A DISCURSIVE ANALYSIS EXPLORING CONSTRUCTIONS OF SEX ADDICTION IN CLINICAL TEXT AND 'ADDICT' ACCOUNTS

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Thesis Abstract

Introduction: Numerous accounts have been developed which portray sex addiction and the sex addict. These in turn have led to screening tools, said to be capable of accurately distinguishing the sex addict from non-addicts. However, there are a wealth of various, diverse and conflicting understandings of addiction, sexuality and sex addiction. Sex addiction also carries moral implications, leading some to argue the term is used as stigmatising label for those who deviate from a socially constructed sexual standard. Despite the clinical significance of the growing use of the term, to date there has been a dearth of research which has critically reflected on sex addiction as a concept, and the meaning for those who identify as sex addicts.

Objective: This study aimed to explore a seminal text and screening assessment's description of sex addiction; as well as sex addicts and non-addicts' own descriptions of their sexual behaviour and perspectives on sexual addiction; using a qualitative methodology sensitive to the adaptable and social and historical contextual aspects of discourse.

Design: A primarily Foucauldian Discourse Analysis approach was taken in the analysis of data from text and semi-structured interviews

Method: Data was collected from the book "Out of the Shadows: Understanding Sex Addiction" (Carnes', 2001), and the "Sex Addiction Screening Test – Revised" (Carnes, Green & Carnes, 2010), as well as from nine interviews conducted with men identifying as sex addicts and non-addicts from both the UK and USA.

Results: The findings demonstrated three main discourses: A Loss of Control, 'Good' vs. 'Bad' sex, and a Cultural Imperative to Intervene in Sex Addiction. The study demonstrated expert, addicts and non-addicts talk about sex addiction show a number of similarities and some select distinctions. The ways in which sex addiction was talked about were complex and at times inconsistent. Scientific, psychological and moralistic discourses were commonly drawn on to position sex addiction as distinguishable from 'normal' sexual behaviour. Health and biomedical discourses were also drawn on to manage accountability, and

to construct the sex addict as sick, naïve and disempowered. Correspondingly there was a reciprocal-construction of experts as credible and impartial in being able to identify sex addiction. These experts and wider society were necessitated to identify and protect against a projected exponential rise in sex addiction, catalysed by the advance and accessibility of Internet pornography.

Discussion: The study offers new understanding on the discourses of sexual addiction and the subject positioning, actions and subjectivities it creates and restricts for those identifying as sex addicts. Those discourses identified correspond with contemporary discourses surrounding addiction and sexuality; though offer novel permutations which invite further research. The results of this study ascertain that there is a need for healthcare professionals to reflect upon the risks of uncritical acceptance and practice using the sex addiction label, given the breadth and diversity of discourses it encompasses.

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This one is dedicated to S.B.B.

"Everything in the world is about sex except sex. Sex is about power."

— Oscar Wilde

"Love is the answer, but while you are waiting for the answer, sex raises some pretty good questions."

— Woody Allen

Statement of contribution

I, James Briggs, declare that this research is the product of my own original work conducted since my commencement of the Trent Doctorate in Clinical Psychology in 2011. The project design was developed in consultation with my research supervisors Dr. Roshan das Nair and Dr. Brendan Gough, from whom I also received regular guidance and supervision. I have been the sole researcher, responsible for obtaining ethical approval, collecting and analysing the data, conducting the literature review and writing this thesis. Appropriate recognition has been given where reference is made to others.

Table of contents

SYSTEMATIC REVIEW	**Pages 7-36**
Title Page	Page 8
Background	Page 9
Methods	Page 10
Results	Page 12
Discussion	Page 27
Conclusion	Page 31
References	Page 32
JOURNAL PAPER	**Pages 37-74**
Title Page	Page 38
Background	Page 39
Method	Page 43
Analysis and Discussion	Page 46
Conclusion	Page 63
References	Page 68
EXTENDED PAPER	**Pages 75-163**
Extended Background (section 1)	Page 76
Extended Methodology (section 2)	Page 90
Extended Analysis and Discussion (section 3)	Page 101
General Discussion (section 4)	Page 134
References	Page 147
APPENDICES	**Pages 164-175**
Systematic Review Appendices	Page 165
Extended Paper Appendices	Page 167

A systematic review exploring available evidence on the effectiveness of psychological interventions for people with sex addictions[1]

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Abstract

Introduction. Despite the current lack of a recognized diagnosis, several psychological interventions have been developed which target sexual addiction or sexual compulsivity. Given the dawning of the controversial 'Hypersexuality' diagnostic label in the DSM-V, there is a great need to review the available evidence on the effectiveness of contemporary psychological interventions.

Aim. This study provides a systematic review and critical appraisal of existing research that has empirically evaluated interventions designed to target sexual addiction.

Main Outcome Measures. Reported empirical and qualitative data surrounding the outcome of sexual addiction interventions.

Methods. Electronic databases and reference lists of published articles were searched in August 2012. Primary research studies were included in the review if they explored a psychological intervention centered on benefitting those who identify as sexually addicted. Studies were limited to the past 10 years, and published in English. Each study was reviewed and assessed.

Results. Eight studies met the inclusion criteria. The methodological quality of the studies was moderately poor. Four studies were based on case studies of individual clients, and four were based upon repeated measures interventions without randomization or clinical controls. In almost all cases participants self-referred to intervention, and few studies used an objective assessment of sexual addiction. The assortment of included studies makes it difficult to draw direct comparisons. The review did not highlight a superior form of treatment, though there is a suggestion that examining social comparison, improving support and acceptance, are important therapeutic ingredients.

Conclusions. There is a dearth of empirically based, good quality research, which clearly evidences effective psychological intervention. Though reports were generally supportive of their intervention, a great deal of ambiguity and uncertainty remains over how best to conceptualize and assess sexual addiction, and how this might influence intervention.

Background

[1] This review has been written in preparation for the Journal of Sexual Medicine.

There is a growing trend for the construct of addiction to be applied to sexual behaviours. This follows developing clinical concern in relation to descriptions of impulsive or compulsive sexual behaviours, which interfere with everyday living [1]. Akin to the field of drug dependence, 'sexual addiction' is thought to involve a loss of control over sexual behaviour, governed by strong reward seeking and disinhibition this [2-3]. People are increasingly categorized as suffering from sex addiction or 'hypersexual' disorder[2] [4]. Indeed, hypersexual disorder is expected to become a formal clinical diagnosis in the upcoming DSM-V [1].

This clinical diagnosis implies an advance in the 'science' and medicalization of sexual addiction. Some have even promoted the prescription of selective serotonin reuptake inhibitors, typically used to improve or stabilise mood, in order to treat sex addiction [5-6] though most accounts suggest that sexual appetite diminishes with decreased mood [7]. Work has also investigated the use of opioid antagonists to treat sex addiction (e.g. naltrexone), based on the cross-sensitisation thought to occur with sex and drug addiction [8-9]. There are also an increasing number of psychotherapies available for sex addicts, including the 45-day inpatient 'Gentle Path' programme developed by Patrick Carnes [10]. However, earlier reviews have noted a lack of empirically well-validated interventions for sexual addiction, and the impact of available psychotherapy interventions upon sexual addiction remains unclear [11]. The benefit of these interventions may stem from improvements comorbid substance dependence, anxiety, and mood disorders, commonly reported by 'addicts' [12]. To date there appears a lack of consensus on the effectiveness of available interventions for sex addiction.

Addiction is a complex construct, and the concept of sexual addiction contains various descriptions and understandings [13]. Unlike substance dependence, the subjectivity of what defines sexual addiction, and successful outcome for sexual addiction, makes it difficult to integrate and evaluate research. Also unlike substance dependence, sexual addiction does not involve a foreign substance, and abrupt cessation of sex does not involve a physical withdrawal state, or risk of death [14-15].

Despite such differences, the use of a modified version of the 12-step program, typically used for alcohol dependence, has been advocated as an intervention for sexual addiction [16-17]; though most do not see sexual abstinence as the goal of treatment. Instead these programmes advocate acknowledgment of the problem, installing faith, acceptance, and forgiveness in individuals; sometimes supplemented

[2] The term 'sexual addiction' is used at points throughout this report to refer to conceptualisations of sexual addiction, compulsivity, impulsivity, hypersexuality. However, it is acknowledged each conceptualization carries different implications for the individual and their potential treatment.

with medication to reduce sexual desire [18]. Group contact and support may be crucial here [17]. However, to date there is an absence of randomized controlled trials identifying or comparing effective interventions, or components of treatment. Indeed, earlier reviewers have commented on the lack of available literature in support of a specific intervention [19-20]. Thus, there is a great need to appraise recent advances in sexual addiction intervention, particularly given the imminence of formal diagnosis in the upcoming DSM-V.

Aims

The aim of the present review is to critically analyze available literature related to the question, *'what available evidence is there for the use of psychological interventions to treat sex addiction?'* The review aims to identify and appraise studies which suggest effective interventions, ascertain whether research suggests a superior form of treatment, and to identify distinct aspects of interventions shown to improve the well being of the sex addict. Given the high rates of co-morbidity of sex addiction, mood disorders and other addictions [6, 18, 21], the analyses will focus upon interventions targeted primarily at sexual addiction. The large degree of variation in the classification of sexual addiction means the work will also concentrate upon how this classification is determined.

Methods

Systematic Literature Search

A series of search criteria were pre-determined in order to reduce bias. Inclusion criteria were purposely broad in order to capture the range of possible conceptualisations of sexual addiction, psychological interventions, and experimental methodology, for different genders and sexualities (see Appendix A). The review is limited to studies published within the past 10 years, given the progression of this topic area, and the importance of up-to-date research in informing the up-coming Hypersexuality classification in the DSM-V [1]. Studies were included in they

1. Included some classification of sexual addiction/compulsivity/hypersexuality, or some detail on sexual addiction/compulsivity/hypersexual conceptualisation.
2. Constituted primary research (including case studies)
3. Noted which form of psychotherapy had been used (studies which used combined pharmacotherapy *and* psychotherapy were included, though only if there was sufficient detail of the psychotherapy used),

4. Noted some form of standardised or unstandardized outcome measure, or feedback from client or report from author.
5. Used Human, Adult (18+) populations,
6. Were published in the last 10 years (2002 – Present)
7. Were published in English.

A systematic search was conducted on three electronic databases: PsycINFO, Medline and EMBASE, in between July and August 2012. Together these databases were seen to provide comprehensive coverage of the available literature. The same grouping of search terms were used across each of these databases; i.e. (i) terms relating to sexual addiction, (ii) terms relating to psychological intervention, (iii) terms relating to methodology or effectiveness (Appendix A).

Initially, the title of retrieved papers was screened, and where this was ambiguous the abstract was reviewed to check their suitability. Following a seemingly relevant abstract or where abstracts could not be obtained, the full text version was and reviewed. Reference lists of articles identified were also searched in order to identify potential studies. Editorials, book chapters, conference papers, and unpublished dissertation abstracts were checked for references, though were not included in the systematic review. In addition the contents page of the Journal of Sexual Addiction and Compulsivity was hand-searched given its significance in the area. Grey literature searches were not conducted, though key words were entered into Google scholar, with the same limits as above, and the first 50 results were checked.

Data Extraction

Data extraction focused upon: Author, date of publication, aim of the study, sample characteristics, assessment of sexual addiction, method of data collection and key findings. This was based upon previous guidance [22-23].

Assessment of Study Quality

It is important when conducting and reporting systematic reviews to utilise some form of systematic assessment of study quality. There is however no gold standard of quality criteria. Downs & Black [24] created a single instrument to assess the quality of randomized and non-randomized studies in systematic review or meta-analysis. Quality is based on evidencing reporting, external validity, internal validity and power. The statistic shows good validity and reliability, compared to other less well empirically supported instruments such as the NOS [25] or the SIGN [26], which have little published literature assessing their reliability and validity characteristics [27]. This

measure has also been used previously in systematic reviews of other addictions [22, 28]. It was determined a priori that a customized version of this measure would be utilized to assess quality in the present review following previous literature [22, 27]. For example given the ambiguity of the power item, quality would be assessed by authors outlining whether the study had a suitable sample size to detect clinically important effects [22].

However, the large proportion of case studies included and overall low study quality meant this tool was no longer seen as appropriate. The small number of identified studies meant individual quality assessments combining qualitative meta-synthesis and quantitative meta-analyses for study categories [29], would be inappropriate here also. Therefore, the more flexible evaluative criteria of Lincoln and Guba [30], was used in order to assess the quality of the work. These criteria assess quality of work, though not the effectiveness of an intervention. Calculation of treatment effect magnitude, and comparison of individual effect sizes was not possible across included studies. Instead work was evaluated upon its credibility, transferability, dependability and confirmability. Credibility assesses the degree of confidence we can have in the truth of the findings; transferability assesses whether the findings have applicability in other contexts; dependability determines whether the findings are consistent and could be replicated; and confirmability looks at the neutrality of findings, and the degree to which bias may have impacted them [30]. Lincoln and Guba, suggest ways in which authors can provide evidence of these concepts, typically grounded in rich description and reflection. These suggestions, as well as those of Baxter & Eyles [31] informed the present evaluation.

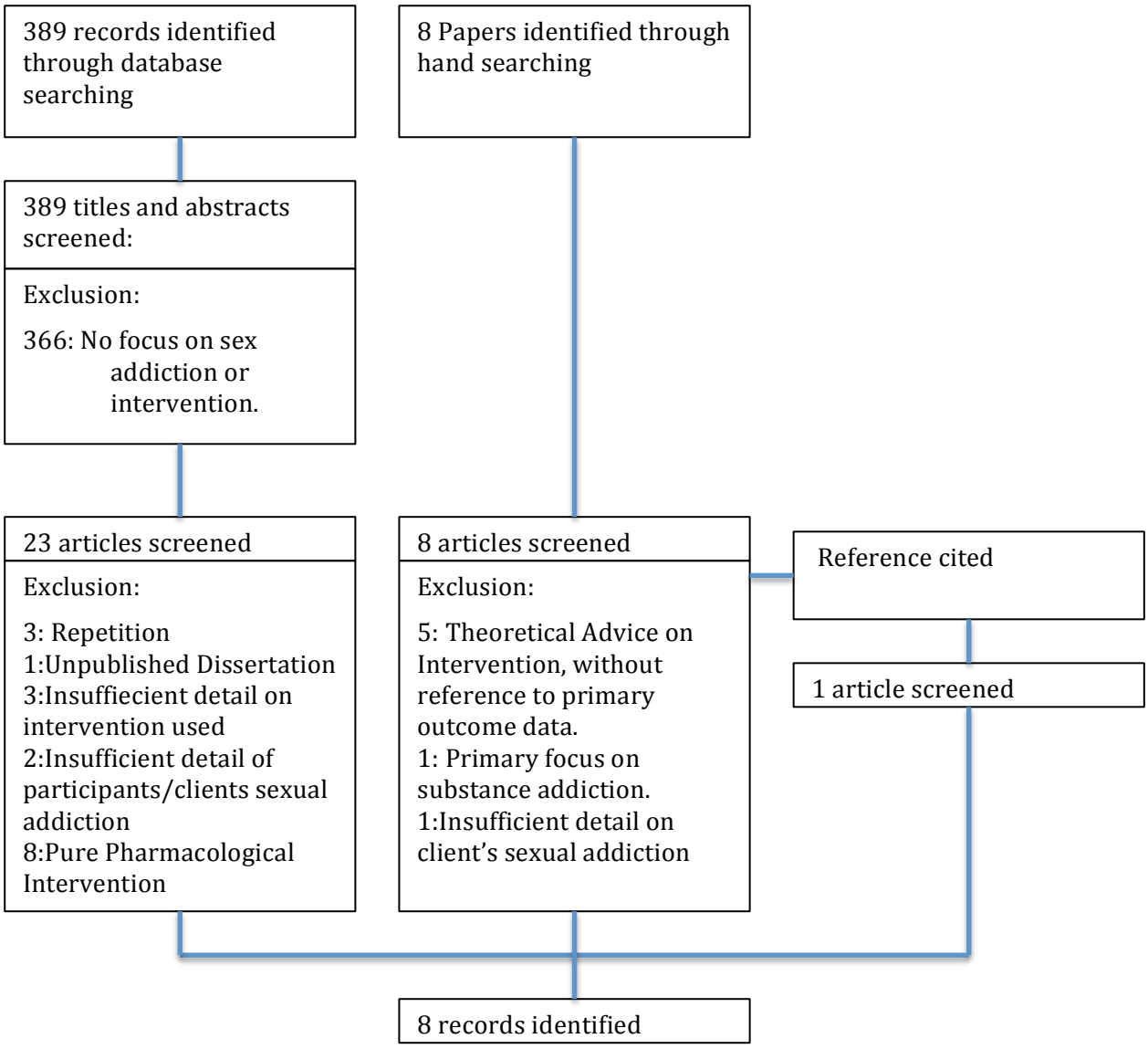
Results

Of the databases searched, 389 abstracts were obtained. The majority of these were excluded following the criteria outlined above. In total 23 articles were reviewed. Following the removal of duplicates, non-primary data research, an unpublished dissertation, papers without a description of sex addiction/hypersexuality or intervention, and purely pharmacology intervention (following full paper text review) nine papers were identified. An additional three were later removed as their primary focus upon pharmacology, made any psychotherapeutic intervention unclear [32-34].

Hand searching of reference lists identified one article [35], and hand-searching journals revealed two articles which meet inclusion criteria [36-37]. However, one further case study was removed following screening of the full text as its focus upon managing the post-traumatic stress and borderline personality disorder of the client

also made the focus of sexual addiction unclear [36]. There were therefore eight articles that met the broad inclusion criteria. Figure 1 illustrates the results of this process.

Figure 1: Flow chart of records through review process



Study Characteristics

The general characteristics of the identified records are outlined in Table 1. Each of the eight papers outlined different theoretical perspectives on how to intervene in sexual

addiction. The majority of the work was conducted in the United States (six of eight), in addition to the United Kingdom and Israel. Four studies were published in 2010.

For the most part participants[3] had self-identified as addicted to sex, and self-referred to interventions. Five studies' participants self-referred due to their sexual-addictive/compulsive behaviour; one case-study was referred to intervention due to depression and anxiety; one study looked at men seeking HIV-testing and/or counselling; and one study reported mixed referral (self, therapist, legal practitioners) due to paraphilia not otherwise specified (NOS) or impulsive control disorder NOS. No studies considered how this sampling might have impacted upon outcome.

Four of the studies were case studies, three of which centred upon one client, and one paper detailed two cases [38]. Case studies followed participants from 6 to 38 sessions. Aside from these cases, sample sizes ranged from 35 to 336, though this largest sample study was based upon a reanalysis of data from a larger study [39]. Study designs consisted of before-after designs, and one retrospective cross-lagged panel analysis [37]. Two studies assessed behaviour beyond immediate post-intervention period, including 2 month [42], 6 month [39-40] and 1 year [39].

[3] The terms participant and client are used interchangeably here given the nature of the included studies.

