Working with Compulsive Sexual Behavior and Sex Addiction: A Contemplative Approach

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Abstract

Contemplative Psychotherapy offers a powerful lens through which clinicians can approach the complexities of human suffering and identity exploration, including in the context of sex and sexuality. Through the cultivation of mindfulness and self-awareness, therapists can create a supportive environment for clients to bravely explore their own identities and behaviors. However, this process necessitates a significant amount of introspection on the part of the therapist in order to understand their unconscious biases and assumptions around “healthy” and “moral” sexual behavior. Clinicians must recognize the importance of inclusive definitions of “healthy sexuality” that underscore the variability in human sexual behavior. Challenging societal norms and biases in the therapeutic space must be normalized to provide effective, nonjudgmental care. Through discussion of compulsive sexual behavior, this paper will attempt to deconstruct some of the factors that ultimately determine how we define “healthy” vs “addictive” sexual behavior. It will also demonstrate the ways in which a Contemplative Psychotherapeutic approach can be used to avoid the pitfalls of many traditional approaches, while compassionately and effectively working with compulsive sexual behavior.

Key words: sex, sexuality, porn, addiction, contemplative psychotherapy

Author’s Note

Much has already been written about the pitfalls of gendered norms and the limitations and dangers that 'masculine' or 'feminine' labels can impose on us. While I do not intend to explore gender directly in this paper, I would be remiss not to note the fact that - whether we subscribe to these ideas or not - we live in a gendered world that attempts to make sense of things within a binary (good/bad, male/female, and so on). Many of the books written and research conducted on sex and porn addiction is specifically on men and their relationship to their masculinity and their sexuality. I have attempted to "neutralize" some of the language where it makes sense and would not be harmful to do so; for example, in places where the literature notes "men and women" I have opted to use "people".

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Most if not all of us have deeply embedded notions as to what constitutes "normal" or "moral" sexual behavior. These notions influence both the way we treat compulsive sexual behavior societally as well as the work we as clinicians do with individuals exhibiting these behaviors. As clinicians, we must examine our personal reference points and biases within larger systems that uphold limiting views of what is sexually moral, healthy, permissible, or ethical. Only with this self-awareness can we work effectively with our clients to understand their needs and help them grow.

My introduction to "sex addiction" (which we categorize under the "compulsive sexual behavior" umbrella) came in the form of a class through the Institute for Sexuality Education and Enlightenment (ISEE), where a lecturer attempted to dissuade the class that sex addiction exists at all and should instead be considered ‘out of control sexual behavior’. While I did not have much of an opinion on the matter at the time, I more recently came to develop my own understanding of compulsive sexual behavior through my clinical work. As part of my degree requirement for a master’s in Contemplative Psychotherapy, I was placed at a sex and porn addiction treatment center for several months to complete my practicum. I worked primarily in groups with people experiencing sex and porn addiction, as well as in groups and 1:1 therapy with their partners.

During my time at the sex and porn addiction treatment center, I saw traditional views of “healthy” sexuality being reified through the discourse of treatment for “non-normative” behavior. While some clinicians identified as recovering sex addicts, others, like myself, were merely interested in the topic as an area of focus. Most of the language and literature used in this

center was extremely gendered and lacked a queer perspective or approach. Additionally, due to the nature of our faith-based programs (synonymous in this case with Christian programs), therapeutic approaches often upheld deeply religious beliefs that centered a heterosexual view of the world (ie. heteronormativity) and positioned most non-conventional sexual behavior as potentially problematic.

It is the perspective of the author that clinicians and diagnostic literature alike should maintain an overarching assumption that sex and sexuality are integral parts of healthy human development. This requires inclusive definitions of sex and sexuality, acknowledging the variability and the positive influence of sexual desires, attractions, intimacy, orientation, and eroticism on individual, relational and community development (Clements, 2023).

> The denial of pleasure is characteristic of oppressive systems. Any social order - or religious ethic, for that matter - that discourages people from trusting their feelings, especially their sensuality, or from enjoying their bodies will be experienced as oppressive to the human spirit. Instead of trying to restrain sexual expression through fear, shame, and other social sanctions, we should be enhancing people's interest in growth toward mature intimacy relations (Ellison, 1996, p.77).

Ellison, while not speaking directly of beneficence (our ethical duty as clinicians to act in the client's best interest), emphasizes the need for clinicians with role power to empower others to explore sexual pleasure and variety, rather than upholding the status quo. The clinician's role is to prioritize the well-being of their clients, provide compassionate and effective care, and empower clients to improve their quality of life, whatever form that may take. Therefore, a clinician's

personal views must be in alignment with providing accurate and effective information and treatment to clients. If we, as clinicians, can reserve our judgments about a client's sexual behavior - provided it is legal, consensual, and free from abuse - we can create openness and curiosity in hearing from the client about what is problematic or distressing.

This is easier said than done, especially in the context of sex and sexuality. As you read this paper, try to notice if you make judgments about "sex addiction" or "sex addicts". What assumptions you are making? In thinking more generally of addiction, we might assume to know exactly what is being discussed. However, there is a lot of variability in who is a sex addict and what their actual behaviors are; many of them arguably should not be labeled as sex addicts just because they find their own behavior distressing.

Patrick Carnes (1983), the original expert on sex addiction in the 1980s, defined sex addiction as any sexually compulsive behavior seen as interfering with daily living and that has resulted in severe stress on the individual, their loved ones, and their work environment. Based on this more traditional definition, we can see how stigma and bias can easily creep in. If an individual's family and community is homophobic, for example, then any non-heterosexual activity by this individual could be seen as "resulting in severe stress"; perhaps the resulting shame, guilt, or fear as a result also impacts this individual's daily living. Are they then a sex addict beacuse they are compelled to engage in non-heterosexual sexual acts?

It becomes obvious that we need to have some shared and useful understanding of addiction in order to proceed. One of the most practical definitions I have come across is from Canadian physician, Gabor Maté. In his TEDx talk, Maté (2012) defines addiction as "any behavior that gives you temporary relief, temporary pleasure, but in the long term causes harm, has some negative consequences and you can't give it up, despite those negative consequences."

Maté's definition is broad and could obviously encompass a whole range of addictive behaviors that many clinicians would debate, whether that is shopping, use of our mobile phones, or sex itself.

