Stick, twist or fold?

Paula Hall discusses the ethical choices for counsellors when an established client discloses a compulsive sexual behaviour disorder

Seeing a client for the first time is a bit like playing a game of cards. We have no idea what problems we'll be dealt, nor indeed what additional issues will be put in our hands along the way. What do we do when we're presented with an issue we're unsure about? Do we 'stick' and continue working with the client? Or, do we 'twist' and get as many additional skills and resources into our hands as we can? Or do we 'fold' and refer to a more experienced and specialist trained therapist?

Unlike a game of cards where the risk is totally our own, in therapy we're gambling with someone's mental health and hence 'folding' is often the most ethical thing to do if we don't have the training to work in a particular field. But what if the client can't afford specialist help, or if that help isn't available due to geography or other accessibility requirements? And what if we've been working with the client over a long period of time and they say, 'I don't want to start all over again with a stranger'?

There are many areas in therapy where additional training is recommended, such as trauma, sexuality issues, relationships and fields like my own, compulsive sexual behaviour disorders (most commonly known as sex or porn addiction). But that doesn't stop these issues presenting in general therapy. And for people struggling with their sex or porn use, it's not uncommon for disclosure to happen weeks, or even months, into therapy, once the therapeutic alliance is strong enough to counter feelings of shame. So, what do you do if a client tells you their sexual behaviours are out of control – 'stick', 'twist' or 'fold'?

1 Stick – continue working

Working with sex and porn addiction can seem daunting, not least because there is ongoing controversy over whether such issues are best understood as behavioural addictions or impulse control disorders. This debate continues despite the acceptance of compulsive sexual behaviour disorder (CSBD) into the 11th edition of the *International Classification of Diseases* (*ICD-11*) by the World Health Organisation in 2019. Thankfully, the majority of researchers agree that compulsive sexual behaviour is a real phenomenon with clinical implications.[1] The ongoing results of the International Sex Survey, a large, cross-cultural collaborative study in 45 countries, continue to provide important insights on prevalence, screening tools and theoretical understandings.[2] In the meantime, while these arguments may seem important to professionals, few clients care how their problem is classified, and are far more concerned about getting help.

Whatever your theoretical understanding, working with compulsive sexual behaviour is complex. A key part of the work is pragmatic behaviour change – identifying triggers, rewriting faulty cognitive scripts and developing meaningful relapse prevention strategies, all while navigating the highs and lows of motivation. But equally important is working on the conscious and unconscious underlying issues, including those that might have caused or significantly contributed to the cause of the problem, and those that are blocking clients from making the changes they say they want to make. In this work, it's not enough to ask why a client is here – we must also ask why they are still here and why they keep coming back.

When the compulsive behaviours are sexual, another key component of the work is helping clients to identify what positive sexuality means for them and how they can express their sexuality in a way that enriches their life. In addition, many arrive for therapy because of the consequences of their behaviour, such as relationship breakdown, disciplinary action or social isolation, all of which also need to be addressed.

Deciding whether or not to 'stick' and work with the presenting problem will depend on your individual level of training and experience, and also on the severity of the problem. If the client has been struggling with the behaviour over many years and has had many failed attempts at stopping, including other forms of therapy, then you may decide that 'folding' and seeking specialist help is the best approach. Similarly, if the potential consequences of further relapse are severe, such as divorce, committing a sexual offence or wanting to end their life, then the most ethical decision will be to help them find specialist help as soon as possible. You might also decide that it's time to 'fold' if you're not making progress. While it's tempting to blame the client if they continually relapse, sometimes it's the therapeutic approach that isn't working.

2 Twist – add more resources to your toolbox

There are probably more tools available for developing positive mental health today than at any point in history, primarily fuelled by the technology industry, but also by demand. The digi-health market has been growing consistently for a number of years but COVID 19 sent that growth stratospheric. Downloads of mental health apps increased by around 200% from summer 2019 to summer 2020 and there are currently an estimated 350,000 wellness apps on the market.[3]

Self-help is, of course, nothing new – it's common for clients to bring reflections and ideas from self-help books into the counselling room and, in turn, for counsellors to recommend further reading to supplement their work. But we're also increasingly more likely to recommend digital support, and in the field of sex and porn addiction there are a growing number of digital resources available. These include relatively simple apps that block adult content and provide 'accountability' reports to designated recipients, such as Covenant Eyes, which has 1.5 million users. There are also more complex apps such as Remojo, which reports more than 250,000 downloads, and provides content blocking, self-mastery courses, coaching and an online support community. You can also find a number of self-help forums with a range of additional services – NoFap, a porn addiction recovery forum, is currently the biggest with 333,000 registered members and a similar number of regular visitors.