Table 1: General Characteristics of Included Studies

Study reference	*Aim*	*Sample size*	*Sample characteristics*	*Assessment of Sex Addiction*	*Design*	*Intervention*	*Outcome Measure*	*Key Findings*
Cavaglion (2010) [43]	Detail a Jungian Interpretation and intervention of sexual addiction	1 (Male)	Referred by community Psychiatrist to psychotherapist due to mixed anxiety and depression disorder. Israeli sample	Unstructured interview revealing concepts of disinhibition and expense to other activities	Case Study	Jungian Interpretative Developmental Approach 38 sessions	None clarified: Sexual behaviour	The meaning of the second half of life, and the archetype of the "shadow" may be an important focus for therapy, though Jungian therapy can be ineffective in coping of problems of sexual addiction.
Cox & Howard (2007) [41]	Detail the use of EMDR in the treatment of sexual addiction	1 (Male)	Self-referral for psychotherapy following reading 'Out of the Shadows' and self-identification as a sex addict (Carnes, 1984). US sample	Unstructured interview	Case study	EMDR (Shapiro, 2001), 15 x 1hr session	Processing of trauma evidenced by Subjective Units of distress and Validity of cognition.	EMDR reduced impact of traumatic cognitions, and helped 'pave healthier sexual behaviours' (sic)
Del Giudice & Kutinsky, (2007) [38]	Provide an empirical framework for treating sexual compulsivity using	2 (Male)	Self-referral for residential treatment of sexually compulsive behaviours	Unstructured interview	Case study	Motivational Interviewing + 'Eclectic mix of 12-step, Psychodynamic, CBT &	None clarified: Treatment engagement and Sexual behaviour	Motivational Interviewing techniques were useful in helping one clients commit to change, and in reducing

Dilley et al. (2010) [39]	Reanalysis of data of results from HIV counselling	336 (Male)	Men who have sex with men (MSM), with a history of unprotected anal sex in the past 12 months with men whose serostatus was unknown or positive. Men presented for HIV testing and counselling US sample	Kalichman Sexual Compulsivity Scale [62]	Before – After assessment of sexual behaviour following therapy	Personalised Cognitive Counselling (PCC; Dilley et al., 2007) 1 x 50 min session	Unprotected Anal Intercourse (UAI) Behaviour with "nonprimary partner" in the prior 90 days. Assessed at baseline, 6 months and 12 months.	PCC appeared to reduce UAI the most in the sample reporting the highest sexual compulsivity (however p>0.05)
Klontz, Goros & Klontz (2005) [40]	Assess treatment outcomes of 38 self-identified sex addicts who participated in a brief residential, multimodal group therapy	38 (Male and Female)	Self-identified sex addicts participating in residential group therapy. US sample	Self-identification.	Before-after assessment of psychological distress and 'deviant' sexual behaviour following therapy	32 hours of internsive group experiential residential therapy, utilizing psychodrama (3-10 members per group); mindfulness meditation & reading self-help literature.	Psychological distress [57] Deviant sexual behaviour [58]	Significant reductions reported in psychological distress and preoccupation with sex and sexual stimuli after treatment and at follow up
Orzack, Voluse, Wolf & Hennen (2006) [35]	Assess the utility of multimodal group work in reducing internet-enabled sexual behaviour (IESB)	35 (Male)	Self-identified, or referred via therapists, significant others, or members of the legal system, diagnosed with paraphilia NOS or impulse control NOS, also diagnosed with comorbidy mood and anxiety disorder US sample	Unstructured Interview & Orzack Time Intensity Survey (OTIS) [59]	Before-After assessment of quality of life and internet use of 3 treatment groups.	16 week group therapy, using a combination of readiness to change, Cognitive behavioural therapy, and Motivational Interviewing.	Quality of Life assessed via BASIS-32 [60] Depression, assessed via the BDI, [61] IEBI assessed via OTIS [59]	Group treatment improved quality of life, though failed to reduce 'inappropriate computer use'.

Shepherd (2010) [42]	Detail the use of CBT in treating sexually addictive behaviour	1 (Male)	Self-referral to clinical Psychologist following concerns about 'obsession' with sexual behaviour. UK sample	Unstructured interview, based upon DSM-IV criteria for substance dependence	Case study	Cognitive Behavioural Therapy 6 x 1hr session	Self reported frequency of sexual partners; hours spent online at work.	CBT reduced frequency of sexual behaviours.
Wright (2010) [37]	Retrospectively explore 12-Step Peer and Sponsor Supportive Communication in reducing sexual compulsivity	97 (Male)	Self-identified sexually compulsive heterosexual males, participating in 12-step group. US Sample	Self-identification & Averaging participant responses to 3 six-point questionnaire items	Retrospective 'Cross-lagged Panel analysis'	12-step (Varying durations of contact with group)	Self-reported sexual compulsivity; Meeting attendance; at self-defined subjective time-points.	Time one meeting attendance and sponsor work did not explain individual change in sexual compulsivity.

Methodological Quality

All studies were published in peer-review journals, with five published in the of Sexual Addiction and Compulsivity. Despite the range of methods used issues of quality arose across several studies. Table 2 summarises the c each study based on the dimensions of credibility, transferability, dependab confirmability [30]. Clarity of description and reflexivity are emphasised in these criteria, and common methodological problems across studies related ambiguity in the description of assessment of sexual addiction, use of measures, and of the intervention itself.

All eight studies definited the aim of their work, though most authors offered subjective aim such as to *'examine the issue of trauma in the treatment o addiction'* [41, p.1], which made it difficult to assess the degree to wh achieved it. Two studies offered objective aims, and a consistent meth detailing participants and variables [39-40]. Conversely, one study discusse methodology was inconsistent with their stated aim [37]. Each study noted capacity of the methodology meant further work was necessary in extrapolate their findings. All studies, except for one [40] investigated sol samples, again making the extrapolation of findings inconclusive.

Purposeful sampling of people with sexual addiction or sexual compulsi sought in each report. Sufficient detail on individual cases and their re intervention was evident in all but one case study [38]. Two of the four papers did not provide sufficient detail on the demographics of those intervention, nor how they had reached services [37, 40]. No study w identifying participants discussed the possible implications of this. Instead seen to be beneficial, as they 'realized' they had a problem [41]. Participa identification and selection to a certain therapy could be argued to impro chances of benefitting from this over random allocation [40].

Table 2: Quality of reports based upon summarising Lincoln & Guba's quality criteria.

Study Reference	Credibility	Transferability	Dependability	Confirmability
Cavaglion (2010) [43]	• Extensive detail of case history, and of session content. • 'Non-directive, interpretative and open, laissez-faire approach of Jungian therapy' means treatment provides no clear goals or outcome measures to review the work. • No triangulation with other professionals or psychometrics. • Lack of triangulation from client on attrition makes the utility of the intervention unclear.	• Clear description of client. • No objective assessment of sexual addiction. • Well-described and referenced interpretations of client's distress. • Initial diagnosis of 'mixed depression and anxiety', and prescribed anti-depressant and tranquilizer, makes extrapolation to other clients unclear. • Ideographic nature of clients quest for meaning and self-realisation will be different for different clients.	• Use of client's own language is present throughout. • Relative focus on therapist's interpretation rather than client's description. • Lack of clear therapeutic goal or outcome measure.	• Detailed reflection on case, and limitations of intervention. • Reflection on conceptualisation of sex addiction and possible impact on therapy. • No clear declaration of interest.
Cox & Howard (2007) [41]	• Clear detail of case history. • Little information on client's current sexual addiction. • Clearly structured and referenced EMDR intervention. • Intervention is described as on going, and	• Clear detail of client's demographics. • Clearly presented stages of intervention • Unreferenced 'Sexual Dependency Inventory' was used to develop a sexual arousal template.	• Inherently subjective outcome measures (i.e. SUD), arguably not directly related to sexual addiction. • Client is treated with antidepressant, and attends weekly 12-step and sponsor meetings; as well as other intervention	• Evidenced application of referenced guidance on EMDR. • Multiple authors. • No declaration of interest or funding. • Unexplained and poorly described incorporation of 'empty-chair work, letter

Del Giudice & Kutinsky, (2007) [38]	• Clear, if limited, detail of case history. • No triangulation with other professionals or psychometrics. • No clearly defined outcome measures. • No evidence of transcript. • No evidence of 'member checks', i.e. client corroboration of the review.	• Detail of age, gender, sexual behaviour of client. • Limited detail of aspects of intervention based on referenced guidelines. • Mixed evidence of clients' conceptualisation of their behaviour. • Vague detail on comorbid psychological distress (depression, substance use).	• Multiple authors. • Lack of corroboration from client. • Lack of objective assessment or outcome. • 'Eclectic mix' of the intervention, makes effectiveness of components unclear.	• Evidenced application of referenced guidance on motivational interviewing. • Ambiguous goals of intervention • Lack of reflection from authors. • No declaration of interest or funding.
Dilley et al. (2010) [39]	• Purposeful sampling of those with high-risk sexual behaviours. • Clear bracketing of clients based upon objective scoring. • Prolonged follow-up (6 & 12 months). • Initial randomisation of participants to intervention or 'usual counselling' (though not on sexual compulsivity). • Lack of analysis of comparison group data ('usual counselling')	• Clear presented demographics of sample (in original paper). • Use of objective assessment tool used in order to classify individuals into high and low sexual compulsivity groups. • No measure of comorbid psychological functioning in participants. • Lack of description on how high-risk sexual behaviour parallels conceptualisations of sexual compulsivity.	• High-risk sexual behaviour used as a proxy for sexual compulsivity, without corroboration from participants. • Lack of detail on confounding variables through follow-up process. • Clear rationale for analyses. • Multiple authors.	• No declaration of interest or funding. • Clear description of first analyses, and progression to re-analyses. • Lack of reflection from author on conceptualisation of sexual compulsivity.

Klontz, Goros & Klontz (2005) [40]	• Purposeful sampling of self-identified sexually compulsive males. • Lengthy description and referenced description of group modality, though lack of clarity as to how it is operationalized. • Objective, referenced assessment of sexual addiction.	• Lack of clearly defined demographics of the participant sample. • Comorbid psychological distress is assessed initially and over the course of intervention. • Use of objective, referenced psychometrics. • Male and female participants.	• Clearly defined outcome measures. • Analysis controlling for gender. • Clear rational for analysis. • Unclear how to replicate intervention. • Unclear on participants' perspective of treatment. • Attrition of participants not included in analysis.	• No clear declaration of interests and funding. • Reflection from author on implications and limitations of work. • Multiple authors.
Orzack, Voluse, Wolf & Hennen (2006) [35]	• Purposive sampling of men with dysfunctional Internet-enabled sexual behaviour. • Classification of sexual behaviour based upon self-referral. • Mixed clinical diagnosis and comorbidity within sample. • Clearly described, structured intervention used. • Clear, objective outcome measures used.	• Clear description of sample demographics. • Sex addiction here limited to Internet use and based upon self-referral. • Classification and assessment of comorbid psychological distress.	• Clearly defined outcome measures. • Clear rational for analysis. • Unclear on participants' perspective of intervention. • Clear detail of treatment intervention. • Lack of clarity of relative impact of treatment components. • Multiple authors.	• No clear declaration of interests and funding. • Evidenced application of referenced guidance on motivational interviewing. • Ambiguous goals of intervention • Reflection from authors on limitations of methodology. • Lack of reflection on the possible impact of conceptualisation of sexual addiction.
Shepherd (2010) [42]	• Clear, well structured detail of case. • Triangulation with DSM criteria (for substance dependence), though no formal assessment measures used. • Clearly defined intervention, goal-setting. • Objective outcome measures.	• Detail of client's age, gender, sexuality, and sexual behaviour. • Clearly presented case conceptualisation and formulation. • Clinical reflections on working with client.	• Clearly identified outcome measures. • Use of clients own language in report, though lack of corroboration from client. • Clear Formulation and structure of intervention.	• Clear declaration of interests and funding. • Clear structure to and detail of goals and topics covered in session. • Reflection from author on treatment process. • Reflection on the impact of sexual

	• Clear detail of sessions, and length of engagement.	• Proposed treatment implications from the case, and recommendations to clinicians. • Sadness and anxiety conceptualised as part of sexual addiction rather than co-morbid problem, thus no comorbid psychological distress	• Two month follow-up.	addiction conceptualisation.
Wright (2010) [37]	• Purposeful sampling of self-identified sexually compulsive males. • Transparent and subjective self-report measures of sexual compulsivity, group attendance, and sponsor work. • Correlational analysis unable to answer causative effect of treatment. • Effect of time, and duration of treatment not assessed.	• Lack of clearly defined demographics of participant sample. • Participants' experience of group not clarified. • Ideographically defined temporal data points. • No assessment of co-morbid psychological functioning.	• Clear rational for analyses. • Subjective measures, and retrospective answers may influence participant answers.	• No clear declaration of interests and funding. • Reflection from author on limitations of the work. • Unclear methodology based upon aims.

In terms of methodological design, no research paper randomised or pr based upon sexual addiction, or other experimental controls. Nor participants or assessors, or pre-determine necessary power for their one study made explicit reference to consideration of ethical iss confidentiality, anonymity or informed consent [41].

Similarly, no case study outlined 'member-checks' from clients, which clients had not had input in the final report. Case studies were based up client work, and each referenced practitioner notes taken throughout th though these notes were not included as part of the papers. It appear cases the research authors were also those who facilitated group wo study was based upon on their experiences of different group [37], employed paraprofessional counsellors, with 4 hours training in PCC intervention [39]. Few reports [39, 40] provided detail of the t psychotherapist.

Given the lack of clear declaration of interests and funding, in all but on is unclear what impact the clinicians training, experience and interests findings and presentation of the work. Based upon the quality criteria Guba, this lack of detail and possible author bias, translates as credibility, transferability, dependability and confirmability.

Intervention Characteristics

In three of the case studies participants were conceptualised as addiction [41-43], and one used the terms sexual addiction an interchangeably [38]. Research interventions, using before-after group and cross-lagged panel analysis, referred to sexual compulsivity in th [35, 37, 39], though one study conceptualised the sexual addiction of th [40]. Despite the potential influence of differences in these concep intervention and treatment goals [44], only two reflected on the potentia conceptualisation on the intervention [38, 42].

Case studies investigating treatment of sexual addiction utilised CBT [4 Jungian Psychotherapy [43] and motivational interviewing plus a group mix of 12-step, psychodynamic, cognitive-behavioural and behaviou approaches' [38, p.309]. Research studies reviewed cognitive cou Dilley), 12-step groups [37], and other multimodal group formats [35, 40]

While there was much variation in these interventions, in three studies 12-step groups were used, either as part of the main intervention [37], one dimension of the intervention [38] or an addition to the main intervention [41]. However, the lack of 'thick description' of these groups in studies makes their comparability and the specific impact of 12-step intervention components hard to decipher.

These and multimodal group interventions [35, 37, 38, 40] were often described as being based upon previous 'evidence' [10, 45-46] though only one of these studies provided detail of the goals and process of group work [35]. Lack of description of these interventions meant that the outcome measures of many studies were also hard to determine. For example Klontz and colleagues explain the *"major goal is the resolution of unfinished business"* [40 p.280].

Outcome Measures

Only two studies used an objective assessment of sexual addiction at the outset of work [39-40] though these were not used to classify inclusion into the study, but rather as a retrospective re-classification tool [39], or as a test-retest outcome variable [40]. The reliability of measures was only reported in one of these studies [40]. The remaining studies used unstructured interviews to evaluate sexual addiction/compulsivity. These interviews typically followed their respective school of thought, or were based upon sexual addiction literature [45-46].

A range of overt sexual behaviours were considered as representations of sexual addiction/compulsion, including frequency of Internet-enabled sexual behaviour [35], unprotected anal sex [39], frequency of sexual partners and hours spent online looking at pornography [42]. Other studies discussed problematic sexual behaviour more subjectively, based upon reported a range of behaviours and distress. One study [41] focussed on processing of trauma memories as an outcome, given theory suggesting this would alleviate addictive behaviour.

Where objective outcome measures were labelled, a reduction in frequency of sexual behaviour [35, 39, 42] or reduction in subjective units of distress associated with a traumatic memory [41], were used as evidence of an improvement in sexual addiction/compulsion. One case suggested commitment to therapy as evidence of *'a viable treatment of sex addiction'* [38 p.313]. Another also used self-reported 12-step meeting attendance, as well as self-reported sexual compulsivity ("i.e. I engaged in sexual compulsive behaviour during this phase") as an outcome [37]. Several authors

describe anecdotally the general improvement, or lack of improvement, in participants over time [38, 41, 43].

Studies that utilised numerical outcome measures used well-referenced and argued approaches to analysis. Inferential statistics were calculated using analysis of variance [40], correlation [37], STRATA assisted trend-analysis [35] and regression [39]. Only one study utilised baseline degree of sexual compulsivity as a factor in their analysis [39]. Importantly, two studies did not include participants' that did not provide follow up data in their analyses [35, 40].

Intervention outcomes

Of the eight studies, seven reported their intervention had achieved positive outcomes for the participants. However, one case study noted that *'after 38 sessions [the client] abruptly halted therapy'* [43 p.202]. Several studies reported mixed results, meaning that they found improvements on some, but not all expected dimensions [35], or suggestions of association but not causality [37]. Outcomes of the interventions are described below and are summarized in Table 1.

Case Studies

Del Giudice and Kutinsky [38] felt that Motivational Interviewing (MI) had been critical in one client's recognition of discrepancy between client's goals and his sexual behaviour. Similarly they reported how MI had helped a client shift from appearing 'somewhat sullen' to feeling optimistic, and in 'eliciting change talk' from him. This was thought to benefit their overall treatment outcomes. Though the authors review their group treatment as being very positive, they provide little detail on the treatment approach itself, and they emphasize that their report is not intended to promote motivational interviewing as an intervention in and of itself. The authors highlight the need for future comparative studies measuring the effectiveness of interventions.

Shepherd [42] provides a clear description of her CBT intervention with a 41-year-old gay man self-referring for his sexual addiction. The intervention also included MI, following the 'evidence' reported by Del Giudice and Kutinsky [38]. CBT strategies were reported to have reduced the amount of time spent online, and frequency of sexual partners, though these behaviours were self-reported and may have been inaccurate given his *'perfectionism and reluctance to "fail"'* (p.24). Interestingly she reflects on how her intervention would have consisted of 'more physical barriers' should she have conceptualized her clients distress as sexual compulsivity.

Cox and Howard [41] review evidence suggesting that trauma may be key in the etiology of sexual addiction. The often 'overlooked or minimised' employment of EMDR methodology is suggested to have prevented their client from becoming 'stuck' into relapsing addiction. Although this account is well argued, they note that the treatment process for the client was relatively young at the time of writing the report. It had also incorporated empty chair work, letter writing, relapse-prevention and 12-step psychotherapies, and additional prescription of anti-depressants. Improvement in the sexual-addiction of the client is not clearly explained and it is hard to determine how this multimodal treatment could be extrapolated, particularly to work with addicts without co-morbid trauma.

Cavaglion [43] emphasises that one way to assess the presence of a real distress/disorder/disease is to listen to first hand reports of people who define themselves as sexually addicted. The clients' sexual addiction in middle age was argued to be particularly relevant to a Jungian attention on midlife crisis. Sexual addiction may also be an expression of the repressed "shadow" (a Jungian Archetype encompassing the dark side of personality). Though an interesting interpretation, Cavaglion himself reports that the *"course of therapy and its dramatic end calls for some consideration either on the diagnosis or the therapeutic relational level"* (p.205).