Even so, why is there such a distinction between watching porn and watching Tik Tok or the NFL? Many clients I have seen at the walk-in Crisis Center where I currently work report using social media, Reddit, or Youtube to regulate themselves or to unwind at some point nearly every day. Many of us cannot be without our phones for more than a few minutes. And yet, the person watching porn weekly or the person wanting to have sex daily is deemed "addicted". Now, I'm not advocating there is anything healthy or unhealthy about these behaviors. The real interest I have is in when the client reports the behaviors have become problematic.

Ellison (1996) describes sexuality as a critical form of communication. What is our sexual behavior trying to communicate? By paying attention to a client's sexual behavior, we can get greater insight into their needs, wants, fears, desires, and even their grief. Maté (2012) says that "if you want to understand addiction, you can't look at what's wrong with the addiction; you have to look at what's right about it". In what ways is the addiction meeting needs that the individual has? When it comes to sex addiction, "addicts may perpetually feel abandoned, unwanted, scared, helpless, hurt, lonely, and isolated, and they use sex outside of the primary relationship to keep these feelings at bay" (Barta, 2018, p.9). By acknowledging sexuality as a profound mode of expression and recognizing the underlying needs driving addictive behaviors, clinicians can foster a deeper understanding of clients and offer more effective support in the journey towards client healing and fulfillment.

As a contemplative counselor and scholar, it has been my undertaking to explore an alternative understanding of compulsive sexual behavior, examining some of its roots,

manifestations, and associated terminology. I aim to foster a fresh perspective on how we can approach clinical treatment and healing with greater effectiveness and compassion by using a Contemplative Pschotherapeutic approach. In doing so, I hope to underscore the vital role of the therapeutic relationship, emphasizing the importance of clinicians with role-power engaging in their own inner work. This inner work involves cultivating mindfulness and loving-kindness through training in meditation, which allows therapists to develop greater self-awareness and mitigate the impact of their own biases on the therapeutic process.

Treatment of compulsive sexual behavior can illustrate extreme examples of when clinicians fail to do the things that an effective contemplative psychotherapist is supposed to and the ways we will show up poorly for our clients as a consequence. Whether that is by bringing in our own unexamined biases, being therapeutically aggressive or judgmental towards our clients, or being unable to notice and manage our own discomfort while in session. In this paper we will discuss the drawbacks of traditional approaches to sex and addiction therapy, how these challenges happen in individual cases and at the level of the discipline, and how a contemplative approach offers an antidote to many of these pitfalls.

In navigating this work, I recognize the inherent complexities of my identity as a white queer individual, which inevitably informs my perspectives on sexuality and sexual behavior. My understanding of what constitutes "healthy" sexuality is a culmination of mainstream and nontraditional influences, shaped by my own experiences as well as broader societal norms.I firmly believe that healthy sexuality is individual and personal, despite being influenced by family, community, and cultural values. It is crucial to acknowledge that my social identities, encompassing aspects such as gender, race, and education, inevitably color my interpretations of research and inform my approach to supporting clients. Thus, my exploration of compulsory

sexual behavior is inherently situated within the context of my queer, white, educated, contemplative, liberal, and progressive perspective. It is imperative to approach this exploration with an open mind, recognizing both its potential insights and limitations, and to consider alternative viewpoints with curiosity and respect.

Traditional Approaches to Sex Addiction

The term 'sex addiction' has gained increased prominence in popular discourse, particularly fueled by instances of politicians and celebrities seeking to manage their sexual misconduct in private, often with support from eager and accommodating medical systems looking to make a profit or corner a new market. The intersection of sexual "misconduct" with addiction offers a convenient spectacle, drawing ongoing public attention. Clinicians and diagnostic tools have not been impervious to this influence. Overall, the diagnosis of sex addiction has been heavily influenced by media and popular culture in ways that reflect our broader societal attitudes toward sexuality, addiction, and mental health. This is reflected in the way that compulsive and addictive sexual behavior has been addressed, or sometimes overlooked, in the latest editions of leading diagnostic manuals.

Compulsive sexual behavior disorder (CSBD) is a relatively new diagnosis, only just recently included by the World Health Organization (WHO) in its 2021 edition of the International Classification of Diseases, the ICD-11. CSBD is classified by the WHO as an impulse disorder, characterized by an ongoing (e.g. 6 months or more) inability to control persistent, intense sexual urges, with resulting patterns of sexual behavior that are experienced as disruptive and distressing (2021). The argument can be made that sex or porn addiction easily meets these criteria and could be properly diagnosed as CSBD. However, due to a lack of

empirical evidence around compulsive sexual behavior, CSBD was not included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013).

While sex addiction is not listed in either as an official diagnosis, there is plenty to be said about how sex and sexual disorders are classified and discussed in the DSM and the ICD. "Erotic energy is viewed as an alien, negative force impinging from the outside on the 'real' self and threatening reason and order. When viewed this way, sexuality becomes a problem that individuals and society must manage, by external controls if necessary"(Ellison, 1996, p.55). Because of this, our diagnostic tools have been rife with discrimination and bias, influenced by popular culture and changing social norms. For example, homosexuality was listed as a disorder in the DSM until 1973 (Drescher, 2015) - not all that long ago - and many sexual behaviors that fall within a fairly common range of human experience are pathologized and listed as paraphilias. Beyond diagnosing official disorders, clinicians may still pathologize consensual behaviors like the exploration of various kinks and fetishes, despite a client's expression of the positive experiences and benefits these behaviors may offer.

Another challenge has been "trying to identify and quantify exactly how much of a particular sexual behavior it takes to qualify for a diagnosis" (Joannides, 2012, p.72). There is then significant inconsistency in how research is conducted and study participants are recruited, given that clinicians and participants alike are not speaking with the same language. Joannides (2012) notes that the clinical approach to diagnosis regarding sexual behavior seems to be that if there is "too much" of a given sex act, the client is diagnosed with sex addiction or compulsive sexual behavior, whereas if there is "too little" then they are diagnosed with hypoactive sexual

disorder.. But who gets to decide what is "too much" or "too little"? Cultural, familial, and religious norms seem to dictate so much of what is deemed appropriate behavior.

Given these inconsistencies, clinicians need to be all the more wary of jumping hastily to diagnose without considering both the harmful implications or the beneficial value in giving someone a diagnosis. A psychiatric diagnosis has serious consequences: “Diagnosis informs treatment, and getting the wrong treatment can have disastrous effects. Also, a diagnostic label is likely to attach to people for the rest of their lives and have a profound influence on how they define themselves” (van der Kolk, 2014, p139). Whats more is many researchers and clinicians believe that the distinction between paraphilic disorders and sex addiction is slim, if non-existent, despite the fact that the DSM classifies paraphilic disorders separately (Joannides, 2012). Thus, not only is it important to understand and clearly define a diagnosis if applying one, discussing how a client will or currently does/does not relate to their diagnosis is worth deeper exploration.

