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7 Questions Before You Hire a CSAT

A print-ready interview guide for the first consultation call with a Certified Sex Addiction Therapist or any infidelity-focused clinician.

The CSAT credential alone tells you almost nothing about whether a clinician will help you or pathologize you. The questions below are diagnostic. They identify which clinical tradition a practitioner actually operates in, and they separate genuine framework fluency from inherited vocabulary used without examination. Each question includes guidance for interpreting the answer in real time.

> A clinician who reacts to any of these questions with irritation, dismissal, or the phrase *I don't really get into all that theoretical stuff* has given you the answer regardless of what words followed.

QUESTION 1

Do you use the co-addict or co-dependent label for me as the betrayed partner?

Why it matters: the original sex-addiction framing treated the partner's symptoms as parallel pathology. Trauma-informed practice has since rejected this framing explicitly, on the grounds that hypervigilance and emotional dysregulation are trauma responses to sustained deception rather than evidence of the partner's own disorder.

> **TRAUMA-INFORMED ANSWER**
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> Rejects the label; names the partner as a trauma survivor, often referencing Minwalla's DSTT framework or APSATS's Multidimensional Partner Trauma Model.
>
> **RED-FLAG ANSWER**
>
> Still uses co-addict or co-dependent without qualification. May reframe as "betrayal trauma" but continue to work from a systems-pathology framework.

QUESTION 2

What is your approach to disclosure: structured or emergent?

Why it matters: structured disclosure (eight to twelve weeks of preparation, a single comprehensive written account, a therapeutic event with both clinicians present) produces better long-term outcomes than disclosure that emerges across sessions. Kevin Skinner's research specifically supports the structured model. Emergent disclosure reproduces the original trauma mechanism because each new revelation confirms that deception is still operating.

TRAUMA-INFORMED ANSWER	RED-FLAG ANSWER
Full Therapeutic Disclosure (FTD) over weeks of preparation, often with polygraph integration, and clear sequencing of individual work before couples work.	Emergent, "as it comes up in sessions." May describe disclosure as "letting it out naturally" or "whenever the unfaithful partner is ready."

QUESTION 3

Do you see my partner's behavior primarily as an addiction, or primarily as sustained deception?

Why it matters: this is the question that reveals the clinical framework most directly. Both positions are defensible, but they are not the same treatment plan. An addiction frame targets sobriety. A deception frame targets integrity across all domains. A clinician who cannot articulate which one they use, or who pivots without coherence, is working without a framework rather than working across frameworks.

TRAUMA-INFORMED ANSWER	RED-FLAG ANSWER
Can articulate their framework clearly. Either names the behavior as primarily deception (DSTT-aligned) or describes a thoughtful addiction framework while acknowledging its critiques.	Cannot articulate framework. Waves off the question as theoretical. Says some version of "I just help people, I don't get into all that."

QUESTION 4

What is your position on couples therapy while deception is still being uncovered?

Why it matters: the trauma-informed position is that couples therapy is contraindicated while integrity abuse is active and undisclosed. Attempting to do relational repair inside a relationship where one partner is still operating a hidden compartment recapitulates the original dynamic. The partner is asked to regulate their trauma so the work can proceed, and the underlying deception continues to cause new injury under the couples-therapy container.

> **TRAUMA-INFORMED ANSWER**
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> Individual work first, structured disclosure second, couples work third. Names couples therapy as contraindicated while active deception remains.

> **RED-FLAG ANSWER**
>
> Willing to begin couples work immediately. Frames the infidelity as one issue among many the couple can address together.

QUESTION 5

Are you familiar with the DSTT model, APSATS, or other trauma-first frameworks, even if you do not practice within them?

Why it matters: the specific framework names matter less than whether the practitioner recognizes them. A clinician who has never heard of Deceptive Sexuality and Trauma Treatment, the Association of Partners of Sex Addicts Trauma Specialists, or the Multidimensional Partner Trauma Model has not read the field's major recent critiques. A clinician who recognizes the frameworks and can describe where their own practice agrees or disagrees has current clinical literacy.

> **TRAUMA-INFORMED ANSWER**
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> Recognizes DSTT, APSATS, MPTM. Can describe their relationship to each. May name Minwalla, Mays, or other primary sources in the field.

> **RED-FLAG ANSWER**
>
> Has not heard of any of them. Reacts as if the question is obscure. Treats clinical currency as optional.

QUESTION 6

How do you address the betrayed partner's trauma specifically, beyond the couples work?

Why it matters: the betrayed partner's trauma is not downstream of the offender's recovery. It is its own clinical entity requiring its own treatment, typically trauma-specific modalities such as EMDR, somatic approaches, or trauma-focused CBT.

TRAUMA-INFORMED ANSWER	RED-FLAG ANSWER
Describes individual trauma-specific work, either with the same clinician (if scope permits) or through an active referral pathway.	"We handle that in couples sessions." Or: "The partner's trauma resolves as the addict's recovery progresses."

QUESTION 7

If I feel blamed in our work together, what is the repair process?

Why it matters: this question tests something different from the others. It tests capacity for relational repair and humility. Every clinician will occasionally produce a rupture in the therapeutic alliance. Capacity to repair that rupture is what separates durable therapeutic work from iatrogenic harm. In the middle cases where other answers are ambiguous, this question is often the tiebreaker.

TRAUMA-INFORMED ANSWER	RED-FLAG ANSWER
Describes an actual repair process, including clinician responsibility for noticing ruptures and naming them. May invite the partner to raise concerns early and often.	Reacts defensively. Says "I wouldn't do that" or "that hasn't come up." Cannot imagine their own contribution to alliance rupture.

How to score the answers

A clinician who gives trauma-informed answers to six of the seven is usually workable. A clinician who gives two or fewer trauma-informed answers is not the clinician for this situation, regardless of credentials, reputation, or fee schedule. The middle cases are where the judgment is hardest, and in those cases the seventh question tends to be the tiebreaker.

These questions do not test personal fit — voice, pace, presence. That is a separate evaluation, and fit inside a sound framework often develops over the first three or four sessions. What the questions test directly is whether you will be pathologized for having been deceived. That is the variable most worth testing before committing to weekly work.

PRINTABLE QUICK REFERENCE

Four questions for the first five minutes

If the call is short and you only have time for the essentials, these four questions compress most of the diagnostic value. Ask them before you are asked about insurance.

1. Do you still use the co-addict or co-dependent label for betrayed partners?
2. Is your approach to disclosure structured, or does it emerge across sessions?
3. Are you familiar with the DSTT or APSATS frameworks?
4. If I feel blamed in our work together, how do you repair that?

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Deceptive-sexuality-and-trauma-informed individual and couples therapy
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