Research

Dilley [39] found that a lengthier, focussed form of cognitive counselling (PCC) reduced the incidence of unprotected anal intercourse (UAI) in men, in comparison to usual counselling (UC). Though the initial study did not control or randomise for sexual compulsivity at the outset, retrospective analysis showed comparable self-reported sexual compulsivity scores in those randomised to PCC and UC, though higher sexual compulsivity score was associated with higher numbers of sexual partners at baseline and follow-up. Following a quartile split based on self-reported sexual compulsivity; the highest rated group showed the greatest relative reduction in UAI, though this change was non-significant. Equally, there was no assessment of change in sexual compulsivity itself.

Wright [37] employed a 'retrospective two-wave' panel design to address the competing perspectives of "*12-step communication enables addicts to change behaviour"* versus *"addicts able to change their behaviour diligently attend the 12-step process".* Self-identified sexual addicts were asked to retrospectively rate their sexual compulsivity and meeting attendance using 5-point, 3-item Likert measures (e.g. "*I engaged in sexually-compulsive behaviours at this time*"), at self-defined 'post-labelling'

(when their partner had labelled their behaviour problematic) and 'post-frustration' (after the labelling phase had ended) time-points. Result showed that high levels of meeting attendance and sponsor work at an early stage was associated with reductions in sexual compulsivity at a later stage, though attendance and sponsor work did not account for change in sexual compulsivity. The authors reiterate the need for further empirical enquiry [47].

Klontz et al. [40] report clear benefits in participants' self-reported psychological distress and pre-occupation with sex and sexual stimuli over the course of treatment, which remained stable or improved further at 6-month follow up. However, 15 participants either did not wish to participate or did not provide follow-up data. Also, eighty-nine per cent of participants also regularly attended 12-step groups, and eighty-seven per cent also attended undefined 'out-patient counselling'. The lack of control group, or analysis to control for these covariate therapies and attrition makes the findings hard to interpret. Equally the authors note the transparency of self-report measures and participants' motivation to portray greater improvements than had actually occurred in therapy should be acknowledged.

Orzack and colleagues [35] report 'the first-known', empirically based outcome study regarding the effectiveness of group therapy treatment for men with internet-enabled sexual behaviour. Again this group employs a multi-modal approach including MI and CBT. Overall in their sample of 35 group members, they found group reduced depressive symptomology and increased quality of life, though report the group had no impact on Internet usage. They dispute this finding and argue the need for the 'ignition' of further empirical research.

Discussion

This systematic review identified a small body of research, comprised of eight articles, which have evaluated interventions that target sexual addiction. Overall, the studies were of poor-to-modest research quality, featuring small sample sizes and lack of randomization or clinical controls. The lack of clarity in reported classification, intervention, and appropriate outcome measures arguably reflects a difficulty in empirically evaluating interventions of this controversial diagnosis, as well as the newness of research exploring this field. This is reiterated in the wide-range of psychological interventions and multi-modal approaches authors have drawn upon.

A major methodological limitation of the included studies is that no study recruited participants based upon an objective assessment of sexual addiction. The majority of

those seeking treatment had self-identified as a 'addicted' or 'compulsive', which was confirmed by unstructured interview. There was therefore a great deal of subjectivity across classification. The synthesis supports previous discussion surrounding the difficulty in conceptualizing sexual addiction. The concept of sexual addiction contains various, often discrepant, theoretical underpinnings [48]. Some academic and clinical communities have even questioned whether sexual addiction is a legitimate label, or is instead a stigmatising label for those who deviate from the 'sexual standard' [15, 49]. This parallels one study's categorization of sexual addiction as based upon when their partner *"became aware of their behaviour or defined it as problematic*" [37, p161]. Similarly one author noted his client *"stated that he felt good about what he was doing, and was aware of the negative consequences"* [43 p206], but was manifested the self-destructive symptomology detailed in published definitions of sexual addiction [10, 45-46] Further investigation into discrepancy between client and expert viewpoint would be extremely valuable.

Undoubtedly some of this discrepancy will be founded in broader socio-cultural values surrounding sex. Two of the three studies which describe their client's upbringing, make explicit reference to the strict Jewish upbringing of clients, whose parents' valued perfectionism [42-43]. Guidance on sexual addiction assessment argues, *"sex addicts come from families which are strict and authoritarian…excess in religiosity, or extreme sexual negativity or both, most likely will intensify sexual curiosity or obsession"* [50, p.7]. Likewise, it is doubtful whether clients would view the same degree of sexual behaviour as pathological, distressing or addictive without this pervasive anti-sex, perfectionist contrast.

The one other study, which described their client's upbringing, outlined an extensive history of sexual abuse [41]. Again, assessment guidelines suggest a positive correlation between sexual addiction and trauma [45]. However, there is a contrasting literature which discusses how childhood sexual abuse can lead to misconception and confusion about appropriate sexual behaviour, following developmentally inappropriate and interpersonally dysfunctional sexual contact [51]. The use of EMDR here could be conceptualized to benefitting distress relating to 'traumatic sexualization' rather than 'sexual addiction' [51].

Shepherd [42] outlines, the numerous ways which sexual addiction can be defined and formulated, means detailed descriptive case studies in this area are invaluable. Similarly, Cavaglion [43] stresses the importance of first-hand ideographic reports in assessing distress. These clinician accounts bring into question what value the

reductionist diagnostic label of hypersexuality would bring to their approach to intervention.

Studies reporting positive results emphasized the utility of Motivational Interviewing [38, 42]. Del Giudice provide a clear outline of how this helps foster an unconditionally supportive relationship, where the client is viewed as fundamentally a good person, who is loved, accepted and respected; and advises this stance as a fundamental 'centrepiece of therapy', which seems to contrast the 'shame and relational deficits' which accompany the addiction and compulsivity label (p.306) [22]. These reflections, which praise the effect of acceptance, seem fundamentally incongruous with the momentum driving the pathological 'addiction' classification.

Studies for the most part outlined 'symptomology' as risky or problematic sexual behaviour, however where studies investigated it there was also a great deal of co-morbid psychological distress in the form of depression, anxiety, and obsessional compulsive disorder [35, 40, 41]. Orzack and colleagues' finding that quality of life and sexual behaviour were not impacted in the same way by intervention [35], suggests that their relationship is not perfectly correlated or causally related. Future studies untangling connections and overlap between sexual 'addition' and wider psychological distress and systemic issues are vital.

Given the complexity of psychological interventions listed in most studies it would be valuable for research to explore the experiences of those who complete treatment, including what they found beneficial and whether this has affected their distress, addiction, or both. Similarly, it would have been interesting to ascertain the experience of those who left intervention, and their reasons for attrition.

This could also help clarify the utility of extrapolating other addiction models and interventions to sexual addiction. For example classical disease models of addiction suggest it would be unfair to expect a sex addict to manage any sexual relationship as this will always lead to distress [52]. Similarly, Shepherd outlines the need to consider physical barriers to sexual behaviour in some instances [42 p.26]. These abstinence and restraint conceptualisations parallel fundamental criticisms of the disease model of addiction as misleading in implying that addicts are impotent onlookers and the only way of stopping them is physical restraint [53-54]. Also it would be unethical to enforce abstinence from the Internet or any form of sexual behaviour [35]. There is therefore an arguable discrepancy in how classical 12-step approaches can be applied to sexual addiction.

From the studies included in this review, it appears that recent research does not suggest a superior intervention for sexual addiction. Although there are reported strengths and weaknesses across those interventions reviewed, the modest quality of reports makes it hard to determine aspects of treatment which are beneficial, and indeed why. This ambiguity appears to stem from a more fundamental issue of how to conceptualize and measure sexual 'addiction' or 'compulsivity'.

This report has limitations, including the small number of studies included and the heterogeneity of the included studies. Across those included, the different types of report, their different conceptualization of sexual addiction and compulsivity, and their exploration or evaluation of different types of interventions, made drawing comparisons difficult. Additionally, studies varied in methodological quality, and were not seen to be able to be judged by more objective assessments of quality such as that proposed by Downs & Black. Though the inclusion criteria were purposely broad, the review excluded early studies (pre-2002) given the need for contemporary guidance upon the release of the DSM-V. It also excluded intervention studies focused on sexual behaviour without detail of sexual addiction or compulsivity, which left some studies of high-risk sexual behaviour [55], and clearly a body of literature on sexual offending. As discussed, the lack of clarification as to the term sexual addiction, it may mean that relevant studies were not identified. It is hoped that the use of a range of search terms and electronic databases, reduced the possibility of this. A more extensive search of grey literature may have minimized the likelihood of publication bias. This may be particularly pertinent in this review, given that five of the eight included studies were published in the same journal. The majority of the included studies used a US participant sample, and so the cross-cultural generalizability of our findings may be restricted. Equally the majority of studies focussed on male participants, and given differences in the effectiveness of intervention of drug addiction in men and women [56], the generalizability of findings to female samples may also be restricted.

Conclusion

This review revealed a small number of studies seeking to explore and provide an empirical basis for psychological intervention in sexual addiction. The findings produced by the eight included studies are mostly supportive of their respective intervention. However, modest methodological quality, common use of multimodal intervention and a general lack of consensus in findings suggest the need for more rigorous research into the area. Importantly, it is recommended that a first line of enquiry is to clarify the concept of sexual addiction, including the view of 'addicts' themselves, and an open discussion on what value the diagnosis adds.

Declaration of Interest

None

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JOURNAL PAPER

Losing Control in Sex Addiction: 'Addict' and 'Non-addict' Accounts[4]

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Abstract

There has been a recent trend for the construct of addiction to be applied to sexual behaviors. A growing number of people recounting excessive sexual thoughts or behaviors have been categorized as suffering from sex 'addiction' or hypersexual disorder. Sex addiction is said to involve a pathological relationship to sex, with the symptomology of sexual addiction akin to drug dependence. Opposing interpretations have argued that sex addiction is used as a stigmatising label for those who deviate from a socially constructed sexual standard. A Foucauldian form of discourse analysis was used to analyse semi-structured interviews with nine men who identified as sex addicts, or as highly sexual though not addicted to sex. In this article we present this analysis, exploring how sexual addiction is constructed as a genuine medical/diagnostic entity, focussing on the discursive theme of losing control, used by interviewees to construct their positioning and moral status.

[4] This paper has been written in preparation for Qualitative Health Research.

An increasing number of people recounting excessive sexual thoughts or behaviours have been categorized as suffering from sex addiction or hypersexual disorder (Stein, 2008). Such 'diagnoses' involve descriptions of a compulsive obsession with sexual behaviours, which interferes with everyday living (e.g., Hall, 2013). These definitions appear to assimilate problematic sexual behaviour to diagnostic categories such as drug dependence, or obsessive-compulsive disorder, and discard timeworn public conceptualisations of 'horny', 'oversexed', 'nymphomaniac', etc. Reflecting this growing clinical concentration, there has been a body of work asserting the need to include 'hypersexuality' as a diagnostic category (e.g., Kafka, 2010) within formal diagnostic manuals such as the DSM-5 (American Psychiatric Association, 2013). However, addiction is a complex construct, and the concept of sexual addiction contains various descriptions and understandings (Hughes, 2010). Some academic and clinical communities have even questioned whether sex addiction is a legitimate concern, or is instead a stigmatising label for those who deviate from a hegemonic sexual standard (Levine & Troiden, 1998). The search term 'sex addiction' produces more than 83,000,000 results using Google, 26,000 using Science Direct and, 2,000 searching Cosmopolitan magazine's online content, highlighting both the prevalence and span of narratives of sexual addiction, in both scientific and public discourse.

Patrick Carnes was the first to define sex addiction and its dynamics, following his own clinical work and observations (Carnes, 1983). For Carnes, the addict's sexual behaviour is not at the extreme of the normal range, but is qualitatively different from the norm, encompassing a pathological relationship to sex with symptomology analogous to that of substance dependence or alcoholism (Carnes, 2001; Kafka, 2010). For Carnes, sexual addiction is marked by tolerance; for example use of pornography can progresses to homosexual and illegal practises, and cascade toward extreme and

dangerous sexual activity, culminating in sexual offending (Voros, 2009). Described this way, progression of sex addiction is not simply sexual nonconformity, but can lead to risky, coercive and criminal behaviour (Denman, 2004). This intimates that identification and intervention with sexual addicts becomes a scientific, social and moral issue.

This conceptualisation has led to the growing medicalization of sex addiction. A number of screening tests have been developed to identify and diagnose sex addicts based upon diagnostic criteria developed by Carnes and colleagues. Examples include the Sexual Addiction Screening Test (SAST, Carnes, 1991), the Sexual Dependency Inventory (Delmonico, Bubenzer & West, 1998), and the Compulsive Sexual Disorders Interview (Black et al., 1997). Presenting increased objectivity, and constructing a science of sex addiction, is paralleled by a rise in exploratory biomedical treatments. For example, some have promoted the prescription of selective serotonin reuptake inhibitors to treat sex addiction (Kafka & Hennen, 2000), despite most accounts suggesting that sexual appetite diminishes with decreased mood (Araujo, Mohr & McKinlay, 2003). Also, work has investigated the use of opioid antagonists to treat sex addiction, based on a purported cross-sensitisation across sex and drug addiction (Fiorino & Phillips, 2001; Grant & Kim, 2001).

However, a recent systematic literature review revealed few and disparate research papers, primarily based on anecdotal accounts, as the foundation of these interventions (Briggs & das Nair, in prep.). Reports promoting the evidence base and scientific rigour of sex addiction are nevertheless common. For example Carnes (1998) states the ratio of sex addicts to be approximately 3:1 male to female, despite a scarcity of large-scale epidemiological studies or published peer-reviewed research to date. Such examples of disparity between diminutive evidence and the prevalence of scientific

discourse highlight how the authority of the expert can serve to reify the construct. Indeed, some argue that the advance of sex addiction as a diagnosis is based less on the "rigor of the arguments put forward by the clinicians and scientists than to the authority inherent to their social status" (Voros, 2009, p.245). This expert authority is used in most cases to help enable the addict to overcome perceived denial and admit their addiction (Cordonnier, 2006).

Addiction (particularly behavioural addiction) is an abstract concept. It is socially defined, meaning opinions and thus definitions can legitimately differ, and it cannot be said that one definition is unequivocally correct (West, 2010). The limited consensus in academic and clinical literature, and wider lay discourse, translates in the variety of discourses used by other addict populations to endorse or reject constructions of addiction (Benford & Gough, 2006; Gillies & Willig, 1997). Similarly, it remains unclear what the parameters of normalcy are regarding sexual behaviour, and precisely where and whom these parameters have arisen from (das Nair & Butler, 2012). It remains to be established how the combined construction of sex within addiction discourse might serve to position the individual. The number of discourses used to endorse or reject constructions of addiction is most likely amplified in sexual addiction given the aforementioned controversy surrounding the legitimacy of the diagnosis, and its current position in the "diagnostic wastebasket" of sexual disorders not otherwise specified (Schneider, 1994). The content and function of these discourses require clarification, particularly given their strength in being able to empower/disempower individuals who accept or reject the addict positioning.

The controversy and complexity of addiction discourses in relation to sexual behaviour, in both expert and lay constructions, makes it valuable to explore how sexual behaviour can be constructed as addictive or not. In the present article we outline

discourses used by individuals to define and preserve their subject positioning as addicted to sex. We compare these accounts with those of individuals who identify as having a large amount of sex, though not as addicted, instead positioning as possessing a healthy sexual appetite. Qualitative methodology is used here to explore and contextualise the addict and non-addict, and capture cultural, situational and value factors critical in these constructions (Parker, 1992; Peele, 2000; Willig, 2008).

Theoretical Framework: Foucauldian Discourse Analysis

Michel Foucault has explored and described in depth how sexual behaviour, and sexuality have historically been conceptualised and moralised (Foucault, 1984; 1990). Foucault's work on the relationship between language and available ways of ordering, understanding and experiencing the world, have been highly influential in drawing attention to the importance of discourse in coding and regulating psychological phenomena and social life (Cheek, 2004). Discourses offer subject positions which, when taken up, have implications for rights and responsibilities, experiences and subjectivities for those who adopt them (Harre & Van Langenhove, 1999). According to Foucault, the constitution of subjectivity through discourse is the modern form of power (Benford & Gough, 2006). Dominant discourses privilege those versions of social reality that legitimate existing power relations and social structures.

Some discourses are so entrenched that they have become common sense, and it is difficult to see how they could be challenged (Foucault, 1990). However the utilisation of alternative constructions or counter-discourses is possible (Parker, 1989), and dominant discourses can change over time (e.g., Foucault, 1990). Foucauldian Discourse Analysis (FDA) was selected here to help shed light on the emergence of ways of referring to sexual addiction, and classifying sexual behaviour (Kafka, 2009).

This analysis focuses upon "types of normativity and forms of subjectivity" in sexual addiction (Foucault, 1984, p.10); i.e. how language constructions make available ways of seeing the world, and ways of being in the world for those who identify as sex addicts and non-addicts (Willig, 2008). Discursive practices as well as resources of those who identified as addicts and non-addicts to manage stake and interest were also attended to in the present analysis (Potter, 1996). This helped balance systemic features while also grounding the analysis in the data (Wetherell, Taylor & Yates, 2001).

FDA does not enable understanding of the true nature of psychological phenomena (Willig, 2008), and it is important to highlight that the current work does not seek to determine the validity of sex addiction as a construct. Equally, the present work does not set out to identify factors that cause people to become addicted to sex, but rather how people position themselves (and are positioned within) discourses of addiction, and with what consequences.

Method

The data we analyse in this project are drawn from one-to-one semi-structured interviews conducted face-to-face, or via the telephone or Skype with nine interviewees. Interviewees comprised men who self-defined themselves as having a high level of sexual behaviour and identified as not addicted to sex (non-sex-addicts, n=4), and those who did identify themselves as sexual addicts (sex-addicts, n=5). This group size was informed by previously published FDA research into behavioural addiction (Benford & Gough, 2006), and guidance on data selection in discourse analysis (Parker, 1992).

The study was promoted through recruitment information (posters and leaflets) distributed primarily in bars and clubs, as well as via email communication with

consenting sexual addiction groups and organisations. A dedicated Twitter account was also set up to recruit via online social networking, and interviewees were invited to promote the study through their own social networks. Inclusion criteria and exclusion criteria were kept purposely broad given the wide range of cognitions and behaviours that form the nosology of sexual addiction (Kafka, 2010). However, those aged under 18 were ineligible to take part, and the study focused solely on males, given the distinctions in the discourses of male and female sexuality and sexual behaviour, which could distract from the current analyses (Schneider, Cockcroft & Hook, 2008).

'Sex addicts' could self-diagnose or have been diagnosed by a third party. 'Non-sex addicts' could potentially meet criteria to be formally classified as addicted to sex by available diagnostic criteria. Therefore, both those who identify as sex addicts and those who do not, might express very similar sexual behaviour, urges and fantasies, but subjectively identify as different subject positions. Sexual orientation and sexual behaviour were not used as exclusion criteria, nor were age, education, relationship status, religious affiliation, or cultural context. Though information was not explicitly collected on these demographic variables, the men ranged from their early 20s to mid 60s, and had a range of educational qualifications, employment, and relationship statuses. Men participated from the UK and the USA.