In support of diagnosis, there are all kinds of scales, surveys, scoring sheets, criteria, and language being used to describe sex addiction or compulsive behaviors. While aspects of them can be useful, I am admittedly disinterested in the particulars or differences between them for the purposes of this paper. Their goal is to pathologize a range of human sexual experiences and attitudes, while in reality “one person's normal sexual behavior might be another person's out-of-control behavior" (Joannides, 2012, p.69). I believe there may be a way to assist a patient or client that doesn't necessitate diagnosis in the instance of sex addiction. Truly helping a person depends on understanding where they are at - what is distressing about their sexual behavior, what needs is sexual behavior meeting or not meeting, how they are relating to it, and where

their beliefs, attitudes, and values originated. Effective treatment planning is possible in working with the energy of the client, their motivations, and their inner and outer resources.

This would also be a good place to mention that there is a major difference between self-identifying (or diagnosing one's partner) with sex addiction based on personal or religious values versus using qualifying DSM or ICD criteria. There are plenty of people who classify any porn use or any extra-marital sex immediately as an addiction or compulsion. A prime example of this is evident in a friend of mine, post-college, who considered any engagement with pornography as unacceptable, akin to infidelity. She even threatened to divorce her new husband upon discovering it in his browser history. Despite the severity of her reaction, further investigation revealed that her husband's behavior did not align with the compulsive or distressing patterns associated with addiction; rather, it posed challenges within their relationship dynamic that were rooted in different sexual values. Such misconceptions about sexually compulsive behavior, whether self-diagnosed or perceived by a partner, are not uncommon in relationships here in the United States.

Another common experience is for differences in values or desires to cause significant conflicts within relationships. However, what distinguishes these conflicts concerning sexual behavior is their potential to be pathologized within dominant mental health models. In relationships where one partner has a higher sex drive or expresses interest in unconventional or socially marginalized behaviors, their preferences may be "perceived as pathological, depending on the clinician's ideas about 'normal' sexuality and its expression" (Joannides, 2012, p.72). This tendency to pathologize certain sexual behaviors highlights broader societal attitudes and underscores the need for a more nuanced understanding of sexual diversity within therapeutic contexts.

While distress can be an important signal that there is something in need of attention, perhaps a more useful indicator in the case of compulsive sexual behavior is noticing when a lack of control or agency over one's sexual behaviors becomes present. As a behavior becomes more compulsory and an individual loses the ability to choose when and how to engage, this is likely a sign that something has gone from just an activity to an addiction. Carnes (1989) notes that "contrary to enjoying sex as a self-affirming source of physical pleasure, the sex addict has learned to rely on sex for comfort from pain, nurturing, or relief from stress, etc." (p.5). People who develop sex or porn addictions have learned to use "behaviors such as sexual pleasure to relieve emotional dysregulation" (Barta, 2018, p.10). But where did this dysregulation originate and why the need for self-soothing?

The interplay between compulsive sexual behavior and trauma is complex, shaped by a variety of environmental factors and personal experiences. Compulsive sexual behavior often emerges as a coping mechanism for individuals grappling with some type of unresolved trauma, frequently from childhood (Barta, 2018; Carnes, 1989). Trauma disrupts "the proper balance between the rational and emotional brains", leaving individuals either hyperaroused or shut down, impeding their capacity to learn from experiences and respond adaptively to stressors (van der Kolk, 2014, p.207). Consequently, sexual behavior may serve as an unconscious and readily available response to overwhelming emotions and sensations; sexual stimulation can offer a semblance of control and system-regulation amidst the experience of internal chaos.

As individuals turn regularly to these behaviors as a means of seeking comfort from emotional distress or relief from stress, their bodies adapt. "Once hooked on the biochemicals that these regulatory behaviors and substances provide, what was once solely an issue of unresolved traumatic experience now becomes a much bigger problem of addiction" (Barta,

2018, p.86). " Sex and masturbation then elbow their way into a role as primary coping mechanisms at the expense of other aspects of their lives. “The obsessional illness transforms sex into the primary relationship or need, for which all else may be sacrificed, including family, friends, values, health, safety, and work" (Carnes, 1989, p.5). This is usually the point at which the compulsion or addiction starts to have consequences that outweigh the original benefits. There may be resulting upset, distress, and turmoil in the individual’s day to day life and relationships, which eventually leads to either a breaking- or existential-point where treatment is sought out.

Generally, options for traditional sex addiction treatment have considered both psychological and behavioral perspectives. Common interventions include psychotherapy and counseling (which could be in the form of individual, group, family, or relationship therapy), 12-step programs (such as Sex Addicts Anonymous or Sexaholics Anonymous), or medications. While medication is typically not a standalone treatment, it can play a supportive role in managing underlying mental health conditions, such as borderline personality disorder or bipolar disorder, which can contribute to compulsive sexual behaviors and sex addiction (Toates, 2022). Regardless of approach, **e**ducation related to healthy sexuality and boundaries plays an important role in treatment. Individuals can learn to differentiate between healthy sexual behavior and compulsive or harmful sexual behavior and develop skills for establishing and maintaining healthy relationships. Individuals must also work to develop new coping skills to manage cravings and urges, creating a support network, and making lifestyle changes to reduce opportunities for engaging in compulsive behaviors.

