycle of despair, as the individual feels more and more out of control. Severe depression, even suicide, may result.

Sexual compulsivity can be viewed as an intimacy disorder. It is difficult to be intimate when there is a secret to keep. Furthermore, the preoccupation with sex results in isolation and emotional distance from others. Sexual compulsivity thrives on isolation. There is also lack of intimacy with the self, since sexual behavior is used to disconnect from painful inner awareness. To compound the problem, within the primary relationship the individual may be "sexually anorexic," actively withholding sexual intimacy, while secretly acting out alone or with others.

Treatment

As with any behavior, it is important to understand it in order to treat it. If sexual compulsivity is used to disconnect from inner sensibilities and painful realities, then healing involves the reverse process: connection to inner experience and awareness of and working through emotional pain. Goals of treatment include learning new coping skills; learning to self-soothe in healthy ways; resolving shame and guilt; improving self-esteem; and integrating sexuality as a healthy part of self and as a way of expressing care, so that it promotes intimacy. Therapy with a professional knowledgeable about sexual compulsivity is essential.

Twelve-step recovery groups geared toward sexual compulsivity can be invaluable in breaking isolation, reducing shame, promoting new coping skills, and providing ongoing support. Family members' involvement in treatment is important, to face the full reality of the disorder and to learn to create genuine intimacy, nurturing, and honesty in the family system. Throughout the United States, there are also specialized inpatient treatment programs that provide intensive treatment for both the sexually compulsive individual and the family.

A broad array of treatment tools is helpful to treat this recalcitrant disorder. Experiential therapies, such as gestalt and psychodrama, help the individual connect with the self at a deeper level. Cognitive therapy addresses denial and distorted thinking, including rationalizing, minimizing, and justifying to continue the sexually compulsive behavior. Behavioral techniques are useful to identify triggers and to prevent relapse. A family systems approach helps the individual to step back and look, in a non-blaming way, at the family-of-origin, in order to gain an understanding of family legacies.

Treatment is not a short-term process; healing does not proceed in a straight line. Slips are not uncommon, especially during the first year of recovery. It is not called "compulsive" for nothing! However, with a commitment to change and the right help, recovery is possible.

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Dr. Helen Friedman is a clinical psychologist in full-time private practice in St. Louis, Missouri, with 30 years of experience working with sexual trauma and sexual compulsivity. She has presented on these topics at national and international scientific conferences and has made numerous appearances on television, radio, and in print (New York Times, Washington Post, Jerusalem Post, USA Today, Los Angeles Times, New York Post, Psychology Today, Cosmopolitan, New Woman, Mademoiselle, SELF, Redbook, YM, CosmoGIRL!, Salon, etc.). Dr. Friedman is an associate clinical professor in the Department of Community and Family Medicine, St. Louis University School of Medicine; a former president of the St. Louis Psychological Association; and an advisor to the board of the Society for the Advancement of Sexual Health (SASH—formerly the National Council on Sexual Addiction and Compulsivity). She is the recipient of the 2005 SASH Merit Award "for exceptional commitment to the organization" and is featured in the book, *The Successful Therapist* (Wiley, 2005). You may contact Dr. Friedman at (314) 781-4500.

Penn. State Sex Scandal Not Unusual

by Mic Hunter, Psy.D., LMFT

For weeks now the print and broadcast media has been focused on the history of sexual abuse of boys allegedly at the hands of a beloved coach. Although you may not know any of the alleged victims at Penn. State, you most certainly know some males who were sexually abused. Research has found that 1 in 6 males in the general population report they were sexually abused before the age of 18, and that child sexual abuse is the most under-reported crime in America. The prevalence of sexual abuse is much higher in males who are in psychiatric and substance abuse treatment programs. MaleSurvivor.org is a free site for victims, their loved ones, and supporters. There is accurate information on prevalence, impact, and treatment options, as well as chat rooms where people can anonymously interact with others. This is particularly useful for those in places where face-to-face resources are not available. To give you an idea of how many people are seeking help:

Between January 1, 2010 & August 31, 2011 there were 2 million unique user hits to the web site (that is visitors who accessed the home page) which is more than 100,000 hits each month from all over the world.

Between January 1, 2010 & August 31, 2011, there have been 35 million page hits to areas of the web site beyond the home page (each time a visitor checks another section of our website, it is recorded as a separate page hit).

Whatever setting you are practicing, please post information on MaleSurvivor.org so that your clients know it is safe for them to disclose to you their histories of sexual abuse, and have a place to break out of their isolation.

Mic Hunter, Psy.D. Licensed Psychologist, Licensed Marriage & Family Therapist is based out of Saint Paul, MN and is the author of *Abused Boys: The Neglected Victims of Sexual Abuse*.

***"I have found myself. I do not want to let go of this person that I am now. Santé has helped me find my true authentic-self and for this I am truly hopeful and grateful for my future."
~ Santé Alumni***