Interviewees were given an information sheet explaining the purpose of the study, were free to ask questions, and given a minimum of 24 hours to consider participation. They were then asked to provide their informed consent in accordance with key ethical safeguards such as right to withdraw and anonymity (interviewee names used in this article are pseudonyms). The University of Lincoln gave ethical approval for the study.

In interviews the interviewees were invited to discuss their story as freely as possible (Hollaway & Jefferson, 1997), although an interview schedule was used so that the interview kept sight of the interview agenda, and in order to create some comparability across interviews (Willig, 2008). This interview schedule follows the guidance of Spradley (1979), in incorporating descriptive, structural, contrast, and evaluative questions. These questions allowed interviewees to provide general accounts, personal anecdotes, prompted them to identify their personal categories and meaning that they use to make sense of world, and also make comparisons between experiences, and share their appraisals (Willig, 2008). The interview schedule was informed by issues in the literature, and focussed upon the interviewees' experiences and their understanding of sexual addiction. Interviews lasted around 60mins and were recorded using a Dictaphone.

The interviews were first transcribed into written text, and initial ideas and associations to the text were recorded (Parker, 1994). The analysis draws upon several sources of guidance including that of Parker (1992) and Willig (2008), and focuses on identifying discursive resources in the text, their social and historical construction, the subject positions they contain, and exploration of their implications for subjectivity and practice. In line with previous FDA research on addiction, special attention was paid to contradiction between voices, and the discourse of the addict and non-addict (Benford & Gough, 2006). Together these guidelines are thought to offer a comprehensive means of addressing construction of the individual subject by wider normative and institutional qualities of discourse (Arribas-Ayllon & Walkerdine, 2008); as well as identifying subject positions and subjectivity and so the consequences of discourse on subjective experience (Davies & Harre, 1999; Harre & Van Langenhove, 1999).

Analysis

Those who identified as addicts utilised discourses of conflict and a progressive loss of control over their sexual behaviour to align their position as comparable with other established addictions. Desirability of control and self-restraint were used to construct this loss of control as problematic (Valverde, 1998). An allied discursive theme of 'good' vs. 'bad' sex constructed the behaviour of the sex addict as a deviation from a sexual norm. For the most part addicts' constructions of bad sexual behaviour incorporated notions of dirt and danger; capable of generating fear, shame, and guilt in the sex addict. This promoted their seclusion and secrecy, given their projected judgement from an unaccepting society.

The construction of losing control was often presented through a personal narrative, where addicts outlined instances of intrapsychic or social conflict and concern (Wenger, 1998). In order to manage their opposing 'bad' sexual behavior and wider moral impetus toward 'good' sexual behavior, many addicts employed discourses of illness to distinguish their behaviour and aspirational self. This served to protect the moral status of the addict, and correspondingly created the reciprocal subject positioning of the knowing expert, able to identify and intercede the addicts' sexual behavior. The expert is aligned with powerful psychological and medical institutions and is entrusted to help the addict, and furthermore to protect wider society and future generations. For example, interviewees constructed the need for an expert preventative mediation of Internet pornography, given its overwhelming power to generate and maintain addiction.

Together these topics were collated into three central interconnecting discursive themes: a loss of control; good vs. bad sex; and the cultural imperative to intervene in

sex addiction. A thorough account of the discursive themes produced in the analyses is beyond the scope of the current article, and so the article presented will focus upon the loss of control discourse, noting important connections with the two additional themes.

A loss of control

A central construction apparent in addict accounts was their positioning as unable to control consumption choice. Those who identified as addicts appeared to distinguish self-governed behaviour and addictive behaviour as mutually exclusive; where an inability to self-govern behaviour was constructed as indicative of addiction.

> Sex is optional. If it isn't optional for you, or if certain behaviours are not optional, if they control you and not you control them, if you cant say no, when no is appropriate. You have got a problem. Full stop. (Alistair 637)[5]

This loss of options and control is constructed as a problem, or disorder. Alistair uses a discursive strategy of a three-part list (Jefferson, 1990), based around option, choice and ability to say no, in order to build this construction. The use of the pronoun 'you' is notable. This both serves as an agency shift of a morally loaded discourse to the wider reader, and also accentuates the construction of addiction as pervasive within society as a whole. The construction of a loss of control appears to be a form of stake inoculation in which interviewees mitigated persistent bad sexual behaviour and the apparent psychological conflict this caused them (Potter, 1996). For most addicts, the loss of control was linked to discourses of failed attempts to stop thoughts or behaviours from happening or stopping them once they had started. This was constructed as an

[5] Names represent pseudonyms of interviewees. Numbers represent line numbers in individual interview transcripts.

abnormal experience, incomparable to capacity to control other aspects of their life, i.e. the loss of control of the sex addict was constructed as exclusive to sexual behaviour.

> Many times I would go online and say, 'oh I am only going to go on the Internet for 5 minutes' . . . there is no way that I can guarantee there will be 5 minutes of pornography. I might be lucky and it might be 5 minutes, but there is a distinct lack of control as to when I've started, there is a lack of control as when I will stop. (Alistair 315).

> And I almost did a bit of a double take, and sort of came out of myself and thought that 'this is really weird that I cant do this', I mean I have stopped all these other things, so other things I can sort of have self control over but I can't not do this. That was the first sort of realisation that I had a problem. (Chris 250)

A loss of control is often noted as a core criterion of addiction, and the inability to appropriately withhold or terminate thoughts and actions features strongly in contemporary biomedical and social science theories of drug addiction (see Cote, Rolland & Cottencin, 2013; Weinberg, 2013). Relatedly, contemporary health discourses are marked by a key-theme of personal agency and control, and so by losing control the addict is deemed unhealthy (Willig, 2000). Akin to discourses of drug addiction, the interviewees explained sex addiction as a dualistic disorder whereby they had both an amplified drive to engage in an activity (e.g., take drugs/view pornography), combined with a decreased ability to inhibit this (Berridge et al, 2009). A litmus test of addiction is therefore constructed as attempting control over drive and failing. In the extract below Tony uses the footing shift 'we' to presenting his account as impersonal and generalizable to the wider sex addict (Goffman, 1981).

> And then when we eventually tried to stop, we just couldn't. (Tony 512)

Jonathan, who positions himself as a man with a high sexual appetite, though not an addict, outlines a similar conceptualisation having a high drive toward sex, but also having some sense of control over this. The 'non-addict' position appears to be constructed relative, but not in accordance to the loss of control construction of the addict (e.g. 'I might be less in control'). Jonathan draws upon Freudian 'libido', as a way to communicate the nature of his allurement to sex, which he constructs as having imperfect control over, though he is able to control the risk or danger associated with sex.

> So in the practicalities of sex, including, and especially, the safety aspect around sex, the health and safety aspect of it, I'm entirely in control of it most of the time. I think sometimes where I might be less in control around sex, is my internal motivation to seek out sex, you know. That sometimes perhaps internal emotional drivers, or what Freud might have called, internal libido, kind of takes over a little bit and then it's difficult for me to remain fully in control of my sexual needs, when perhaps I might know differently, you know. (Jonathan, 351).

The 'taking over' of libido, anthropomorphises and empowers this seemingly internal state. This construction is strengthened by its comparability to the dominant psychoanalytic construction of sexuality, and the Freudian topographic schema of the id, ego and superego (Freud, 1949). Here sexual drive is constructed in accordance with the impulsive, hedonistic id, whose actions are entirely unconscious, and so out of cognitive control. Though the construction compels the counterpart construction of self-restraint or 'super-ego', Jonathan uses minimisation in this account ('most of the time', 'a little bit'), to inoculate against the capacity or necessity to be in complete control of his sexual behaviour.

Though the Freudian construction of libido is typically associated with a life drive, some sex addicts constructed their unconscious drives, or urges, as pathological and destructive. For example below Pete describes that he does not want to be driven by his sexual urges, and goes further to suggest it is important to regulate these (by stress management). In this instance sexual drive is constructed as a conscientious practice, whereas being 'urged' is constructed as more unhealthy and unconscious (see Berridge, 2009).

> So the reason to have compulsive behaviour around sex for me, is more related to managing personal stress. And there's a point where it overtakes, if I don't manage stress, it overtakes. I have a physical urge, which is not a sexual, clearly it results in a sexual urge, but it's not a sexual drive. It's a physical drive to behave in a way, which I feel unable to control. That's different from wanting to have sex. (Pete, 354)

The urge toward sexual behaviour and progressive loss of control creates a dynamic discrepancy, positioning addicts as unable to curb the escalation of their problematic sexual behaviour, despite the discourse of moral value and health in self-restraint.

The progressive nature of Addiction

Addicts' constructions of escalation parallel substance dependence discourses of tolerance, i.e. requiring a markedly increased amount of substance to achieve a desired effect (Koob & Le Moal, 2008). Interviewees described increasing risk and deviance (i.e. 'bad' sex), rather than amount of sex, as a way in which their sexual behaviour had, and may continue to escalate. Discourses of tolerance to progressively 'bad' sex appear tied with the discursive resource of stake confession, whereby the author is presented as

open and honest in their account despite the morally charged positioning (Potter, 1996). As below, examples of this discourse typically involved minimisation ('probably', 'kind of'), and a passive formulation ('over time'), to indicate the lack of culpability the addict had in this behaviour.

> Over time you're looking for more and more of a thrill about it, I probably have done more and more, in some ways, degrading things as I went through my life . . . I kind of moved from straight sex to looking for dominant women and, you know, more of a BDSM kind of role, a submissive partner to that. And again, a lot of that is just about looking for something that's even more forbidden and even more exciting I think, to keep that going, you know. (Barry 116)

Barry's varying sexual behaviours are constructed as progressive ('more and more'), rather than as distinctive categories of sexual behaviour he sought out. This progressive discourse reproduces a moral order, whereby the sexual behaviours of the addict are comparatively abnormal and morally unacceptable in 'normal' society (Foucault, 1967). Those identifying as addicts experienced increasing discomfort in constructing their sexual behaviour as increasingly forbidden, putting them at increased risk of being ostracised by others in wider society.

> The worst case scenario for me would be that I end up escalating to a point where I end up doing things that are illegal and that yeah I end up arrested, and my life collapses around me and my family don't want to speak to me, and that I end up without a job and with everyone turning their backs on me and that sort of thing. (Chris 476).

In line with Chris' depiction above, most addicts constructed 'end points' of this progressive escalation of sexual behaviour. The addict identity was often constructed in the extent to which other normal interests and responsibilities are subordinated or damaged by sexual behavior (Room et al., 2003). Such extreme case formulation adds legitimacy to the constructed damage that addiction can propagate (Pomerantz, 1986). A variety of social positions and circumstances appear to be deployed in the process of creating distance between addicts and non-addicts. Institutions, such as religion, were drawn on to maintain this distance. For example, some addicts outlined the conflict between their behavior and societal religiousness meant they were unable to communicate with non-addicts. For example, Barry constructs religion in America as an obvious barrier to open discussion about sex.

> And it's hard, we're still a puritan country from way back when. There are things people don't talk about and, you know, you certainly don't just trot those out as part of every day activity. (Barry, 524)

Psychological discourse was also drawn upon to create distance between addicts and non-addicts. For example, a 'salience' discourse, based on faulty prioritization of sex, was used to totalize the individual's identity as addicted (Valverde, 1998). Sex addiction here is constructed as identifiable through objective outcomes, involving type of sex, rather than purely on subjective experience. Similarly to Barry's earlier extract, Tony talks of an escalation of 'degrading' sexual behaviour, which involves concerns about the focus of his sexual desire.

> If you look at my viewing, it started off with topless women, I remember, you know, topless women, straight, then anal, then group, then quite hardcore, hardcore, hardcore, then transsexual and then this feminisation, sissification,

> humiliation, anything degrading to me. And I thought, if I continue down this route, who knows how deep the rabbit hole will go, you know. What will I be looking at, what will I actually do? Because if I've had the guts and nerve to go and visit a transsexual prostitute, what will I do in the future? (Tony 421).

Tony employs a range of strategies to manage accountability in this progressive narrative (Gergen & Gergen, 1988). He begins by minimizing and normalizing ('you know…') his early pornography experience, and minimizing and questioning his agency in the process ('what will I do?'). Drawing on the 'down the rabbit hole' reference in the story of Alice in Wonderland, Tony conjures images of a fall "never coming to an end" and Alice's venture from a tranquil and safe world into another more dangerous and alien (Carroll, 2001, p.13). He constructs a psychological strength ('guts') to his seeking of sexual behavior, but also constructs this as outside of his control. Tony positions himself as not-accountable or responsible for his previous sexual behavior (and this fall), paralleling the 'insanity defense' in criminal trials (De Fabrique, 2011), and the passive-patient discourse common in health discourses (Jutel, 2009). The discourse of reflection ('And I thought'), consideration and self-restraint incorporates construction of Tony as honest and morally robust for being able to accept his addict positioning and endeavor to ascertain future self-restraint (Parker, 1996; Willig, 2000).

The moral imperative to exercise self-restraint over sexual behaviour corresponds with previous qualitative literature recounting individuals' construction of the pleasure of eating as a vice rather than a harmless enjoyment (Lindeman & Stark, 1999). Hunger and sex have long been linked in scientific and societal discourses of pleasure (Olds, 1958), as well as in neurobiological theory on motivational drive (Pfaff, 1999). There has also been a paralleling rise of addiction discourses in both fields (Burmeister et al., 2013). It is therefore perhaps unsurprising both addict and non-addict

interviewees used hunger as a discursive reference in their construction of sex and sex addiction.

Hunger

Sexual desire was constructed by non-addict interviewees as dependent on numerous dynamic factors, and was constructed in accordance with discourses of hunger and appetite. Contrastingly addict interviewees used hunger as a reference to distinguish it from addictive drive. For example, Jonathan and Alistair despite their opposing subject positions both construct their sexual appetite, drive and control in relation to their appetite for cake. Jonathan uses cake as an analogy for sex. He employs discursive resources, such as the three-part list ('child', 'teenager', 'father of three'), to present his construction of sexual appetite as aligned with appetite for cake as clear fact ('if you think about it'). Contrastingly Alistair uses extreme case formulation ('I love cake! You can bet your mortgage') to distance sex addiction from appetite for cake.

> So it's not that I kind of felt, you know, that I had no control over what I was doing and I was blindly being pulled along, you know, that this is something that entirely takes over, it's not that. As much as it is, you know, sometimes you know you shouldn't have that extra piece of cake but you do. Something when you have you think, that was maybe not the best thing to have done . . . And I think it's no coincidence that we talk about a sexual appetite, you know, that it is very much linked to food. And if you think about the food that a child eats versus the food that a teenager eats, versus the food that a very athletic teenage boy eats, versus the food that a father of three who is stressed at work eats, and it can be the same person who goes through those different phases, whose diet changes all the time, you know. (Jonathan 392)

> I have a very strong appetite for cake. I love cake. But I can sit here today and say to you I wont eat cake for a month, and I can be utterly confident of keeping that promise. Despite the fact that I love cake! Despite the fact that I have a very high cake appetite. I can be certain that I am going to keep that promise to you. As an active addict, if I say I'm not going to do porn for a month, you can bet your mortgage I'm going to do it. (Alistair 331).

For Jonathan, it appears control is something he is able to relinquish more transitorily. Despite constructing the consequences of this loss of control as sometimes problematic ('was maybe not the best thing to have done'), he does not fear loss of control. However, for Alistair, loss of control is presented as comparatively nefarious and enduring.

In line with previous research exploring discursive constructions of chocolate addiction, cake serves as a helpful analogy as it carries both positive and negative constructions, connotations similar to sex. Cake has a natural allure, due to the pleasure, comfort and reward it offers, but it also has a rival construction as something unhealthy and bad (Benford & Gough, 2006). Alistair constructs his loss of control on porn use, as aligned with breaking promises, and so subtlety connects this addictive sex as interpersonally problematic and as bad.

Despite the first person narrative used initially by Alistair, the use of 'an active addict' constructs his account as common of a wider shared addicts' positioning. One way in which interviewees constructed their sex addiction was as analogous to a wider addict positioning, which negated the individualism and privacy discourses of sexual behaviour such as Jonathan describes. This aligned their sex addiction as representative of a scientific medical condition (Goffman, 1981).

Science of Addiction

Those who positioned themselves as sex addicts worked to present their addiction as something that should be taken seriously, similarly to previous qualitative research investigating the language used by other non-drug addicts (Benford & Gough, 2006). Most interviewees noted the aforementioned controversy and scepticism surrounding the diagnosis of sexual addiction to construct their accounts as socioculturally informed, though this was typically contested using constructions of authenticity of the disorder. One of the clearest discursive strategies employed by sex addicts was to use discourses related to substance dependence and alcoholism in order to unify the positioning of 'addict'. Below Tony constructs this positioning as an obvious fact that should be kept in mind ('Remember'), in constructions of sex addiction.

> Remember the alcoholic will start off with one glass of whiskey but they'll end up having three bottles or wine every night, that's their progression. For me I've been, you know, having these orgasms every night for about fifteen years, needing them to relax me. (Tony 451)

> I'd say an addiction is something that you withdraw from when you can't get it. And it leaves a, some sort of physical, maybe mental hole when you're deprived from it. So that, if you can't get hold of porn or if you can't, if you're used to a certain way of relieving yourself and pleasuring yourself, then that's not available to you anymore. And you start to stress or you start to worry and get anxious or you take it out on other people. (Scot 478).

Many sex addicts positioned themselves as at risk from other established addictions. For some, identifying with this addict position caused discomfort, whereas for others it appeared to comfort, as they were able to use the medicalized and

established discourses of addiction as a form of stake inoculation to avoid personal culpability for their behaviour (Potter, 1996). The medicalized construction of experiential and social phenomena of addiction, carry moral implications in relation to aetiology and responsibility. The addict was typically constructed as a patient or sufferer of a genetic predisposition, and so unaccountable for 'bringing on' sexual addiction or inhibiting it (Barnes & Shardlow, 1997; Willig, 2011). Several interviewees positioned themselves as destined to be 'addicts' in some form.

> I know heroin does do it for me, because I have had diamorphine in hospital, because I was in terrible pain, and boy that is serenity in a bottle, let me tell you, it is a dangerous damn drug, and it did it for my dad. Do I think that is a genetic thing? Yes I probably do, there is no way I could have you know been nurtured in a way that my brain responded like that to diamorphine. In a very similar way I think that sex and relationships, though I think that is a very stimulating neural pathway for a lot of people, I am sure that my particular brain chemistry is such that I respond in a particularly extreme way to that. (Alistair 254)

Alistair's constructs his addiction as genetically predisposed, despite the different content of his and his father's addictions. Biomedical discourses of neurobiology were frequently drawn upon to position the sex addict as a casualty of a set and uncontrollable biological makeup ('neural pathway' 'brain chemistry'). For example, Pete conceptualises his behaviour as the result of his amygdala, an area of the brain thought to have an important role in human sexual behaviour (Baird et al. 2004).