It is important to note that, regardless of approach, treatment for sex addiction should be highly individualized; what works for one person may not work for someone else. Traditional

approaches generally include some combination of the above strategies, depending on the individual's needs and circumstances. But what does recovery from sex addiction actually look like and what are the goals for sex addiction treatment? When we think of connection between trauma and addiction, it makes sense to take note of the work of Bessel van der Kolk, a trauma professional, and his description of what recovery actually looks like:

> The challenge of recovery is to reestablish ownership of your body and your mind - of your self. This means feeling free to know what you know and to feel what you feel without becoming overwhelmed, enraged, ashamed, or collapsed. For most people this involves (1) finding a way to become calm and focused, (2) learning to maintain that calm in response to images, thoughts, sounds, or physical sensations that remind you of the past, (3) finding a way to be fully alive in the present and engaged with the people around you, (4) not having to keep secrets from yourself, including secrets about the ways that you have managed to survive (van der Kolk, 2014, p. 206)

When I consider van der Kolk's view of recovery, a contemplative psychotherapeutic approach aligns closely by providing a framework for individuals to reestablish ownership of their body and mind and reclaim their sense of self. As we will see, a Contemplative approach can help clients orient to the present moment through the use of mindfulness techniques, and through greater self-awareness and self-regulation. This involves being fully present and aware of one's thoughts, emotions, and bodily sensations without judgment or reactivity. By learning to anchor themselves in the present moment, individuals can regulate their emotions and responses to triggers from the past, thus maintaining a sense of calm amidst distressing experiences. There

is a fundamental belief that there's help for someone even if the behavior they are presenting with is neurotic and a potential for circumstances, behaviors, habits, attitudes, and beliefs to shift.

An Introduction to Contemplative Psychotherapy

Rooted in a perspective that approaches reality quite differently from traditional Western methods, Contemplative Psychotherapy's belief in humanity's fundamental goodness offers a holistic approach to understanding and addressing mental health concerns. It embraces a view of human beings as *brilliantly sane* yet often deluded and unaware of repetitive (or potentially harmful) thought and behavioral patterns. It emphasizes the cultivation of self-compassion, awareness, and non-judgment, recognizing the interconnectedness of all beings, as well as the pervasive influence of our unconscious habits. The therapeutic process focuses on increasing our capacity to bring awareness to internal states and storylines, while fostering deeper intimacy and relational skills. The approach is non-pathologizing and non-aggressive, aiming not to fix or change individual clients but to support their journey towards self-awareness and growth.

Meditation and mindfulness play pivotal roles in contemplative psychotherapy, offering both therapists and clients powerful tools for self-awareness, emotional regulation, and transformation. Meditation is seen not merely as a personal practice but as a foundational aspect of contemplative therapeutic work. It serves as a starting point for cultivating mindfulness, awareness, and compassion, enabling therapists to be fully present with themselves and their clients (Strong, 2021; Wegela, 1994). Through meditation, practitioners learn to be with themselves and watch what their mind does, as well as the stories they create about themselves and others. Meditation, when used as a personal practice by clinicians, can thus become a useful tool in noticing where the desire to pathologize a client or a clinician's own bias may be creeping

into the therapeutic space. Additionally, meditation and mindfulness practices can help therapists become less self-centered, more flexible in treatment, and attuned to both themselves and others in the present moment (Strong, 2021; Wegela, 1994).

By embracing a non-pathologizing stance and emphasizing the healing power of relationships, contemplative psychotherapy supports individuals on their journey towards self-discovery and growth. There are several critical components or core practices that include brilliant sanity, maitri, and exchange and I will explore each of these in turn.

Brilliant Sanity

Contemplative practices can be extremely useful in reconnecting with our inner wisdom and our 'whole self' by tapping into *brilliant sanity* (sometimes known as 'buddha nature'), or our inherent nature of compassion, awareness, and openness (Wegela, 1994; Patton, 1994). In contemplative psychotherapy, the commitment to recognizing and returning to brilliant sanity is fundamental. Contemplative psychotherapists recognize that as human beings, we often try to find happiness by doing the very things that produce suffering and pain. Suffering may then manifest in a variety of ways, including negative emotions (discomfort, anger, longing, etc), aggression towards self and others, unhelpful habitual patterns, and so on. It may also look like grasping for positive feelings, like joy and pleasure, while rejecting our current experience and whatever it is bringing us. However, "whenever we are not trying to maintain ego and its storylines, our true nature shines through. It cannot help itself" (Wegela, 1994, p.37).

Both meditation and mindfulness practices can help to bring down the walls between therapist and client, allowing for more connection and exchange to happen. Having cultivated their own direct connection with brilliant sanity through meditation, clinicians can guide clients

towards recognizing their own innate wisdom and compassion (Wegela, 1994). This perspective serves as an antidote to traditional narratives surrounding mental health pathology, promoting healing, resilience, and growth instead. By embracing this concept of basic goodness, therapists nurture clients' ability to recognize their inner wisdom, fostering a therapeutic environment grounded in unconditional positive regard and attuned empathic attention (Strong, 2021). This shift away from the traditional approach, which often views clients as fundamentally flawed, enables therapists to support clients in cultivating awareness and action, acknowledges the wisdom and truth of their personal experiences, and thereby facilitates client transformation.

Maitri

Commonly translated as loving-kindness or friendliness, *maitri* refers to the process of "making friends with oneself as the starting point for developing compassion for others" (Trungpa, 2005, p.191). In contemplative psychotherapy, maitri involves allowing whatever arises (thoughts, feelings, behaviors, etc) to be present without the need to control, judge, or manipulate it, fostering a sense of unconditional warmth and acceptance towards oneself and others (Wegela, 1994). By nurturing maitri, individuals can learn to be present with their experiences and develop a sense of unconditional friendliness towards themselves, others, and their overall experience. Ultimately, the practice of maitri empowers individuals to navigate their inner and outer experiences with mindfulness and compassion, creating an environment that is conducive to growth and healing.

Extending maitri, or unconditional love, to others can be a challenge for us, "largely because we cannot exercise control over the behavior of someone else and we cannot predict or utterly control our responses to their actions" (hooks, b., 2000, p. 67). The contemplative approach supports letting go of control and needing to anticipate or account for other's actions.

We have the potential to create more awareness and acceptance of what is happening in the moment without needing to change, push, or rage against it. This applies to therapy in that it need not be a self-aggressive process; contemplative clinicians can encourage clients to focus on the present moment and let go of their attachment to end results (e.g. “getting rid of my anxiety”). This attitude of openness and acceptance to whatever is brought into the therapeutic space can promote self-compassion, acceptance, and resilience in clients, enhancing the therapeutic relationship and potentially rallying clients’ inner strengths along a path to healing (Wegela, 1994).

Exchange

Put simply, *exchange* is an individual's direct experience of someone else. Exchange underscores the interdependence and deep connection between individuals: "exchange occurs because we are not solid, separate, and permanent selves; we are connected with others. Therefore, we can pick up on, or tune in to, what is happening with somebody else" (Wegela, 1994, p. 42). It is a common human phenomenon that happens because we are permeable and interconnected, often communicating with each other in nonverbal ways (Strong, 2021).