I recently added to the digi-health field with Pivotal Recovery (www.pivotalrecovery.org), a not-for-profit, web-based recovery course for sex and porn addiction that consists of 60 podcasts and an accompanying workbook. The programme went live in September 2022 following a feasibility study, and we are currently undertaking a pilot study in collaboration with the University of Leeds. Meanwhile, we've received a number of enquiries from therapists who've wanted to signpost to the site and some from counsellors and health advisers within the voluntary ▶

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sector who have asked if they can continue to work with clients alongside the programme. The unequivocal answer to that question is yes. Furthermore, users will almost certainly gain more from the programme, the more opportunity they have to reflect on the content and develop insight.

The programme follows the six steps of the CHOICE recovery model.[4] The first seven sessions provide basic psychoeducation on compulsive sexual behaviours from a bio-psychosocial perspective before leading into step one - challenging core beliefs, especially any damaging self-beliefs that have previously sabotaged recovery. Step two helps build motivation using the principles of positive psychology, while step three provides the nuts and bolts of practical behaviour change. Step four focuses on identifying positive sexuality, and step five on the importance of relationships and healthy attachments. Finally, step six, which is the longest, is about establishing confident recovery. With any addiction, stopping is the easy bit, staying stopped is the challenge, hence this final step is all about life change - understanding the role of trauma, managing uncomfortable emotions such as anxiety and depression, anger, loneliness and low self-esteem, establishing boundaries and building resilience.

While the programme has been designed to be self-guided, there will inevitably be times when it raises more questions than answers and, indeed, times when the content may be challenging or even triggering. These are the times when working with a counsellor would make the programme much more effective.

3 Fold – refer to a specialist

If you're looking to refer a client for specialist help with sex and porn addiction then the Association for the Treatment of Sexual Addiction and Compulsivity (ATSAC) is a good start. ATSAC was founded more than 10 years ago to provide a specialist register of counsellors and organisations with additional training and experience in the field. Regrettably, some continue to refer clients to psychosexual therapy, assuming therapists receive sufficient training in working with compulsive behaviours, but alas this is not the case. Similarly, some counsellors refer to addiction therapists but they have little or no training in human sexuality. As discussed earlier, CSBD is a complex disorder, requiring focus on pragmatic, sustained behaviour change as well as addressing conscious and unconscious underlying issues, and helping clients enjoy their sexuality - hence training must cover many bases.

In some instances, counsellors are highly experienced and confident working on the underlying and contributing issues, but lack the skills to work effectively with behaviour change. In these cases, an effective option would be to continue to work with the client individually and refer to a recovery course for the relapse prevention work, such as those provided at the Laurel Centre, a specialist centre for sex and porn addiction therapy (www.thelaurelcentre.co.uk), which has been proven to be effective for reducing and stopping unwanted behaviour.[5] Co-working with other therapists is common practice in some organisations and in some modalities, but some in private practice fear that boundaries may be blurred, which could confuse clients. In my experience this is not the case when the client is collaboratively involved in the referral process.

In the field of compulsive sexual behaviours where specialist therapists continue to be few and far between, and where NHS provision is almost non-existent, working alongside a professionally created online resource can be a cost-effective option, and it's an option that will undoubtedly be significantly more effective when emotional support continues to be provided by a counsellor. The ever-expanding range of digi-health products can also provide valuable additional resources to a therapist's toolkit to enable therapists to continue to work with clients who need specialist help but who can't be, or don't want to be, referred.

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Clients will inevitably present us with problems and issues we don't feel sufficiently trained or experienced to work with, and when that happens we must decide whether to 'stick' with the work, 'twist' and gain more skills and resources, or 'fold' and refer to another therapist. This is a decision that's always best discussed in supervision, with the best interests of the client, and safe and ethical practice, as core guiding principles. ■

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About the author

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