> I thought, I knew it was wrong, I knew it was expensive, I've been covering it up, you know, money that you spend on sex workers etc, but I just thought I can

manage it. And then I'd have these terrible, you know, like amygdale hijacks . . . (Pete 235)

These passive formulations of behaviour, and the construction of sexual preference and behaviour as driven by neurochemistry are also apparent in the perspective of non-addicts. The prominence of this discourse across both addict and non-addict positioning is arguably fuelled by the hegemony of the evolutionary sexual drive discourse (Holloway, 1984). Here sexuality is constructed as determined by innate biological make up.

> So some people are absolutely Oxytocin driven and they have a high need for cuddles and hugs and that kind of, what might be thought of as deeply intimate or connected sex. Other people are much more adrenalin based or, you know, are dopamine based, and they're very pleasure seeking and they want high energy sex and they don't want any cuddles afterwards. And as soon as they cum, that's it. And they might, some people are very receptive to the effects of Prolactin, which is the kind of satiating hormone, that kind of switches us all off . . . Other people have no, or very little, susceptibility to Prolactin, and they can have an orgasm and then have another orgasm pretty much the same, immediately afterwards, or maybe in a day can have eight to twelve orgasms, they're wired differently. (Daniel 253)

The individual 'wiring' of sexual appetite serves to diminish agency, and constructs the sexual behaviour as a phenotype of a biological genotype. The use of neurochemistry discourses bolsters the strength of this construction through aligning it with dominant scientific institutions.

Addiction and Stress

Interviewees often used psychological discourses to construct a dualistic 'diathesis-stress' consonance to their sexual behaviour. Genetics as well as early childhood experience were constructed to produce a pre-dispositional vulnerability to addiction, which could then be triggered by stressful life events. The diathesis-stress model is well established, and aligned with many powerful psychological and medical scientific institutions (Hankin & Abela, 2005). Indeed, the stress discourse "needs no introduction and is familiar to laymen and professionals alike" (Mulhall, 1996; p. 456). The use of stress to explain sex addiction normalises the construction and reduces related stigma and accountability. Instead stress discourses highlight external forces and volatility (Mulhall, 1996).

> I was being driven by stress at work because that was my real trigger, was stress at work and sort of the emotional, my inability to deal with that emotion was what was triggering me over and over. So I never, I mean I went to counselling for four or five years for stress at work, I never mentioned the sex side of things because I always thought that would go away as soon as I wasn't stressed anymore. (Jake 209)

Sex addiction as a consequence of stress was constructed as such an obvious link that for Jake it did not merit discussing in therapy ('I never mentioned it'). The link between stress and sexual behaviour was also a feature of non-addict discourses.

> I think most male students kind of tend to masturbate more often when it's exam times (Jonathan 368)

These discourses again externalise the impetus to sexual behaviour, and place onus on environmental stimuli ('I was being driven by stress at work'), rather on the individual control. Although for Jake (and also Pete's quote (354) above), there is an acknowledgement of interviewees' role in the problem (Jake: 'my inability to deal with that emotion'; Pete above: 'I don't manage stress'), it is presented as distal from the problematic sex. Therefore, when accountability is acknowledged, it is constructed as an antecedent that only materialised in unfocussed hindsight.

Finding control/Recovery

The variance in constructions of loss of control predictably causes variance in constructions of recovery. Given the construction underlying biology or historical factors, many addicts constructed recovery as sustained endeavors to cope in daily life, arbitrated by wider society and experts (Flaherty, 2006; McKay, 2005; McLellan et al., 2000).

Sex addicts constructed when the state of recovery is achieved, lost, and reacquired relative to discursive constructions of drug and alcohol rehabilitation, and other psychological diagnoses (White, 2007). Such constructions incorporated the positioning of experts to guide recovery and propagated the discursive theme of a cultural imperative to intervene in sexual addiction. However, some addicts and most non-addicts were skeptical about the credibility of professionals who positioned themselves as capable of resolving addiction. Below Daniel, who identified as a non-addict, constructs 'those therapists' as money driven quacks, who use the addiction label in their work instead of 'clinically robust' constructions of sexual distress. Distinguishing 'those therapists' from clinically robust therapists is clearly not a neutral

differentiation. Daniel's differentiation implies that recovery based upon the sexual addiction construction is clinically and morally wrong.

> And then all those therapists, who have run up these clinics, making a fortune, particularly in the States, that sexual addiction and recovery might well swap businesses. Oh well, you know, we don't believe in sex addiction but come and treat, and will just simply earn their money with something that's a bit more clinically robust. (Daniel 525).

Many addicts constructed recovery as an enduring process, which required awareness and self-surveillance to remain 'healthy' (Willig, 2010). Their current position was often constructed as a state of flux between active and non-active addiction, which cultivated discourses around lapse, experimentation with therapies, and self-imposed parameters of sexuality and health. The multiplicity and dynamic nature of recovery, lapse and relapse, appeared to construct recovery as an ongoing attempt to resolve, rather than the successful or concrete resolution of problems. However, despite the complexity of constructions of recovery, Alistair employs extreme case formulation ('anything that goes against that'), in order to condense and boundary health and normalcy from addiction.

> Some people say well look at the things that caused you the greatest consequences and cut them out, some people just say look at the things that you're powerless over. Whether or not they are causing you trouble . . . Erm, for me I said to myself, listen, I'm powerless over this much, but actually the man I want to be is this much, and therefore I am going to define all of that in my bottom lines, in my addictive behaviour category, and say you know what sexually I am the man that I want to be and anything that goes against that is

> wrong is compulsive and I shouldn't be doing it and I should be defining that as a relapse, as a slip, but it is fair to say there are different views, everybody can self define what their bottom line addictive behaviours are. (Alistair 468).

In line with the notion of a loss of control in addiction, acceptance of powerlessness over certain behaviours appeared as an important discourse of the recovering addict positioning. This parallels discourses of the 12-step therapy model, and their use of the serenity prayer "God grant me the serenity to accept things I cannot change". Those things addicts were powerless to manage are constructed here as 'bottom-line' forms of sexual behaviour. The addict position appears to negate discourses around healthy practice of these sexual behaviours (e.g. 'appropriate' or 'sufficient' use of pornography). Instead the addict is morally driven to practice the necessary self-surveillance to avoid these behaviours, and manage stress, aligned with the second line of the prayer emboldening "courage to change the things [addicts] can". Experiencing and managing responsibility through the positioning as a recovering sex addict appears to be a complex process of moral renewal ('courage') and issues of stake and ability, where they must both accept accountability for their inability to manage certain behaviours, while also accepting responsibility for other behaviours through self- (or other-) surveillance. Similarly, non-addicts constructed a need for self-surveillance in sexual behaviour. Sexual desire and drive is also constructed as dangerous force by Daniel, which necessitates self-reflection and mastery.

> Sex is dark and dangerous and exciting and difficult. And our sexual desires and our drives are very powerful forces in our lives, and we need to understand ourselves and take mastery over them. (Daniel 618).

Daniel and Alistair both identify the need to understand their sexual desires. For Daniel this knowledge appears to equate with empowerment to take mastery over them. However, for Alistair the phenomenological repercussion of self-understanding is not empowerment over sexual behaviour, but rather involves the capacity to identify behaviours he is powerless to manage. Alistair's account of separation compresses much of the complex and multifaceted discourses around sexual behaviour into a simple dyad; a person can either be the person they want to be or be a person they do not want to be. This notion parallels the other themes of good and bad sex and a cultural imperative to intervene. As above most who identified as sex addicts constructed their addictive sexual behaviour as conflicting with their own and other people's values. This, plus a loss of control, is constructed to necessitate others to boundary and manage their sexual behaviour, and also to protect future generations from the same addictive fate.

Conclusion

In this article, we have attempted to present a loss of control as a discursive construction of those who identify as addicted to sex, and to consider the implications for consequent positionings available and lived experience of those who identify as addicted. Socio-political and ideological discourses sustained clear moral connotations to this loss of control, which was constructed primarily using psychological and biomedical discourses of illness, vulnerability and stress (Griffiths, 2005).

Together these discourses position many sexual addicts as unaccountable in the aetiology and progression of their addiction, akin to the passive patient discourses common in other illnesses (Mosher & Danoff-Burg, 2009). Addicts worked to construct their addiction as a valid affliction. This entitled them to take up a sick role with certain benefits such as discursive affiliation with biomedical and health institutions, and access

to a collective 'addict' identity and the 'currency' of the addiction discourse (Benford & Gough, 2006; Morrison & Bennet, 2009; Willig, 2011). However, there was a high variability in interviewees' constructions of sex addiction, and the degree to which this was the same or different to other addictions.

As with previous discourse analyses studies, several other discourses, over and above the addiction discourse alone, were used in order to construct addicts' sexual behaviour (Gillies and Willig, 1997). These alternative discourses were common in non-addicts constructions. For example both addicts and non-addicts additionally constructed sex as an outlet for stress, or as an inherent biological hunger, and drew upon neurobiology as a foundation of sexual behaviour. Non-addicts also constructed sex as having the potential to be 'bad', and constructed their control of sexual desire as imperfect. However, non-addicts saw this as less morally problematic and not indicative of an addiction.

The importance of making sense of people's accounts of a loss of control in sex addiction clearly has implications for their requisite treatment and wider societal intervention. It is hoped the publication of personal narratives of sex addiction experiences, including a critical reflection on the social and discursive context within which these experiences has taken place, will foster future work into understanding how the addiction experience is mediated (Willig, 2011). One important discursive context which requires further exploration is the apparent rise in extreme case formulation and scientific language used by 'experts' to endorse and propagate sex addiction as a valid construct, distinguishable from 'normal' sexual behaviour and other conceptualisations of distress, which in turn necessitates its treatment. A detailed analysis of contemporary 'expert' discourses on sex addiction would prove particularly informative in

understanding their discursive constructions of sex addiction and how they advantage certain ways of being for the individual addict.

The degree to which sex addiction is classified as a 'true' or 'pure' addiction, and the flexibility and intricacy of these component constructions clearly have repercussions for current treatment modalities, but also for future societal prevention and controlled access and distribution of sexual material including pornography; such is the power of dominant discourses of sex addiction. Discourses of sex addiction provide valuable insight into the interplay between culturally available repertoires of sexual behaviour, health and illness, equally important to all those 'non-addicts'.

Discursive constructions of sex addiction would be valuable to explore in larger and more diverse samples. One clear starting point would be an exploration of the discourses of women who identify as sexually addicted. Despite Carnes' conceptualisation of a "core addiction", common across all addicts, he also presents gender and sexuality specific aspects of addiction (Carnes, Green & Carnes, 2010). Similarly, previous research has highlighted gender differences in drug addiction "careers" (Anglin, Hser & McGlothlin, 1987). For Carnes, the homosexual sex-addict's self-image is "already marginal", and their sexual encounters are often under "degrading or even dangerous circumstances" (Carnes', 2001, p.47). Though this is clearly a pathologised perspective on homosexual sex, it is acknowledged that the discourses drawn on by homosexual and heterosexual men may differ in features including individualism and promiscuity, safety and masculinity, which could impact upon relative constructions of sex addiction in these groups (Adam, 2005). For example, previous research has shown gay men to report unprotected sex as indicative of intimacy within relationships (Flowers et al., 2011), whereas several straight men in the

current sample saw unprotected sex as indicative of risk and sexual addiction. As with heterosexual sex, gay sex has no uniform discourse and can be portrayed as intensely masculine, ostensibly heterosexual, and in a range of other ways in public discourse (Baker, 2005). Furthermore, the scope of sexuality and intersectionality means there are a number of areas of sexual and social difference which could impact upon such constructions (das Nair & Butler, 2012). It would be valuable to explore variation across genders, sexualities and issues of masculinity and femininity within sex addiction constructions.

In summary in this study we have highlighted several dominant constructions of sexual addiction and the available ways of being for the sex addict, including the discursive theme of a loss of control. Additional qualitative research and critical reflection exploring the numerous, often contradictory, ways in which sex addiction is constituted and experienced across different groups and contexts would be extremely valuable in elucidating the power-relations and normative cultural values implicated within these discursive constructions; including the meanings and values that are re-produced in the discursive practices of sex addiction assessment, intervention and prevention (Parker et al., 1995).

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EXTENDED PAPER

Extended Background

1.1. Section Introduction

The central interest of this thesis is the assorted expert[6] and nonprofessional constructions of 'sex addiction'[7] and their effects on those who identify as sex addicts and non-addicts. This section situates the thesis within the wider context by presenting the literature that has influenced contemporary understandings of sex addiction. This sections starts by introducing the history of the evolving conceptualisation of addiction, including key components and existing definitions. It then goes on to review some of the controversy that surrounds the term sex addiction, including the limited research which has investigated the topic. Lastly the limitations of previous research will be reviewed, so to highlight the rationale for the present study's use of alternative qualitative methodology in investigating sex addiction, along with the epistemological implications of this approach.

1.2. Introducing Addiction

The word addiction is derived from the Latin verb "Addicere": to give or bind a person to one thing or another (Nelson, Pearson, Sayers & Glynn, 1982). Addiction is thought to manifest psychologically and behaviourally, in feelings of compulsion to behaviour and a difficulty in resisting those compulsions. For example, definitions of drug addiction typically involve a pattern of uncontrollable drug-seeking and drug-taking behaviour which takes place at the expense of other activities, despite the user's knowledge of the damaging health and social consequences (Robinson & Berridge, 2008). Despite a common discourse of 'addictive substances' (Volkow & Wise, 2005) it is important to note that *use* does not always lead to addiction, and that addiction

[6] 'Expert' refers here to a position taken up to profess extensive knowledge or ability on a topic. Specifically here it relates to the authoring of clinical and academic text on the topic of sex addiction.

[7] Throughout this study the concept of sexual addiction is appraised critically. The terms 'sex addiction'/'addiction' and 'sex addict'/'addict' are used throughout for pragmatic reasons given the wide range of terms that could be used to reference these individuals and behaviours. The continued use of inverted commas to signal the problem of the addiction diagnosis may be distracting or confusing for readers and so sex addiction will be employed here despite the risk that I might inadvertently reify the term.

is though to be the consequence of complex interactions between stimulus effects, environmental and neurobiological factors (e.g. Meaney, Brake & Gratton, 2002; O'Brien & McLellan, 1996). Knowledge and understanding of such factors in addiction is constantly expanding and evolving. Understandably, this has led to a number of shifts in theoretical perspective. Some of the main biomedical and social science approaches to addiction, primarily developed in the field of substance addiction, have included the hedonia hypothesis, incentive-salience, rational choice models, response inhibition and salience attribution, and component models, outlined briefly below.

Early theories of addiction focused on the positive affective states that a number of drugs of abuse cause, and the resultant motivation to achieve and maintain these positive states. Essentially these theories saw drug addiction as due to the euphoria and pleasure experienced when drugs are taken. The 'hedonia hypothesis' suggests that dopamine, acting primarily in the nucleus accumbens acts as a 'pleasure neurotransmitter'. Developed chiefly by Roy Wise and colleagues in the 1970s and 1980s, the theory continues to be influential in explaining addiction (see Wise, 2009), and its ideas are echoed in contemporary neuroscience theory (Berridge et al., 2009; Volkow et al., 2009). However, this characterisation does not fit with the social and psychological problems apparent for most addicts and so the hedonia hypothesis is arguably better suited to explaining initiation or recreational use, as opposed to problem use or *addiction* (cf. Koob & Le Moal, 2005).

In order to account for drug use despite negative consequences, some theories of addiction have sought to differentiate the rewarding aspects of drugs, specifically distinguishing the hedonic *liking* and motivational *wanting* of drugs. The incentive-salience theory of addiction focuses on the latter wanting of drugs and specifically how drugs and drug cues trigger excessive incentive motivation to seek and consume drugs, leading to compulsive drug seeking and drug taking (Robinson & Berridge, 2000). It is thought that this influence is mainly implicit, e.g. administration of doses of drugs too low to produce any experience of pleasure can increase drug seeking (Lamb et al., 1991), and so implicit wanting of drugs does not require conscious awareness. Some have explained this wanting as a strong stimulus-response formation, others via neurobiology,

although it is likely to be a combination of both factors (Berridge et al., 2009). Couched, neurobiologically driven, wanting of drugs may therefore explain a great deal of addiction. However, many openly describe their continued addictive behaviour as a conscious choice.

Rational choice theories argue that addictive behaviour is entirely self-governed and, even if counter-intuitively, rational (Weinberg, 2013). The Rational Informed Stable Choice (RISC) model of behaviour describes actions as based on perceptions of their benefits (cf. West, 2006). The model states that we know about and are willing to accept the adverse consequences of our actions. This does not mean that the individual sees addictive behaviour as a definitive good option, but rather "*among the options that s/he sees actually open to him or her, (addiction) is judged to be the best on offer at the time"* (West, 2006, p.29). An important point worth noting is that rational choice does not have to be sensible or adaptive, and is often an unwise choice (Bickel & Marsch, 2001; Reynolds, 2004). In its most extreme version, this theory portrays addicted individuals as having no biomedical abnormality, but instead making a conscious decision based on sociocultural options, dismissing the notion of uncontrollable, compulsive addiction (Davies, 1998).

The RISC argument makes good theoretical sense and builds upon the hedonia hypothesis to explain how negative influences can initiate and exacerbate drug use, although it has a number of problems. Again, its subjectivity makes it hard to operationalise and test. Chiefly however, the theory has problems in explaining the dynamic process of addiction. Although, some drug addicts continue to use drugs at a stable level in order to 'manage' their environments. Addicts typically report an escalation of behaviour beyond their initial intentions, and continue to increase or abruptly stop (Koob & Le Moal, 2005). Addicts typically cycle through consumption and abstinence, bingeing and purging, and addiction typically manifests in parameters of either high levels of consumption or abstinence, not a rational, steady behaviour. Addiction therefore is commonly constructed as illogical, irrational, and senseless. Indeed, despite a great deal of work and commitment, many report failing to change their addictive behaviour.

This incongruity may be moderated by individual expectancies. Expectancies are important in initiation and escalation of addiction. For example, positive expectancy of alcohol to help with social situations, can promote usage (Cooper, Russell & George 1988), and positive expectancies of social facilitation from drinking is thought to mediate the effects of extraversion on drinking behaviour (Fischer, Smith, Anderson & Flory, 2003). Similarly, tackling addiction through generalised campaigns to inform the public can be problematic due to an inherent variability in peoples' view of how relevant the message is to them, based in part, on their ideographic experiences and expectancies. Indeed, whereas most smokers greatly over-estimate the risk of lung cancer in smokers generally, most underestimate the likelihood of lung cancer affecting them as individuals, and so continue to smoke (West et al., 2010). There is therefore a great importance of personal meaning and understanding within addiction.