When it comes to exchange, it is important to note that the clinician is not in fact feeling the client's feeling - they are still feeling their own emotions and having their own experience. This is why I avoid saying things like, "I feel that, too"; while I may be feeling sad upon hearing a client describe something sad, they each have their own unique experience of sadness, which I am not feeling. Additionally, it works both ways - not only can we, as clinicians, exchange with our clients, but they also are capable of exchanging with us. As such, part of the work in therapy can include offering the therapist's nervous system as an attuned reference point for mutual regulation, facilitating a therapeutic environment grounded in openness, warmth, and clarity

(Strong, 2021). I personally have found this most beneficial in my work with individuals in crisis, provided my nervous system can show up as grounded, calm, and available to clients.

Point being, one cannot 'do' it on purpose, exchange just happens; at the same time, through meditation practice, we can work to reduce barriers to exchange, meaning there is greater capacity for the therapist to be fully present with the client. Through this presence and an openness to directly experiencing another person - taking time to notice where storylines, bias, or thoughts are interrupting connection - therapists can cultivate genuine relationships with clients, allowing compassion to arise organically in response to a client's pain. This process requires therapists to relinquish the illusion of maintaining a "safe" distance from clients (e.g. letting go of the idea we are separate and impermeable "experts") and to embrace vulnerability in connecting with their experiences. By bringing mindfulness, awareness, and compassion to the therapeutic encounter, therapists practice opening to the exchange and utilize the insights gained to support clients (Wegela, 1994; Strong, 2021).

A final note regarding exchange: Although it may not be openly discussed or dissected with clients, it is essential that therapists attempt to differentiate exchange from counter-transference and other projections. Clinicians must come into their practice having cultivated curiosity and a deeper understanding of their own emotional patterns in order to manage the multitude of emotional and interpersonal dynamics within the therapeutic alliance. Ultimately, the the basis for exchange lies in "a conviction in brilliant sanity", enabling therapists to fearlessly engage in and navigate the client's experiences with compassion and understanding (Wegela, 1994, p.44).

Clinical Vignettes

The walk-in crisis center is open 24/7 and open to anyone seeking our services - meaning we see a wide variety of demographics, symptoms, and experiences. While compulsive sexual behavior is not regularly presenting 'out in the open' at the crisis center, sexual behavior is a normal and healthy facet of the human experience. It is therefore within the scope of our focus as clinicians when assessing our clients for both risks and protective factors. I can see the crisis center as a whole trying to serve our clients as best we can, as well as the many ways this program is merely a microcosm of the field. Despite our best efforts, there are ways we are failing to effectively serve clients or provide them with opportunities to have their needs met when it comes to sexual behavior. We will first explore this on a systemic level before moving into a client story and the ways some of these issues manifest at an individual level.

At the crisis center, often taboo topics such as substance use and suicidal ideation are laid right out on the table. The crisis intake form is up-front in asking about suicidal ideation with plan/means/intent, to issues with trouble sleeping, eating, making friends, and regulating emotions. There is one brief question about sexual symptoms, included in the form of a check box, that asks if clients are experiencing problems with sexual matters. The intention of this check box, I believe, is intended to help with diagnosing more general/common mental health issues; for example, where a significant decline in libido could be symptomatic of something like depression, while a prevalence for sexual risk-taking behaviors might align more with Borderline Personality Disorder.

There is plenty of stigma in and around crisis work that exists with clients, as we live in a culture that avoids thoughts of death or experiences of psychosis. I often am asked how it is possible for crisis clinicians to work so consistently and intimately with people who are

contemplating or actively engaging in suicidal behavior or experiencing extreme states of mind. It is critical that clinicians are able to hold their own seat (e.g. grounding themselves, staying regulated, paying attention) through experiences with people in crisis, but equally important is curiosity and flexibility. If a therapist holds too tightly to rigid and traditional assumptions about what is right and wrong about a client's experience of suicidality (e.g. "this is a weak person") and have limiting views regarding how to work with it (e.g. thoughts of death automatically require hospitalization), much is missed. It becomes nearly impossible to meet the client where they are, thereby getting in the way of the actual treatment and being of benefit to the client.

Given what we know about exchange, if I were to hold rigid beliefs about suicidality, such as viewing it as a sign of weakness or moral failing, my client may exchange with this energy and I could inadvertently contribute to their feeling misunderstood, judged, or dismissed. This would inevitably create barriers in our therapeutic relationship and inhibit open and trusting communication. This likely would impede the client's willingness or ability to share their honest experience with suicidal thinking or planning. For similar reasons, if I experience fear or trepidation around broaching the topic head-on, the client could see this as evidence that the taboo of speaking openly about thoughts of death is present, and so it is not something they can broach either. This increases the likelihood that critical opportunities to assess and intervene adequately will be missed, thus hindering our ability to collaboratively take steps to keep the client safe.

In several of the suicide prevention trainings I have taken that include clinicians from departments outside of the crisis center, I have noticed a 'one-size-fits-all approach' to working with suicidality. Therapists often incorrectly assume that any mention of suicide from the client immediately equates to a need for hospitalization or medical/police intervention. This type of

intervention may not only be dehumanizing and harmful for clients, but places the therapist's concerns about liability ahead of understanding the unique experience and needs of the client. Having thoughts of death is a fairly common human experience, especially in times of immense stress or overwhelm, that overwhelmingly does not lead to suicide. Many clients in these instances do not meet legal criteria for hospitalization and, after being evaluated, are turned away from hospitals; they subsequently may not feel safe returning to their therapist for support.

As a clinician, I recognize the importance of taking enough time to understand the nuance and uniqueness of each client's experience with suicidal ideation or planning. This includes understanding their supports and protective factors, as well as potential triggers or risk factors. This information can enable me to form a more comprehensive picture of what the risk of imminent harm or death is before I take action - whether that looks like safety planning in my office, referring out to a higher level of care, or placing a client on a mental health hold. Taking an inappropriate course of action due to clinician misunderstanding and fear, such as jumping to hospitalization or police intervention without the above information, can quickly and irrevocably ruin the therapeutic relationship. Clients can easily be misunderstood and are thus unable to trust the clinician's ability to be with their own discomfort.

The taboo of talking about suicide and working with it openly is not that dissimilar to the taboos that are present around sexual behavior and sex addiction. While there is plenty of room to talk about substance use and suicidal thinking, clients are not invited to explore sex as a topic of distress in the same way, if at all. To inquire more about sexual behavior as a normal aspect of a client's life would be aligned with the other items we already ask clients about. Do we really think sex is so special and different as to think that clients are not also having problems or experiences of"crisis" in this realm? How and why is this not coming up?

My question is, why don't we talk about sex with crisis clients? I propose it is a failure of the field and our inability to escape from these societally imposed views around sex and sexuality. The ways that the therapist can hold or reinforce stigma, as well as the therapist's relationship to or definition of "healthy" sexual behavior, is not something that consistently has room to be recognized, discussed, and explored. This is indicative of therapy in general and necessitates the need for specializations, like sex therapy and sex addiction treatment. At the crisis center, sexual behavior is generally being used as a symptom to diagnose something else, instead of being used to look at and welcome sex addiction or sexual compulsion as a conversation.

If, as a field, we could adopt more contemplative approaches broadly, we might be able to disentangle some of the internalized beliefs we have about sex and avoid some of these pitfalls. Certainly, some clients will not want to discuss their sexual behavior at crisis, or perhaps with any therapist, and we certainly will not force them; this is a critical part of meeting clients where they are. Clients deserve to have the opportunity and the invitaiton to bring all parts of themselves into the therapeutic space. Therefore, whether discussing suicide or sexual behavior, it is of paramount importance for clinicians to recognize and challenge their own assumptions, while remaining open, flexible, and collaborative in their approach to treatment.

A Client's Story

Roger is a 54 year old, white, cisgender male living in Texas with his wife. Though Roger was born and raised in rural Texas, he did not come from a family who were Christians, or even particularly religious. Roger's mom died when he was 8, which he reports being a

particularly tender time for him, lacking in unconditional love. He thought he'd found this in meeting his wife, who was his next-door neighbor at university. The two of them refrained from having sex until they were married, just after Roger converted to Christianity at the age of 21. Ever the optimist, Roger thought that once he got married, having a connected, fulfilling sexual relationship wouldn't be an issue.

A few months ago, after moving into a new house together, Roger and Elaine were getting ready to go to a family event when Elaine asked to use his laptop. By Roger's account, Elaine ended up "snooping" through his trash and his browser history, unearthing a number of porn sites, sexual chatrooms for men, and a urination fetish. This was the moment his wife realized that for much of their 30+ year relationship, Roger had been surfing porn sites and chat rooms for both real-life and online connections with men. Over the course of his marriage, he had engaged in sexual behavior with over 150 men in cars, parks, bathrooms, or hotels. Roger said that in the moment of his "outing" he felt like a vulnerable child, confessing to Elaine that he had "all these issues". At the same time, he professed he had never cheated because the only woman he had ever had sex with was his wife.

After the initial shock waned, Elaine decided that if they prayed hard enough and sought enough support, Roger would inevitably stop watching porn or meeting up with other men altogether and they could repair their marriage. However, Rodger was able to admit to himself and to his wife that both his porn use and desire to meet up with other men felt compulsive, distressing, and potentially addictive. Even so, Roger found he had a hard time telling the truth about his behaviors, wants, desires, and compulsions. Ongoing tension at home is what led them to the inpatient program with which I was working.

Discussion

The first thing that struck me about Roger's situation was my own desire to label his identity as "gay". While there is so much to unpack here that the discussion would ultimately require its own paper, Roger never once self-identified as gay, nor would his religious beliefs allow any room for a non-heterosexual identity. It would be inappropriate for me to assume this is a simple case of denial and identity, thereby pushing my own liberal and therapeutic agenda on the client. Not only would that fail to appreciate the nuance of his situation, it also mirrors the inability of those around him to engage with curiosity about his behavior. The alleged 'support systems' he encountered were rife with homophobic rhetoric and ideas that his behavior was some kind of moral failing that merely stood to be 'corrected'. These messages had also been long-held and deeply internalized by my client.

Roger needs to be able to show up in session with whatever beliefs he may have, no matter how paradoxical; for example holding the beliefs that sex with other men is morally wrong and sinful, but that it also was somehow pleasurable, met specific needs, and by some rationale was even viewed as permissible (e.g. "not cheating"). I recognize that my personal judgments have no place in this exploration, which is different from many traditional approaches to treating compulsive sexual behavior. This leads me to another one of the issues, as I see it, which is that the CSATs, or Certified Sex Addiction Counselors, on staff held tight to the faith-based program's values and were using traditionally gendered and heteronormative approaches. "Heterosexism and homophobia pollute the channels of sexual intimacy on which people depend for open and trustworthy communication" (Ellison, 1996, p.55).

Even though these clients were in therapy and experiencing development and change in some areas, clients like Roger were still unable to work with their many different (and often

contradictory) parts in session. Roger could not work through the complicated nature of his desire to have sex with other men given that the faith-based program, whether via clinicians or fellow group members, was reinforcing many of these culturally and religiously held homophobic beliefs. There was no one there to point to a broader, more inclusive way of approaching sexuality, desire, or sexual behavior because that was not in the nature of the program.

While I am not Roger's personal therapist, I can imagine that a contemplative approach would have offered Roger a more inviting, open space for Roger to show up in. I see Roger's porn use and sexual behavior with other men less as symptomatic of some type of addiction and more likely as an outlet for some repressed aspect of his identity or desire. While I will attempt to distill down the ways I would work with brilliant sanity, mindfulness practices, exchange, and maitri in the case of Roger - these concepts are all interwoven and overlapping, therefore nearly inseparable.

Working with Brilliant Sanity

Recognizing the brilliant sanity of clients is a critical component of how we approach treatment.

> If we see our clients as basically flawed or bad, then we will direct our attention toward helping them curb or control their badness. When we see them as possessing the potential to realize their inherent wisdom and compassion, we do our best to nurture that (Wegela, 2014, p.69).

Even behaviors that clients find distressing can have innate wisdom. For example, the coping mechanisms - such as the sexual stimulation many of my clients have used to self-soothe

- is not some type of pathological defect. “Little consideration is given to the possibility that many long-term [risks] might also be personally beneficial in the short term” (van der Kolk, 2014, p149-150). Our brains and nervous systems are always looking for danger, predicting the worst, avoiding whatever scares us, and making sure we fit in with those around us so that we can survive. “If you mistake someone’s solution for a problem to be eliminated, not only are they likely to fail treatment, as often happens in addiction programs, but other problems may emerge” (van der Kolk, 2014, p.149). We cannot merely ask a client to “abstain” from certain sexual behaviors without deeply understanding why that behavior was necessary to begin with, nor without helping the client to develop other more beneficial coping mechanisms.