Despite this ideographic quality to addiction, most biomedical theories of addiction are inherently reductionist and so minimise individual meaning and socio-cultural context in their constructions of addiction. For example, one of the most well known drug addiction theories is the opponent-process theory of addiction, Here universally predictable neuroadaptations as a result of drug use cause diminished reactions to drugs, and a new 'allostatic' basal state. This is thought to ground an increased tolerance to drugs of abuse, whereby increased amounts are needed to gain the 'high' a normally functioning neurobiological system can achieve. In line with rational choice perspectives, the individual escalates their behaviour in order to maintain a set rewarding affect and in order to avoid or escape deficiency or withdrawal symptoms. This theory promotes a cyclical construction of addiction, where individuals choose to use drugs as an escape from unpleasant circumstances and emotions such as depression, anxiety and boredom, though their long term drug use can generate depression, anxiety and in turn, can lead to escalated drug use and dependence in order to reach these previous goals of escape and avoidance.

Developments on the original opponent process theory, show that the complex state of allostasis not only involves the down regulation of systems involved in producing the initial reward, but also loss of executive control, and increased impulsivity via deregulation of neurotransmitters and prefrontal cortex-striatal

loops (cf. Koob & LeMoal, 2008). It is thought that addicts' abnormal frontal cortex function is a neurological correlate of their difficulty in controlling their exaggerated pre-potent seeking and using behaviour (Goldstein & Volkow, 2002; Jentsch & Taylor, 1999). Thus addiction may be a disorder of impaired response inhibition and salience attribution (I-RISA), whereby the drug addicted individual has both an amplified desire to take the drugs, combined with a decreased ability to inhibit the behaviours this desire produces (Berridge et al., 2009). Such theories have promoted the common construction of addiction as a brain disease, with secondary behavioural and social aspects (Leshner, 1999).

The reduction of the complexity of addiction to a disease of the brain has also led some to argue for the amalgamation of problematic users of different substances into the general classification of 'addict'. Furthermore, as Griffiths states "there is now a growing movement which views a number of behaviours as potentially addictive including many behaviours which do not involve the ingestion of a drug … such diversity has led to new all-encompassing definitions of what constitutes addictive behaviour" (2005, p.192). The term addiction is now used to reference an ever-growing number of behaviours (commonly called behavioural addictions) (Juhnke & Hagedorn, 2006). Griffiths and others promote the way of determining whether behaviours are addictive, in a non-metaphorical sense, is to compare them against clinical criteria for established drug addictions. Therefore there has been a recent trend for the research and theories, outlined above, to be applied to numerous behaviours provided they meet certain diagnostic criteria. Amalgamating the features of addiction literature has produced component models of addiction, which aim to operationalise features thought to denote a 'true' addiction, which are generalisable across substances and behaviours. These components typically include tolerance, withdrawal, mood modification, the behaviour becoming the most important thing in a person's life (salience), conflict with other aspects of life or psychological conflict, and relapse following cessation (Griffiths, 2005). Should the person's behaviour meet such diagnostic criteria, it is deemed an addiction, and aligned with the aforementioned biomedical and social science theories of addiction. Framing behaviour as addictive clearly has implications

not only for treatment of such behaviours, but also for how the individual and society perceive such behaviours.

1.3. Introducing Sex Addiction

Sexual behaviour has been increasingly referenced as an addiction (Carnes, 2001; Kafka, 2010). Using some of the criteria of addiction outlined above, sexual behaviours have been defined as compulsive, and interfering with everyday living (Robinson & Berridge, 2008). Individuals who meet these indications may identify as, or be identified as sex addicts or sufferers of 'hypersexual' disorder (Goodman, 1998).

Patrick Carnes was the first to describe sexual behaviour as an addiction in the early 1980s, and his construction was widely embraced (Levine & Troiden, 1988). Since then Carnes has written extensively on the topic; founded the Journal of Sexual Addiction and Compulsivity; developed several screening assessments of sexual addiction (e.g. Carnes, Green & Carnes, 2010); and established a number of psychotherapies for sex addicts and their families, such as the 45-day inpatient 'Gentle Path' programme (Carnes, 1992). Carnes' work has also motivated an exponential growth of descriptions, assessments and interventions for sex addiction. For example, the search term 'sex addiction' currently produces over 1,000 results on Amazon.com, including primarily books defining addiction and offering guidance to the addict, friends and family (Sept. 2013).

The conceptualisation of sexual addiction arguably contains much greater complexity and variation than descriptions and understandings of substance addiction (Hughes, 2010). For example, the subjectivity of what defines appropriate sexual behaviour, and so identification of addiction and successful outcome for sexual addiction, has meant a lack of consensus, and difficulty in integrating and evaluating research. Equally, unlike substance dependence, sexual addiction does not involve a foreign substance, and there is little evidence for physical tolerance or withdrawal states in sexual behaviour (Barth & Kinder, 1987; Levine & Troiden, 1988). Some even argue that the addiction label is applied to sexual behaviour as a pseudoscientific justification for the stigmatisation of sexual behaviours that contradict the prevailing sexual

standard (Coleman, 1986). Furthermore, some have argued that sex addiction interventions are improperly driven by the monetary rewards of the addiction treatment industry (Klein, 2006).

Certainly, despite the wealth of published guidance on assessing and intervening in sex addiction (not least in Carnes' journal), there is a relative dearth of published research on the topic. A recently conducted systemic literature review on interventions for sexual addiction, which used three sizeable electronic databases (PsycINFO, Medline and EMBASE) found only eight studies met the reviews broad inclusion criteria (Briggs & das Nair, in prep). These criteria included some description of how participants had been classified as sex addicts (or classified using alternative conceptualisations such as sexual compulsivity or hypersexuality); that the work constituted primary research (including case studies); that the study provided detail on which form of psychotherapy had been used (studies which used combined pharmacotherapy *and* psychotherapy were included); and that they included some form of standardised or unstandardized outcome measure, or feedback from client or report from author.

The methodological quality of the studies was rather poor, with four studies based on case studies of individual clients, and four based upon repeated measures interventions without randomization or clinical controls. In almost all cases participants self-referred to intervention, and few studies used an objective assessment of sexual addiction. The methods of intervention were exceptionally varied, ranging from Jungian psychoanalysis, Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioural Therapy (CBT) and group work using transtheoretical approaches (Cavaglion, 2010; Cox & Howard, 2007; Shepherd, 2010; Wright, 2010). The disparity of studies made it difficult to draw direct comparisons, and the review did not intimate a superior form of assessment, formulation or treatment (Briggs & das Nair, in prep.).

Though reports were generally supportive of their specific intervention, a great deal of ambiguity and uncertainty remains over how best to conceptualize and assess sexual addiction, and the role of comorbid substance dependence, anxiety, and mood disorders, commonly reported by sex addicts (Black et al.,

1997). Few studies used objective assessment of sexual addiction as part of their inclusion criteria, potentially given their implicit demand to either endorse or reject a limited list of prescribed responses, leaving little room to account for the complexity and variation of those who identify as sex addicts (see Hall, 2013). The lack of clarity in reported classification and psychometric evaluation of review arguably reflects a difficulty in empirically evaluating interventions of this controversial diagnosis, as well as the relative newness of research exploring this field.

Similarly, one key consensus from this review was that the numerous ways which sexual addiction can be defined and formulated meant detailed descriptive case studies in this area were pronounced as invaluable (Shepherd, 2010). Cavaglion (2010) also stressed the importance of first-hand ideographic reports in assessing distress. However, to date, one qualitative study has sought to explore the experiences of men self-reporting as having problematic sexual behaviour (Giugliano, 2006). The meanings identified in this study covered a vast range of themes including 'fulfilment of narcissistic needs' and 'avoidance of feelings', though were each fundamentally intrapsychic and individualistic. By privileging the individual, little attention is paid to the numerous wider socio-cultural perspectives on addition and sex, which define and maintain constructions of problematic sexual behaviour for these men. Indeed, the author acknowledged the importance of broadening the focus on investigation beyond the individual's sexual behaviour. Together these accounts bring into question the value of the reductionist diagnostic label of addiction for investigating sexual behaviour. Instead looking at the ways in which sex addiction could be contextualised using qualitative methodology, including the lived experiences of the sex addict, and the available ways of being that the label sex addict provides for the individual, are thought to be extremely valuable in better understanding this concept.

1.4. Introducing Foucauldian Discourse Analysis

In recent years, there has been a general shift towards qualitative research, given the problematic nature of unquestioned positivism and hypothetico-deductivism, and the general acceptance that observation and description are

individualistic and necessarily selective (Chalmers, 1999). Many of the criticisms of the models of addiction above involve failure to attend to its dynamic, idiosyncratic and culturally bound features. Contrastingly these are features that can be well attended to by qualitative methodologies (Willig, 2008), which can also acknowledge social and historical contexts of addiction (Burr, 1995).

Acceptance of qualitative methods in drug addiction (e.g. Agar, 2003; Martin & Stenner, 2004), as well as in wider behaviour addiction research (Hughes, 2010; Orford, 2001) is steadily growing. For example qualitative research has been used to explore accounts of those identifying as addicted to a diverse range of behaviours, from the use of mobile phones to 'binge flying' (Cohen, Higham & Cavaliere, 2011). Qualitative methodology has helped to identify the personal and social factors, which play a significant role in these addictions, for example features such as tension between changing social norms, managing accountability and related subjectivities of guilt and denial (Cohen et al., 2011; Peele, 1990). Equally this has helped examine the complexities and links between how both experts and lay people alike describe addiction.

The variation and detail of these individual accounts is very important as people situate personal experiences, such as addiction, within social and discursive context (Benford & Gough, 2006; Willig, 2011). Foucault argued that discourses (i.e. *"sets of statements that construct objects and an array of subject positions"* (Parker, 1994, p.245)), make available particular ways of ordering and making sense of the world (Foucault, 1990). The discursive worlds that people inhabit are historically and culturally specific, and govern the possible ways of being afforded to them, including their rights and responsibilities (Harre & Langenhove, 1999). For example, the aforementioned historical and cultural depictions of sex addiction in academic, self help literature and screening assessments would correspondingly impact upon the discursive world and positioning of those who identify as sex addicts. These discursive positions have implications for how others will perceive us, and how we will perceive ourselves (Willig, 2011).

Rather than attempting to establish 'correct' or 'true' accounts of universal addiction, this approach examines what is achieved in talk and how versions of

truth are constructed and authenticated in discourse (Willig, 2008). Foucauldian Discourse Analysis (FDA) is also concerned with the social, psychological and physical effects of discourses of sex addiction; mechanisms that give rise to the formation of particular discourses; and what these discourses mean for the sex addict's sense of self, subjectivity and experiences (Sims-Schouten et al., 2007; Willig, 2008). This means that instead of viewing accounts of sex addiction as being located within the individual and separable from their context, there are numerous versions of sex addiction, and multiple meanings are always contingent on aspects of discursive context.

Important aspects of the discursive context in sexual addiction are the dominant discourses of 'normal' or 'healthy' sexuality and the institutions which support these. Michel Foucault has explored and described in depth how sexual behaviour, and sexuality have historically been conceptualised and moralised (e.g. Foucault, 1990), and similarly Rose has described how historical discourses of addiction have become entrenched in 'common-sense' (Rose, 1999).

1.5. Discourses of Sex and Sexuality

Foucault argues that the history of sexuality since the 18th century can generally be understood in terms of what he calls the "repressive hypothesis" (Foucault, 1990). The repressive hypothesis supposes that given the dominant social institutions and related historical cultural imperatives, expenditure of energy on purely pleasurable activities is regarded as morally problematic. Consequently, sex has been treated as a private, practical affair, restricted primarily to a long-term marital relationship. Consequently a dominant discourse is that sex is 'normally' confined to marriage, or monogamous, hetero-normative relationships (das Nair & Butler, 2012). Foucault argued that sex outside these confines is not prohibited, but societal discourse makes it unspeakable and unthinkable. For Foucault such discourses surrounding sex outside of marriage were restricted primarily to academic and confessional realms of psychiatry. A combination of forces contributes to the establishment of sanctioned discourses on sex. These dominant discourses inform a set of social dividing practices that allow for the specifying and ultimately the assigning of people's sexualities

according to a socially sanctioned hegemony of acceptability. Historically, such hegemony would value a stern work ethic, and would condemn wasting energy on frivolous pursuits. Sex solely for pleasure, then, became an object of disapproval, as an unproductive waste of energy.

Dominant discourses privilege those versions of reality that legitimate existing power relations and social structures. Discourses tied to governing social institutions therefore have a great deal of power in forming dominant conceptualisations of sex and sexuality. For example, powerful institutions such as the church and state would be involved in the maintenance of the dominant discourses of sex as something private and solely within marriage. However, Foucault, does not conceptualise power as a simple, binary relationship between the dominant and the dominated; rather, relations of power are thought to be manifested through a complex network of social arrangements and convergences that never reach homeostasis, and includes forms of resistance (Shovellor & Johnstone, 2006).

For some time the power of institutions such as the church and the state has arguably waned in explicitly governing sexuality, and there has been a corresponding growth in power of previously marginalized sexual communities, such as females and homosexuals (McNair, 2002). Sexuality appears to be a relatively dynamic discursive field, marked by ever changing restriction and emancipation (Giddens, 1993). Some have argued discourses of sex and sexuality are featuring increasingly in public domains, often via the channels of commercialized mainstream media, including art and popular culture (McNair, 2002). At present there are numerous discourses around sex and sex addiction in the public domain. These include health messages aligned with risk and prevention of sexually transmitted disease (Airhihbuwa, Makinwa & Obregon, 2000); stories of sex scandals and the morally loaded criticism and denouncement of political figures and celebrities based upon their sexual behaviour (e.g. Huffington Post, 2013); the ‘pornification’ of sex (e.g. Telegraph, 2013) and the opposing ‘war on pornography’ and ‘anti-porn’ political and feminist campaigns (e.g. Guardian, 2013); sexual conquest stories common in reality TV shows; and ever changing details of ‘what (wo)men want’ (e.g. Fox News, 2012). Discourses such as the ‘Anti-pornography’ discourse appear

aligned with the historical traditions of sex as private and monogamous, and of problematising masturbation. However, discourses of 'sexual conquest' and open discussion about sexual preferences appear to resist these traditions, and liberate sex as a public topic of conversation.

In line with Foucault's writing, there appear several sanctioned discourses around sex, which may serve to separate 'normal' sex from disallowed or marginalized sexual behaviour, including discourses of 'sex addiction', which serves to pathologise sexual behaviour. Rather than seeking objectivity in understanding sex addiction, FDA instead explores the role of such discourses in constructing addiction. Also given the power of discourse to construct and constrain what can be said, done and felt by individuals, these discourses offer available ways of being and experiencing for the sex addict.

The FDA approach acknowledges both dominant and resistance discourse within the discursive context of sex addiction including the topics outlined above, e.g. addiction as a brain disease (Leshner, 1999); sex addiction as controversial (Voros, 2009). Disagreement and contradiction within accounts provide important clues about the contextual, functional, and argumentative features of the discursive world of the sex addict, and are not treated as a problem to be solved, controlled or avoided as assumed in traditional positivist empirical research (Potter & Wetherell, 1987). This approach corresponds with a body of research concerned with the ways in which varieties of expert and lay discourses constitute and regulate 'mental health' (e.g. Georgaca, 2012; Harper, 1995); and its specific diagnostic categories such as 'schizophrenia' (Tucker, 2009), and 'depression' (Crowe & Luty, 2005). For example, discourse analysis has been employed to explore how the Diagnostic and Statistical Manual of Mental Disorders, (APA, 1994) defines mental disorder and the theoretical assumptions upon which this is based (Crowe, 2000). Such work has additional value to primarily psychometric biomedical perspectives on mental health, in contextualizing and illuminating the social and historical context to markers of mental health, and the impact of diagnostic catagorisation on the individuals who receive them, as well as those who resist diagnostic identities.

Correspondingly, it would be valuable here to explore the discursive worlds of those who have a lot of sex, in line with prevailing discourses of sex addiction, though do not take up a position within this discourse. It would be interesting to explore how this 'non-addict' positioning is constructed and maintained acknowledging issues of agency and personal accountability, and to what extent this is comparable to the positioning and discourses of the sex addict. Non-addicts may employ discourses comparable to the addicts to construct their sexual behaviour, which are distinguishable from discourses centred on addiction. For example, previous discourse analytic research by Gillies and Willig (1997) identified that the discourse of addiction is alone insufficient for smokers to depict their subject positioning. Similarly discourse analytic research by Benford and Gough (2006) identified several discourses in the accounts of self-professed 'chocoholics' to explain their subject positioning and uphold their moral status. Therefore, though reductionist, discrete or component models of addiction are useful in their simplicity, they neglect the role of historical, cultural and ideographic context, and the power of discourse in how addiction is understood and experienced by the 'addict' and those around them. The relative benefits and value of being able to explore this context using FDA was the impetus of the present research.

1.6 Section summary

The theory and research discussed in this introduction highlights some of the complex, culturally bound meanings and controversy that surround the conceptualisation of sex addiction. The limited research on the topic is no doubt a consequence of the variation in its assessment and identification. Similarly the methodologies employed in past studies have struggled to sensitively acknowledge the function, variability and context of addicts' accounts, and the impact of wider socio-cultural discourses and biomedical and psychological institutions. It has been suggested that FDA enables the exploration of the discursive worlds that addicts inhabit and what are their implications for possible ways of being, and subjectivities. Expanding this analysis to explore expert discourses of sex addiction and the subject position of the addict; as well as to explore resistant and conflicting discourses in non-addicts, can help explore

how discourse of sex addiction is situated in the wider social and historical discursive context.

The aim of this study was thus to produce knowledge about principal discourses surrounding sex addiction and the discursive economy within which sex addicts find themselves. We sought to explore the ways in which versions of sex addiction are constructed through language, including the possible historical origins of discourses of sex addiction, and their relationship to institutions and social structures.

Extended Methodology

2.1. Section Introduction

This section will detail the epistemology and methodology of the current research. Specifically this will focus upon the motivation for using the qualitative methodology of discourse analysis in studying constructions of sex addiction and the available ways-of-being to those who identify as sex addicts and non-addicts. This is followed by details on the methodology employed in the work including the procedural information, ethical considerations and the quality criteria used to guide and appraise the analysis. The larger study, outlined in this extended paper, goes beyond the interview data, and comprises three interrelated Foucauldian Discourse Analysis (FDA) parts.

- Analysis of Carnes' seminal text on sex addiction, 'Out of the shadows': Understanding Sexual Addiction (Carnes, 2001).
- Analysis of a psychometric tool currently used to evaluate sex addiction, the Sexual Addiction Screening Test-Revised (SAST-R) (Carnes, Green & Carnes, 2010).
- Analysis of semi-structured interviews with men who feel they express elevated sexual behaviour, but do not deem this to be an addiction ('Non-addicts), as well as men who feel they are addicted to sex ('Addicts').

A comparable method of analysis (see below) was used for each data set. These analyses were compared and contrasted to identify dominant constructions and available discourses[8] of sex addiction.

2.2. Data Analysis: Foucauldian Discourse Analysis

A number of different qualitative approaches including Thematic Analysis, Grounded Theory, Interpretative Phenomenological Analysis, Conversation Analysis and alternative discursive psychology approaches were considered in the process of designing this study. However, the aims of the research concentrating upon discourse, historical and social context, and available ways

[8] The broad definition of discourse used in the proposed work, relates to *'sets of statements that construct objects and an array of subject positions'* (Parker, 1994, p.245).

of being, supported FDA as the most suitable methodology to characterise the discursive world of the sexual addict. Indeed, in line with the guidance of Willig, the research question and analysis were chosen in combination (2008). Additional attention was paid to the structural, linguistic and dynamic features of text (see section 2.7), to promote what Hughes calls “contact” with the discursive world of the addict (Hughes, 2007). This was in order to reduce the dependence upon largely mechanistic technical language in understanding sex addiction, and promoting more richly layered, textured and nuanced understanding of the discourses of sex addiction, the addict subjective positioning, and associated activities and subjectivity.