This is not to say that we should not be concerned about the consequences of problematic or distressing behavior or that because there is wisdom in it then it does not need to change. Merely having an awareness of this wisdom can help us work with clients in a nonjudgmental way that opens the door for a more trusting and empathetic therapeutic relationship than they might get in traditional sex-addiction treatment. As a contemplative clinician, I can help clients like Roger acknowledge the ways their body has helped them to survive difficult experiences and kept them safe. "Bodies are good, capable of giving and receiving pleasure. Our bodies deserve respect and care" (Ellison, 1996, p.82). Recognizing that a client found safety, comfort, or self-soothing through sexual contact can be a healing place to start bringing them back into connection with their body.

Working with Exchange

Earlier we talked about exchange as a way for clinicians to engage directly with client’s experience, which is foundational to the contemplative approach. Just as clinicians are able to

exchange with clients, the clients are also capable of exchanging with us as clinicians. “By cultivating openness and [maitri] toward a variety of mental, affective, and existential states, the contemplative psychotherapist uses their mindfulness practice to offer their nervous system as an attuned reference point for mutual dyadic regulation" (Strong, 2021, p. 151). Wegela (1994) has noted that this is arguably one of the most important things that can happen in therapy and part of what makes the contemplative approach so unique.

If a client feels shame or embarrassment in talking about sex and then I, as the clinician, feel my own shame or embarrassment and then react to it, this is what the client will exchange with. While I might not understand or relate to Roger’s urination fetish, if he were to bring that up and I in turn experience disgust - this is something he would likely pick up on, not just through my words, but through my energetic response. If I then react to my own disgust with shame or guilt - thinking “Here I am suppose to be sex positive and now I am experiencing disgust regarding a client’s desire, I must be a terrible therapist” - then the client will additionally exchange with shame and guilt. This can then reinforce the belief that he should in fact be ashamed and what he desires is “wrong” and there we are - back where we started.

A contemplative orientation proposes a different approach to the above scenario: when a client brings up something that makes us feel disgusted or angry, we try to bring mindfulness and maitri to the experience that arises in us. This is what then becomes available in the exchange - the mindfulness and the compassion, not just the anger or disgust. Even as a professionally trained therapist, I cannot ‘make’ the disgust or the anger go away; however, I can greet it with curiosity and space, which is what Roger will pick up on by sitting in an environment of maitri and loving-kindness. This is a huge piece of contemplative practice and it has the potential to become a corrective emotional experience for the client.

Sexually compulsive or addictive behaviors are often laden with shame, which can get reinforced in the therapeutic relationship if a clinician has not done their own work around this. When a client is met with openness, care, and nonjudgment instead of blame, revulsion, anger, or aversion - there is room for something new to happen. Whether working with Roger or another client, exchange offers the client reassurance that we can be with what is here without aggressing or turning away. Whether or not I say anything to the client about exchange, it can be a source of information about what might be going on. With some of the clients I might ask directly - “I'm wondering if you're feeling any sadness as you say that?” Or “I just noticed I was starting to feel sad hearing that, are you feeling any sadness?”

A contemplative approach maintains that the more I know about my own mental, emotional, and nervous-system responses to things, the more I can know when something is off or different in session with a client; these are signs that there is energetic information I may be receiving from the client. Especially with clients like Roger, among other clients I have worked with, who have had a hard time contacting or recognizing certain emotions - nameing my own experience of what is happening can become a gateway for clients to contact what is happening for them internally. This is one place where the overlap with mindfulness becomes quite ovious.

Mindfulness Practices

As van der Kolk (2014) notes, mindfulness can be a powerful tool in aiding clients recovering from sex addiction: “At the core of recovery is self awareness. The most important phrases in trauma therapy are ‘Notice that’ and ‘What happens next?’” (van der Kolk, 2014, p.210). By practicing mindfulness, individuals can develop a greater awareness of their bodily sensations, thoughts, and emotions, which can help them identify triggers and patterns associated with their addictive behaviors. "Mindfulness may help firstly by learning to develop awareness

of the automatic processes so that one is less likely to be hijacked by them" (Groves, 2014, p. 992).With greater awareness, more choice becomes possible.

For these reasons, if working as Roger's individual therapist, I would first focus on understanding what his porn use and sexual behavior with other men does for him, what it allows, what it benefits or harms - rather than merely lumping it all together and labeling it as "a problem". Wegela (1994) suggests that to work with client's "mindless practices", or practices that help clients move towards dissociation from experiences that are otherwise painful or frightening, we must first become curious about them; "this, in turn, may lead to mindfulness" (Wegela, 1994, p. 47). For Roger, this could be exploring questions like - how do you know which pornography to pick or what website to visit? What internal cue tells you when to start? How long do you watch it or chat with other men for? How do you know when to stop? What are you focusing on when you watch the porno? What is happening in your body? (questions adapted from Wegela, 1994).

In session, I attempt to help my clients take a step back, using mindfulness to get into the noticing mind instead of being caught up in their own narrative. "Allowing others to call us out on our intimacy-blocking beliefs and behaviors allows us to soften and be more aware of our autonomic responses" (Barta, 2018, p.133). I can help clients move from thoughts like "I am an addict and so it is in my nature to do XYZ" towards "I am having some blaming or limiting thoughts", while noticing what is simultaneously happening in their bodies. If a client is able to notice the thought, then there is a part of them that has the capacity to notice that is separate from the thought itself. This is the part that steps back and can observe one's thoughts and emotions, avoiding the trap of "I am my feelings and my feelings are me". As clients become more aware of what their internal experience and their habitual patterns are, they can begin to react in new

and different ways.

This may be easier said than done in some cases, as many clients, including Roger, simply cannot identify the feelings or events that "trigger" their need to engage in problematic sexual behavior. Through mindfulness practice, my clients are sometimes able to cultivate greater awareness of the thoughts, emotions, and situations that precipitate problematic behavior. "When we pay focused attention to our bodily sensations, we can recognize the ebb and flow of our emotions and, with that, increase our control over them" (van der Kolk, 2014, p. 210). By observing these triggers without judgment (ie. with maitri), individuals can develop strategies to cope with them more effectively, such as using mindfulness techniques to ground themselves in the present moment or engaging in healthier behaviors as alternative coping mechanisms.

> Generally I encourage clients to bring mindfulness first to their environments and the way in which they are living. Then, as this area of their life becomes more stable, I encourage them to bring mindfulness to body, feelings and sensations. Beyond this, we move into recognizing how their patterns work. Mindfulness helps clients see how their thoughts and actions lead to particular emotions and other consequences; it also helps them explore what happens when they choose to refrain from or experiment with some mental or behavioral pattern. Mindfulness helps them tolerate the intensity and uncertainty which generally arise when mindless practices are altered or given up (Wegela, 1994, p.48).

As Wegela just explained, integrating mindfulness practices that focus on the body can be highly effective, provided the client lacks a history of trauma that makes bodily awareness feel unsafe. With clients like Roger, it would be beneficial to proceed gradually, guiding them to pay attention to sensory and internal experiences. The objective is to enhance sensitivity to physical

cues that precede compulsive behaviors, such as Roger's inclination to solicit sexual acts from men he meets online. By increasing a client's awareness, they may recognize sensations building in their bodies when triggered, enabling them to pause and take a breath before deciding their next course of action. "Becoming aware of how your body organizes particular emotions or memories opens up the possibility of releasing sensations and impulses you once blocked in order to survive" (van der Kolk, 2014, p. 211). With this newfound awareness, clients can potentially substitute more constructive coping mechanisms when confronted with discomfort, stress, or other triggers that may lead to sexual acting out.

As practitioners familiar with meditation might know, mindfulness practice can also help individuals develop greater emotional regulation skills, allowing them to navigate challenging emotions without resorting to addictive behaviors as a coping mechanism. "Learning to be with urges and to step out of compulsive thinking can help to reduce the likelihood of relapse through "mindless obsessing"" (Groves, 2014, p. 992). By learning to sit with discomfort and observe their emotions without reacting impulsively, individuals can develop healthier ways of managing stress and distress. Some models of sex addiction treatment, like TINSA (Trauma Induced Sexual Addiction), maintain that "the addiction started through self-regulation and therefore can be much better managed by increasing one's ability to remain regulated" (Barta, 2018, p.117). The Contemplative approach builds on this by utilizing mindfulness practices as a skillset clients can use to actually put this into practice.

Working with Maitri

In the therapeutic sense, maitri starts with the therapeutic relationship. If a clinician cannot see their clients as brilliantly sane and worthy of love, then there is already a major

barrier to nurturing holistic client growth (Wegela, 1994). Clients can sense judgment or prejudice from their therapist, which consequently can cause a reluctance to open up, share vulnerable experiences, or engage fully in the therapeutic process. Furthermore, if a clinician fails to show up with a welcoming, open, friendliness towards whatever the client is bringing in, the client may feel invalidated, minimized, or dismissed, hindering the sense of acceptance and belonging in therapy that we are hoping to create

This above narrative is a common story with traditional therapeutic approaches, particularly around addiction. The lack of awareness of brilliant sanity and connection to loving-kindness regarding clients becomes apparent, as “expert” clinicians are expected to show up with the knowledge to “fix” their clients based on the diagnosis they have handed down. Clinicians may then become frustrated with clients who do not follow treatment advice and are subsequently judgmental of client behaviors seen as “problematic” (whether that is continuing to engage in behavior seen as problematic or lying about this behavior). Clinicians may be unaware of the amount of therapeutic aggression (their own agenda) that they are bringing into the space, and the room for clients to show up fully is both diminished and disrespected.

Scenarios like one above can be avoided. As such, Wegela (1994) talks about our need as psychotherapists to actively "clean up" our side of the relationship: "In the contemplative approach, it means continuing our meditation practice, so that we recognize what is going on in our own minds as we are working" (p. 39). This is where mindfulness practices can encourage individuals to observe their experiences without judgment, allowing them to approach addictive behaviors (whether their own or their client’s) with greater compassion and self-acceptance. This is an embodiment of maitri in action. As clients start to orient towards maitri, they may become

better equipped to overcome feelings of shame or guilt associated with addiction, ultimately creating more space and openness for engagement in the recovery process.

> As I increase awareness of my numerous states of mind and behaviors, I am able to work more skillfully with them when they do arise. I no longer view them as setbacks to my recovery. Rather, my journey in this life is more focused on learning the art of being a better human being, than on being a perfect one (Patton, 1994, p.125).

Psychoeducation can additionally be a part of helping clients in cultivating maitri. By normalizing brain and nervous system functions as a "normal" and welcome process, the client may be able to reduce feelings of blame, shame, guilt, and self-aggression. For example, a traumatic memory, like the death of Roger's mother, may be trying to keep that person safe from experiencing something like that ever again. "Having a biological system that keeps pumping out stress hormones to deal with real or imagined threats leads to physical problems," which then contributes to the developemnt coping mechanisms that help us to sooth and regulate our bodies (van der Kolk, 2014, p.160).

Mindfulness fosters a sense of self-compassion and kindness towards oneself, which is essential in the recovery process. By recognizing that addiction is a complex and multifaceted issue, individuals can approach themselves with greater understanding and forgiveness, reducing the likelihood of self-blame and self-destructive behaviors.

Conclusion

In conclusion, challenging traditional definitions of sex addiction not only invites necessary dialogue about the nature of "healthy" sexual behavior but also prompts a critical examination of how we understand and work with addictive behaviors. By questioning

prevailing definitions and acknowledging the societal influences at play, clinicians can adopt more nuanced and flexible approaches that honor the diverse experiences of their clients. Recognizing the variability in behaviors that get labeled as “sex addiction” and understanding the social and cultural taboos surrounding sex as a whole can enable us to provide more compassionate and effective care.

The contemplative approach offers a pathway beyond old norms and a new way of working with compulsive sexual behavior. It encourages deeper introspection for therapists, fostering an open, grounded, and inviting presence in the therapeutic space. By cultivating mindfulness and awareness, clinicians orient towards clients' behaviors with wisdom and understanding, recognizing them as coping mechanisms born out of resilience and survival. As Strong (2021) aptly notes, being mindful and genuine as therapists is essential, but integrating these qualities with a deep appreciation for the brilliant sanity within each client is what is truly transformative. A contemplative approach empowers clinicians to hold the complexity and paradox of addictive behaviors without judgment or stigma. In turn, this paves the way for creating a therapeutic environment where clients can authentically engage with their experiences and embark on a journey of healing, self-discovery, and reconnection with sexual pleasure and joy.

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