FDA is concerned with language and its role in the formation of social and psychological life (Willig, 2008). FDA looks beyond the immediate interpersonal context of language to the relationship between discourses and how these both facilitate and limit, enable and constrain what can be said by individuals (Parker, 1992). Discourses are functional, and offer subject positions which, when taken up, have implications for action, rights and responsibilities and subjectivities (Harre & Van Langenhove, 1999). A subject position within a discourse identifies a location for a person within a network of meaning. Subject positions carry implications for what the individual in the position is capable of saying and achieving, and their subsequent accountability and responsibility. Taking up various positions also has consequences for what can be felt, thought and experienced from these subject positions. Discourses therefore construct psychological as well as social realities (Willig, 2008).

According to Foucault, the constitution of subjectivity through discourse is the modern form of power (Benford & Gough, 2006). Power resides in cultural relationships that reproduce the relationships between people in which resistance is supressed. ‘Dominant’ discourses privilege those versions of reality that legitimate existing power relations and social structures. Some discourses are so entrenched, that they have become ‘common sense’, and it is difficult to see how they could be challenged (Foucault, 1990). Such discourses are linked to social and institutional practises, and can serve to reproduce these institutions. For example biomedical discourses work to uphold the status of medicine in society (Benford & Gough, 2006). FDA goes beyond the immediate

context of language, to encompass a historical perspective on the variety of discourses within relevant institutional practices (Rose, 1999). Unlike some qualitative methodologies, FDA is not restricted to use with interview transcripts, and can be carried out *'wherever there is meaning'* (Parker and the Bolton Discourse Network, 1999, p.1).

Despite the power inherent within certain discourses, the utilisation of alternative constructions or counter-discourses is possible (Parker, 1989), and dominant discourses can change over time (e.g. Foucault, 1990). Similarly dominant discursive positions can be subverted or resisted, and ultimately speakers are active users of discursive resources (Willig, 2011). FDA was seen as sufficiently flexible to explore a range of potential discourses of sex addiction within and across a range of materials including interviews and relevant written text (Willig, 2008).

FDA has previously been used to critically examine complex psychological concepts (e.g. Henriques, Holloway, Urwin, Venn & Walkerdine, 1984); and Foucault has analysed historical accounts of sexuality (e.g. Foucault, 1990). In analysing both idiographic accounts, and published research and theory, the proposed methodology is heavily inspired by the research of Carla Willig. Willig utilised FDA to bridge an exploration of her own experience of cancer diagnosis (Willig, 2009), in light of critically reviewed the wider discourses surrounding cancer, and how these serve to position those with the diagnosis (Willig, 2011). The present work sought to adapt such methodology to explore the discursive positioning made available by expert constructions of sex addiction and 'normal' sexual behaviour, and how these relate to the available discursive positions, and use of discourses by those who identify as sex-addicts and non-addicts.

2.3. Theoretical Framework: Critical Realism

In contrast to positivist and empirical construction of universal truths, a common and crude criticism of some forms of discourse analysis such as FDA, is that versions based upon extreme relativism mean its results cannot be extrapolated in any sense beyond the immediate context of data collection (see Potter, 1992). However, discourse analysts agree that discursive constructions have 'real' effects (Willig, 2006). That is the way in which we talk about things offer

representations of the world which have a reality, and which have implications for the way in which we experience the world, both physically and psychologically (Parker, 1992); our discourse is similarly limited by material reality and physical institutions (e.g. the health care system, the police etc.). Here discourse is capable of maintaining and enacting power (Sims-Schouten et al., 2007).

FDA aims to map the discursive worlds people inhabit and to trace possible ways-of-being afforded to them. This methodology does not seek an objective or sole 'true nature' of psychological phenomena, and instead looks at ways in which particular versions of phenomena are constructed (Willig, 2006). In line with this perspective, variability is not viewed as an obstacle but as a central feature of interest. However, this method is also concerned with the social, psychological and physical effects of discourse, and realist interpretations of underlying mechanisms that give rise to conditions that make possible the formation of particular discourses (Sims-Schouten, 2007). This 'extra-discursive' method does not claim that discursive constructions are entirely independent of underlying structures and mechanisms that generate phenomena (i.e. ontological realism) (Parker, 1992). The current work adopted such a critical realist perspective in aiming to obtain a better understanding of the psychological, physical and institutional features within discourses of sex addiction, while acknowledging the data collected does not provide direct, straightforward access to these actualities and, as noted, individuals can work using cultural and discursive resources to construct different versions of experiences (Willig, 2008).

The critical realist positioning of the current work acknowledges that our ways of seeing and being in the world are mediated, and constructed through language, but that these constructions and positionings are grounded in social and material structures, such as institutions and their practises. This approach was considered able to best match the aims of the research, in exploring discursive constructions of sexual addiction and its effects, within the institutional discourses and practices which maintain them.

2.4. Methodology

2.4.1. Selection of Text

Those texts proposed for analysis, are those argued to be influential in shaping current (and future) discussions and appraisals of sex addiction, and so construct and position sex addicts (Davies & Harre, 1999; Kafka, 2010).

Patrick Carnes is regularly cited as the first to 'scientifically' operationalize the dynamics of sex addiction (Voros, 2009) in his formative text "Out of the shadows: Understanding Sexual Addiction" (Carnes, 1983). The book originated from an extended article "The sex offender: His Addiction, His Family, His Beliefs" and is currently in its third edition. The third edition of this text is used for analysis here to acknowledge revisions, temporal context, and the author's evolving perspective on sex addiction (Carnes, 2001). An analysis of the whole text was beyond the scope of the proposed research. Therefore, the analysis focussed upon the introduction (*"A moment comes for every addict"*), and first chapter (*"The addiction cycle"*) of the book. These chapters introduce Carnes conceptualisation of sex addiction and depict the sex addict in greatest detail. These chapters also shape key discourses of sex addiction, which run throughout the book, and permeate contemporary discourses of addiction (cf. Hughes, 2010).

As well as these sections of Carnes' book, FDA was utilised to explore the construction of sex addiction within the Sexual Addiction Screening Test-Revised (SAST, Carnes, Green & Carnes, 2010). The scale is currently utilised by some clinicians to identify and diagnose sexual addiction (see Kafka, 2010), and is also available online as a free resource for those concerned they might be addicts (e.g. recoveryzone.com). The inclusion of the scale in the analysis is also significant as the proposal for the inclusion of *Hypersexuality* Disorder in the DSM-5 was based upon reference to the "scientific basis" for each diagnostic criterion and its relationship to such rating scales (APA, 2012). This particular scale was selected given its prominence in classifying sexual addiction. Carnes' analysis has shown the items of the original SAST load onto a single factor, and that the scale has good internal consistency (Carnes, 1991). Carnes, Green and Carnes (2010), developed and extended the SAST-R to

improve clinical relevance across women, homosexual men and cybersex addicts. This is a 45-item scale, which comprises of 20 core items which retain much of the original SAST, plus an additional 25 *"clinically meaningful"* items, *"based on screenings of tens of thousands of people"* (Carnes et al, 2010). Though these items dramatically reduce the psychometric properties of the scale, they were retained in the SAST-R given their clinical meaningfulness. It is this most recent version of the scale that was selected for analysis

2.4.2. Participants

Semi-structured interviews were conducted with 9 interviewees, comprising men who self-defined themselves as having a high level of sexual behaviour. This group size was informed by previously published FDA research into behavioural and drug addiction (Benford & Gough, 2006; Jones, 2005). Despite the diversity of the interviewees, the men could be broadly positioned into two groups: those who did not identify as addicted to sex (non sex addicts), and those who did identify themselves as sex addicts.

Inclusion criteria and exclusion criteria were kept purposely broad given the wide range of cognitions and behaviours that form the nosology of sexual addiction (Kafka, 2010). 'Sex addicts' could self-diagnose or had been diagnosed by a third party. As self-categorisation is important to the consequent FDA analyses, men identifying as non-sex addicts were invited to interview despite their potential to be formally classified as addicted to sex, or as hypersexual, by available diagnostic criteria. Therefore, both those who identify as sex addicts and those who do not, may objectively show very similar sexual behaviour, urges and fantasies. Those who were under 18 were ineligible to take part, and the study focused solely on males, given the distinctions in the discourses of male and female sexuality and sexual behaviour, which could distract from the current analyses (Schneider, Cockcroft & Hook, 2008). Sexual orientation and sexual behaviour were not used as exclusion criteria, nor were age, educational, marital/relationship status, religious affiliation, and cultural context. Though information was not overtly collected on these demographic variables, the men ranged from their early 20s to mid 60s, had a range of

educational qualifications, and employment and relationship statuses. Men participated from the UK and the USA.

Recruitment

Recruitment methods were selected that were appropriate for men likely to identify as sexually active or addicted to sex. The study was promoted through recruitment information (posters and leaflets) distributed primarily in bars and clubs, as well as via email communication with consenting sex addiction groups, fellowships and organisations. A dedicated Twitter account was also set up to recruit via online social networking, and interviewees were invited to promote the study through their own social networks. Those interested were able to contact the lead researcher via a dedicated email or telephone account.

Those who expressed interest were sent an information sheet (which followed University of Lincoln and NHS guidance on providing clear and thorough information to support informed consent), and were given a minimum of 24 hours to decide if they wanted to take part. In all cases potential interviewees had the ability to ask questions, and were asked to provide oral or written informed consent prior to taking part. The study obtained ethical approval from the University of Lincoln (See Appendix E). No recruitment or data collection took part prior to ethical approval being obtained.

2.5. Ethical Consideration

2.5.1. Confidentiality

Confidentiality was given a great deal of thought throughout the research process. Interviewees were informed that any identifiable information (e.g., names, addresses, organisation affiliation) would be altered to maintain anonymity. The use of an external transcription service for some interviews, and contact of interview content with supervision was discussed with participants prior to interviews. They were informed that the transcription service had signed to their agreement to retain the strictest confidentiality. Similarly, confidentiality within academic supervision was also discussed and agreed to prior to interviews taking place. Following on going counsel from the ethics committee at the University of Lincoln, it was agreed that participants would be able to

maintain anonymity in the interviews and not have to provide an accurate real name in order to take part (and could use a pseudonym in interviews), though they had to provide verbal or written informed consent.

2.5.2. Informed consent

The consent form explained the voluntary nature of participation, the right to withdraw during or up to two weeks after the date of the interview, and that anonymised quotes from the interviews may be used in the study reports and future publications (see Appendix A). Prior to giving informed consent, interviewees were able to ask questions about the research. Interviewees were able to ask these questions via telephone contact, email or face-to-face. Similarly interviewees were able to complete the consent form via email or verbal recitation. As part of the recommendation by the University of Lincoln ethics committee, my academic supervisor consequently verified this informed consent.

2.5.3. Risk of harm

Given the sensitive nature of the research topic, it was considered possible that interviewees might experience distress at topics, which are not commonly discussed in every day conversation. There was an option for interviewees to request additional support, or guidance to alternative sources of support, from research supervisor and qualified clinical psychologist Dr Roshan das Nair. This was not requested by any of the interviewees. In order to reduce inconvenience to the interviewees, interviews were carried out on a day and time, and using a medium most convenient for them. Anecdotally, many interviewees reported that they had found the interviews an interesting and surprisingly enjoyable experience.

2.6. Data Collection

For the most part, interviewees were conducted over the phone or via Skype©, though one interview was conducted face-to-face at the University of Nottingham. Though a range of pragmatic and ethical arguments have been offered in the literature as to mode effects of face-to-face vs. telephone interviews it is understood that these effects are most relevant to the micro-features of conversation which are not attended to in the present analysis (see Irvine, 2013).

Interviewees were invited to discuss their story as freely as possible, although an interview schedule was used so that the interview kept sight of the interview agenda, and in order to create some comparability across interviews (Potter & Hepburn, 2005). This interview schedule follows the guidance of Spradley (1979), in incorporating descriptive, structural, contrast, and evaluative questions (see Appendix C). These questions allowed interviewees to provide general accounts, personal anecdotes, prompt them to identify their personal categories and meaning that they use to make sense of world, and also allow them to make comparisons between experiences, and share their appraisals (Willig, 2008). This variety of questions was hoped to promote rich and detailed accounts. It should be noted that by using probes and follow up questions in eliciting diverse responses from participants I inevitably influenced the interactive process of each interview. I aimed to remain conscious of this fact and minimise and limit my responses as appropriate.

Interviews lasted approximately 1 hour, and were audio recorded using a Dictaphone (Olympus DS-30). The researcher and a professional transcriber produced transcriptions by hand using pseudonyms, devoid of identifiable information. The quality of these transcriptions was evaluated against the audio recordings several times in order to unify verbal speech and transcriptions as closely as possible (Cameron, 2001). Transcription paralleled the level of analyses, where all the words spoken were preserved, though micro-features of data were not stressed. Book chapters and the SAST-R were not adapted in any way prior to analysis.

2.7. Analysis

The analysis draws upon the guidance of Parker (1992), Wodak and Meyer (2009), and Willig (2008, 2011). Parker identifies 20 steps in discourse analysis, from the selection of text, through the identification of constructs, and finally the structure of discursive power relations. This analysis culminates in distinguishing discourses, their social and historical construction, and their implications for subjectivity for the individual. Willig (2008) outlines six stages of analysis which focus on identifying discursive resources in the text, the subject positions they contain, and exploration of their implications for subjectivity and practice. Together these guidelines are thought to offer a comprehensive means of addressing construction of the individual subject by wider normative and institutional qualities of discourse (Arribas-Ayllon & Walkerdine, 2008); as well as subject positions and subjectivity, and so the consequences of discourse on subjective experience (Harre & Van Langenhove, 1999).

Structural and linguistic features of the text and interview data were also paid attention to, in line with the guidance of critical discourse analysis (CDA). This helped to both address overall structural features of the discourse, and helped "embedding the data in the social" (Wodak, 2009, p.9), in exploring how language functions to construct and transmit knowledge (Martin & Wodak, 2003). Both FDA and CDA see 'language as a social practice', and take particular interest in the relations between language and power (Fairclough & Wodak, 1997). The analysis also attended to discursive practices, such as managing stake and interest in version of reality which are constructed (Potter, 1996). This helped to identify how certain discourses and discursive strategies were used to actively manage accounts. Combining FDA and elements of discursive analysis is advocated to attend to the ways in which discourse constructs subjectivity, selfhood and power relations, but also how people use these discursive resources (Wetherell, 1998)

Discourse analysis categories subsume a variety of approaches, which carry guidance on analysis but do not propose rigid methodological protocol (Wetherell, Taylor & Yates, 2001). The synthesis of these methodologies was seen as appropriate for the current research topic and materials analyses

(Alvesson & Karreman, 2000; Fairclough, 2012). This protocol of analyses was followed for both text and semi-structured interviews.

2.8. Quality criteria

There are currently a number of criteria available to help judge the quality of qualitative research (e.g., Henwood & Pidgeon, 1992; Elliott et al., 1999). Generally these quality criteria are based around clear and logical presentation of analyses, which are grounded in data, and take account of the researcher's personal views and opinions (Willig, 2008; Yardley, 2000). The present research is informed by the evaluation criteria of qualitative research presented by Elliot et al. (1999). These criteria include evaluations of presentation and contribution to knowledge, shared across quantitative and qualitative methodology, but also incorporate criteria specific to qualitative work. These qualitative criteria include coherence and integration of analyses; systematic and comprehensive analyses; a disclosure of the researcher's reflexivity and ultimately that the analyses should be presented so as to stimulate resonance with the reader (Elliot et al., 1999).

The work was be evaluated in light of its epistemological position, specifically critical realism, following the guidance of Madill, Jordan and Shirley (2000). Accordingly, the work aimed to demonstrably ground both interviewee accounts and analyses in the conditions in which they were produced, by providing interviewee accounts alongside discussion in the analysis and discussion points. I also aim to provide a clear reflection on the research procedure, limitations and my own reflection, so that the reader themselves can evaluate the work given its research questions, epistemological stance, and likely impact of my reading of the data in the production of themes. The Loughborough Discourse and Rhetoric group's guidance on avoiding common pitfalls in discourse analysis was also used to organise and appraise this work (Antaki, Billig, Edwards & Potter, 2003).

Extended Analysis and Discussion

3.1. Section introduction

The following section aims to orientate the reader to the findings outlined in the journal article, and contextualise these and other themes within the wider analyses of interviews and text combined. Three main interconnecting themes arose in the analysis of semi-structured interviews: A loss of control, good vs. bad sex, and the cultural imperative to intervene in sexual addiction. These three themes were also pervasive within the language used by Patrick Carnes' within his seminal text 'Out of the Shadows: Understanding Sexual Addiction' (Carnes, 2001), and the items of the Sexual Addiction Screening Test (SAST-R; Carnes et al., 2010). In this section these three related topics will be expanded on. Given the focus of the research paper, and in order to avoid repetition, the loss of control theme is presented purely from text analysis here, though the good vs. bad sex and cultural imperative themes are presented using both interview and text data.

The aim of this section is to outline and describe some of the constructions of sexual addiction, and how they make available ways-of-seeing and ways-of-being to sex addicts and non-addicts. These presented constructions and subject positioning stem from the reading and re-reading of interview transcripts and text whilst drawing on wider research literature. I have sought to increase the quality of the analysis through the quality criteria outlined above (Elliott et al., 1999); though do not propose that this analysis includes all readings of the possible stories and positions available. Indeed the limitations on scope and word count of this work have meant I have had to be selective in what is presented. Likewise, my personal experience will have undoubtedly guided my reading of the data. It is hoped that this analysis offers a useful and interesting opening to exploring prevailing constructions of sexual addiction and their consequent implications for those who identify with this positioning.

3.2. Topics

Interviewees and Carnes' description of sex addiction and in the text are complex and multifaceted, though can be summarised into several 'macropositions' or topics (van Dijk, 2009). As with other literature on addiction (e.g., Benford & Gough, 2006; West, 2010), a loss of control is central in discursive constructions of sex addiction. This discourse utilises biomedical constructions of genetic vulnerability to addiction, but also carries a morally prescribed need for self-control and self-discipline. Foucault describes discipline as a power to control and arrange, and as typically established through external agencies, manifest today in institutions such as medicine and contemporary psychiatry (Foucault, 1977). Disciplinary power involves normalisation, i.e. the construction of an idealised norm of conduct, and the reward or punishment of those who conform or deviate from this ideal. The construction of a normalised or 'good' sex is apparent in both Carnes' and addicts' definition of sexual behaviour. This assimilated constructions of control and discipline as essential to uphold personal identity within the construction of hetero-normative and monogamous ideals, promoted by wider legislative and socio-political institutions.

Constructions of deviations from this norm, i.e. 'bad' sex, are seen as morally problematic, and for the most part addicts' constructions denoting addictive sexual behaviour incorporate notions of dirt and danger (Benford & Gough, 2006). Indeed 'bad' sexual behaviour is read as capable of generating fear, shame, and guilt in the sinful and secretive sexual addict, amplified by the expected judgement from the unaccepting, unforgiving public. The dirt and danger of addictive sexual behaviour also carry the inherent risk of psychological and physical harm. As a consequence the introductory chapters to Carnes' books construct sex addiction as carrying inevitable negative consequences, indeed 'a moment' is said to come for every addict. Interviewees identifying as sex addicts typically used a personal story narrative to recount comparable 'moments', and wider experiences of addiction and their path towards recovery (Wenger, 1998). These narratives typically involved several discursive strategies to construct fact and manage issues of accountability (Potter, 1996).

To manage the conflict between behaviour and assumed personal and social aspirations, the addict was repeatedly positioned using constructions of secrecy or rebellion, to avoid or reject societal rules. This positioning fosters discourses of impulsivity, self-indulgence, and weaknesses to construct the “insane” addict, unaware of this conflict (Carnes, 2001). Addicts’ similarly drew upon discourses of impulsivity, profligacy and selfishness to account for their sex addiction. Paralleling medical and psychological discourses of disease and distress the addict was also often constructed as a sufferer of a tangible biological and/or psychological malady. These discourses further serve to bolster the positioning of the addict as unhealthy and disconnected from reality. This passive patient-type positioning promoted the reciprocal role of rescuer or medical expert to aid the addict (Berne, 1975).

The scope of the sex addicts’ role as responsible social actors appears to be limited by their awareness and control of their desire and behaviour. The active addict subject positioning contradicts the subject positioning of the ‘free-agent’ associated with careful deliberation and consideration of the potential ‘bad’ effects and consequences of action on the self (Willig, 2008). This fuelled a construction of a sociocultural imperative to intervene in sexual addiction. For example, the exponential rise in access to pornography via the Internet is constructed as a catalyst for sexual addiction in future generations, which necessitates a greater urgency for experts and wider society to acknowledge, prevent and manage sexual addiction.

The following sections present these discursive themes in detail. Though they are presented under individual sub-headings, it should be noted that they are interconnecting and overlapping in constructing and positioning the sex addict.

3.3. Loss of Control

Conflicting values of strong work and austere ethic, and a consumerist ethic based on hedonism and impulse gratification are evident in both interviewee accounts and text analysis (Bell, 1976). Carnes' construction of addiction appears founded upon this conflict, suggesting addiction as a loss of control over value judgment and consumption choice, and a resultant subordination of personal agency. Here the addict looses their choice, and so their identity.

> "For the addict however, there is no choice. No choice" (p.6)[9]

A core criterion of other addictions is the experience of a 'loss of control' (Griffiths, 2005; Weinberg, 2013); where the behaviour contrives to occur "despite volitional attempts to abstain or moderate use" (Marlatt, Baer, Donovan & Kivlahan (1988, p. 224). Carnes constructs transference of power, using the repetition of an extreme case formulation ('no choice'), whereby the addict is no longer seen as having any control over their choices, and is instead consumed by consumption (Pomerantz, 1986). Carnes conceptualises sexual behaviour as carrying an implicit power, capable of overwhelming the addict.

A loss of control over sexual behaviour is incorporated into items of the SAST-R (Carnes et al., 2010). Here a loss of control is constructed as the addict being controlled by their addiction. The splitting of addiction from 'person', serves to attribute responsibility for behaviour to the addiction, which reduces addicts' accountability for behaviour (Potter, 1996). The person is not acting as an addict, but their addiction is overpowering and afflicting them, despite their efforts (Rapley, Moncrieff & Dillon, 2011). This intrapsychic conflict is presented as reducible to a tangible, empirically measurable component.

> Q. 10) Do you feel controlled by your sexual desire?
>
> Q. 17) Have you made efforts to quit a type of sexual activity and failed?
>
> Q. 19) Do you think your sexual desire is stronger than you are?

[9]In this analysis all page numbers are in reference to Carnes (2001) unless otherwise stated. Similarly all question items are extracts from the SAST-R (Carnes et al., 2010). Extracts reference participant pseudonym and line number in the transcription of their individual interview.

Loss of control here appears linked to contemporary health discourses, which are also marked by a key-theme of personal agency and control (Willig, 2000). The positioning of the addict as someone unable to regulate their behaviour makes available discursive repertoires of ill health. It could be argued this disempowered positioning makes available subjectivities of weakness and frustration. Contrastingly expert discourse and the SAST are empowered through their alignment with the powerful institutions of medicine and empiricism, and capable to identify the unhealthy addict.

The shift in power of the individual from free-consumer to ineffective-consumer of sexual behaviour appears to underlie what Carnes conceptualises as *the moment*, which comes for every addict. Interviewees constructed these 'moments', as times in their life when they had tried and failed to stop or control their sexual behaviour. A progressive loss of control is constructed as subjugating or shadowing an individual's healthy, true identity, and as marked by negative repercussions.

> "A moment comes for every addict when the consequences are so great or the pain is so bad that the addict admits life is out of control because of his or her sexual behaviour" (p.1).

Without intervention, this loss of control is constructed as progressive. The grouping of individual's into 'every addict' constructs this account as neutral and generalizable, similarly to medical diagnostic categories. This is another example of extreme case formulation ('every', 'so great', 'so bad'), which is a discursive strategy commonly used by Carnes to strengthen his case and legitimise claims. The construction of sexual behaviour as out of control, means that the addict is unaccountable to their behaviour, and also develops a construction of addictive sex as intrinsically hazardous.

Progression in Addiction

Tolerance is a diagnostic feature of substance addiction and refers to the process whereby increasing amounts of the particular drug/activity are required to achieve the former effects (Griffiths, 2005). Interviewees described how they felt a combined tolerance and loss of control was leading them to riskier and more deviant sexual behaviour (i.e. bad sex as outlined in the 'Good and Bad sex' theme).

Though increasing quantity of substance often denotes tolerance, here tolerance involved the construction of increasing deviance of sexual behaviour and so distance between addict and non-addict subjection positions. Religion, marriage, the law and work were drawn in to construct this distance. Discourses involving these institutions are involved in defining the parameters of addiction discourses, as the addict is ultimately positioned in opposition to these morally sanctioned institutions, by prioritising sexual behaviour above them.

Q. 20) Has sex become the most important thing in your life?

This conceptualization of progression is fundamentally tied the discursive theme of good and bad sex. The subject positioning of addict makes available discursive repertoires of bad sex, but closes down available discourses of good, healthy and controlled sexual behaviour. Though some addictive behaviours, such as smoking or drinking are activities that can be engaged in concurrently with other daily activities (West, 2006), sexual addiction is constructed as progressively reducing a persons capacity for healthy sexual behaviour and other behaviours constructed as more valuable. In contrast the addict subject position proliferates their potential for bad, dirty and dangerous sex.

The Science of Addiction

One obvious rhetorical feature of the text and SAST is that they are written and presented in a scientific/medical style, according to the traditions of the empiricist repertoire (Gilbert & Mulkay, 1984). Both texts are afforded authority by their publication, and broad dissemination in academic, psychological and social spheres. Carnes' positions himself a neutral and unbiased expert (Dr.

Carnes, PhD; “author of many books”), whose academic and clinical credentials endorse his proficiency to scientifically identify and help addicts.

Sex addiction is constructed as amenable to classically scientific, positivist methods of examination, i.e. sexual addiction is presented as a real subject with common properties, which through the use of the scientific method addiction, can be identified across individuals, time and situations (Gergen & Gergen, 2000). Within the text Carnes utilises models, to align sex addiction with modernism and the rationality of science (Proctor, 2002). For example, the ‘cycle of addiction’ is presented diagrammatically, according to the traditions of a scientific repertoire, which reinforces the construction of sexual addition as predictable and generalisable.

As with interviewee accounts, one way in which Carnes’ constructs the science of sex addiction, and persuades the authenticity of the diagnosis is through comparison with other, more established, addictions. Carnes presents himself as informed of the controversy surrounding sex addiction (Voros, 2009) by acknowledging society “shifting to a more open attitude toward sexual expression… the amount and kind of activity a matter of personal choice” (p.6), however he works to construct sex addiction as qualitatively different from ‘normal’ sexual behaviour. The addict here is not constructed at an extreme end of a sexual continuum, but in positioning of “constant pain and alienation” (p.6).

Similarly to interviewee accounts, sex addiction is constructed as incorporating the physical as well as the psychological; aligning constructions of sex addiction with a state of physiological ‘dependence’.

> “The addict substitutes a sick relationship to an event or a process for a healthy relationship with others. The addict’s relationship with a mood altering chemical becomes central to his life” (p.14)
>
> “The addict’s mood is altered as he enters the obsessive trance. The metabolic responses are like a rush through the body as androgens speed up the body’s functioning… Risk, danger, and even violence are the ultimate escalators. One can always increase the dosage of intoxication” (p.21)

The ‘obsessive trance’, infers the loss of awareness, and by implication positions the addict as less knowing than others, particularly the knowledgeable expert. It is in the private moments section that Carnes first draws comparison to other addictions; he notes “a way to understand sexual addicts is to compare them with other types of addicts” (p.14). Carnes constructs the ‘addictive system’ as a principal feature generalizable across addictions, and the root cause of comorbid addictions; for example “by far the most common combinations of addictions is when the sexual addict is also dependent of alcohol or another drug” (p.29). Association with substance dependency also creates related need for intervention, though Carnes states, “abstinence from alcohol will be easy compared with stopping your sexual addiction (p.3)”. Sex addiction is thus constructed relative to, but not purely in accordance with substance addiction discourses. A central distinction appears to be an increased emphasis on the constraints of the sex addict’s agency in controlling their behaviour, and so a difficulty for the addict to stop this behaviour.

Components used to denote other addictions are each presented in the SAST (see Griffiths, 2005). The SAST is reductionist in implicit demand to either endorse or reject a limited list of prescribed responses, leaving little room for articulation of complexity. Objective measurement with clear boundaries constructs the assessment of sex addiction as scientific, valid and transparent, as opposed to based upon more subjective interpretation. The presentation of responses as either Yes/No serves to dichotomise responses into either addiction or non-addiction, akin to medical conditions (you either have diabetes/a broken leg or you do not). Codifying the distress of sex addiction as if it were a medical condition also aligns it with powerful institutions of modern medicine and aligns it with a diagnosis amenable to scientific study.

Divisions of items in the scale are said to attend to “unique patterns within specific populations of interest” (Carnes et al., 2010, p.23), and are constructed as adding value in terms of “clinical relevance”. This clinical relevance discourse aligns items with a more personal discourse of experience (i.e. what Carnes’ himself has seen in the field); whilst retaining the implied authority of the expert’s verdict (Johnstone & Frith, 2005). The expert position of Carnes places an onus on the respondent to trust what is asked is suitable to best identify true

addiction given both his knowledge, but also his first hand experience (Moynihan & Smith, 2002).

Jargonistic discourse from psychological models and wider addiction literature (West, 2010) accentuates the objectification and medicalization of sex addiction (Johnstone, 1998). Biomedical analogies are used to strengthen the addict's positioning as unwell and a victim of biological ailment. One of the clearest examples of this is the construction of sex addiction as the "athletes foot of the mind" (p.3). Using the analogy of a common bacterial infection to describe addiction supports the construction of the addict as medically unwell, and subjugated to the medical help they necessitate.

> "It never goes away. It is always asking to be scratched, promising relief. To scratch, however is to cause pain and intensify the itch" (p.3).

This analogy also incorporates psychological discourses of compulsion; the sufferer is drawn to scratch, the addict is drawn to sex. Again extreme case formulation is used to describe the compulsion as 'never' abating for the addict. Sex addiction is anthropomorphised into a deceptive antihero, dishonestly leading the addict to problematic sex. This construction of the sex addict within discourses of biomedical and psychological science, positions them as in opposition to health and normalcy.

Recovery

The breadth and depth of conceptualisations of recovery given in interviewee accounts are presented as somewhat simplified by Carnes. He presents recovery principally as a reversal of addictive behaviour, and a rebuilding of healthy relationships. This mirrors the tolerance conceptualisation, which constructs addiction as distancing between behaviour and morally sanctioned normalcy.

> "Recovery from addiction is the reversal of the alienation that is integral to the addiction… With help, addicts can integrate new beliefs and discard dysfunctional thinking. Without the mood-altering insanity to insulate them from knowledge about their own selves, they become participants in the restoration of their own sanity" (p.31).

As opposed to interviewee accounts, where recovery is seen as a dynamic and ongoing process, Carnes constructs addiction as separable from the individual with the help of intervention. This separation of disease from the person enables, with help, a position of 'fully recovered' sex addict. The recovered addicts may regard themselves, and to be regarded, as comparatively healthy, sane and reintegrated following recovery (Helman, 1985; Kirmayer, 1988). A core distinction of the addict and non-addict position thus appears based upon fundamental discursive constructions of good and bad sex.

3.4. Good vs. Bad Sex

In line with the concept of a progressive loss of control, interviewees identifying as addicted constructed their sexual behaviour as becoming increasingly distant from desired or 'normal' sexual behaviour.

Desire and distress

Desire was commonly constructed in interviewee accounts to manifest in pornography preferences, and also in the sexual contact they sought out. Addict constructions were demarcated by a fear that their desire positioned them as pathologically dirty or risky. Carnes constructs unforgiving societal standards as internalised by the addict to critique their own behaviour; for example "She did not like what she was doing'" (p.28). In these descriptions the addict's behaviour and their presumed wishes are constructed as contradictory.

This contradiction is outlined in the 'secret moments' section of the introduction chapter, where Carnes presents nine example moments of conflict addicts may encounter when reflecting on their socially unacceptable conduct, or inappropriate organisation of priorities. The subject positioning of the addict appears to limit available morally valued discursive resources of honesty in the majority of these accounts. Frequently addicts are constructed lying to others, and also to themselves.

> "When you have to tell yet another lie that you almost believe yourself"(p.2)

Items within the SAST also designate subjective parameters of internalised conflict as indicative of sex addiction. Though it appears the individual dictates the precise designation of ‘too much’ based on their ideographic conflict, it is unclear what or indeed who ought define ‘too much’ (Rose, 1999).

> Q. 23) Do you spend too much time online for sexual purposes?
>
> Q. 30) Have you spend considerable time surfing pornography online?

Addiction is also constructed through objective conflict with societal pressure for individuals to be productive, and show a strong work ethic. For example it is constructed as morally problematic to prioritise sexual desires over family, work, and wider economic institutions.

> “When [you] make business travel decisions not on the basis of company interests, but rather to accommodate the affair you are having” (p.2).
>
> “In the morning, looking at the trusting faces of the children, she would feel profound incongruity of where she had been a few hours before. Also her teaching was slipping… What she really wanted was a husband and a family. (p.28)

Carnes offers vignettes such as the one above to develop this discourse of the conflicted and judged addict. Another vignette outlines Del, a “brilliant, charming and witty lawyer, husband and father of three, appointed to work as the governor’s special aide; who was living a double life of prostitution, porn and affairs” (p.11). Carnes uses three-part lists in these vignettes to build up these cases as generalizable of the positioning of the collective sex addict (Jefferson, 1990).

The ‘double life’ of the addict is constructed as too discordant and volatile to function, and so destined to destructive consequences. Carnes uses extreme case formulation in describing how “There can be no neutral responses to sexual compulsivity” (p.6). Sexual addicts here cannot experience neutrality and acceptance in wider society, and so must fragment their lives. This fits with constructions of shame in the discourses of addict interviewees, and their

constructions of splitting and concealing aspects of their sexual behaviour in order to reduce risk of shame from others.

> It's like this, the people in the rooms talk about having a Jekyll and Hyde lifestyle. So if you met me in the street you would think, oh, you know, he dresses well, he's happy go lucky, you know, he's great fun, you know, he's got a new business, he's making his way in London, you know, what a nice friendly guy. But that was the Dr Jekyll side of me. The Mr Hyde, coming home, every night, looking at this horrible, horrible degrading porn, ten/twelve times in a nigh, experimenting with these prostitutes, spending money, avoiding my friends, you know, using women, miserable and unhappy and thinking about suicide in the future, that was my reality. (Tony 435)

This Jekyll and Hyde discourse facilitates a fragmented and contradictory positioning in Tony's account (Edley & Wetherell, 2001). That is Tony constructs a dualistic positioning of the insane addict (Mr Hyde) and the sane and accepted individual (Dr Jekyll), again distinguishing illness from the person (Helman, 1985). Carnes' also uses the Dr Jekyll and Mr Hyde metaphor to construct this dualistic positioning:

> "In the addict's world, there is an on-going tension between a person's normal self and the addicted self. A Jekyll/Hyde struggle emerges. The addictive system is so compelling that to stop would be like death. Yet, as the system continues, the person's values, priorities, and loved ones are attacked" (p.27)

In line with interviewees' construction of recovery, previous qualitative literature has highlighted how this Jekyll and Hyde duality can cause difficulty in determining who the individual truly is (Enander, 2010). The Jekyll and Hyde metaphor is successful as it is possible to communicate the dualistic positioning, though addicts had to draw upon additional discursive resources to construct and negotiate accountability in the complex conflict between them and wider society

In order to manage this conflict, some addicts minimised their culpability via passivity and absence of agency (e.g. 'I came across') (Potter, 1996). Extreme case formulation, such as Tony's description below of absolutely disgusting, completely revolting pornography, also develops accounts of unreasonable desire more vehemently (Pomerantz, 1986). A discourse marker (and then) separates the dualistic constructions of rational (shameful) and irrational (desire driven) properties of the addict position.

> I first came across, basically, transsexual porn, which is men with implants, looking like women, like you see in Bangkok and all that kind of stuff. And I remember the first time I saw it I thought it was absolutely disgusting. Genuinely, I remember thinking, it's completely revolting, what is that? . . . And then I remember, it might have been two weeks later, I just wasn't getting the buzz from all the other kinds of porn that I'd been looking at over the years . . . (Tony 226)

Concerns about thinking sexually about other men, or attraction to homosexual pornography and behaviour, were constructed as symptomatic of addiction by some interviewees. Homosexuality conflicted with dominant discourses of aspiration to heterosexual-marriage and family (Elliot & Umberson, 2008). Some constructed thoughts about men, or interest in male pornography, as shameful, as indicative they were really homosexuals 'in denial', or of inherent impropriety within them.

> It was more an issue of this is where I thought my life was going to be, and this is where my life will be if a) I was gay or b) if I was a paedophile. It would screw up any future relationship I wanted, you know with a marriage or, do you know what I mean. (Chris 395)

> And I could see it getting worse because I was starting to search for, you know, bigger penises and, it was this whole new, whole new playground that I started to explore and love. And, you know, and then I was looking at the old stuff thinking, why doesn't that do it for me anymore? Anyway, this was giving me so much shame that, you know, I really, sometimes I just couldn't look my friends in the eye, like it was really, really, really bad. (Tony 311)

Contrastingly Scot, who positioned himself as not addicted, used similar experiences of viewing transsexual pornography to construct his interest as exploratory and aligned with a healthy rather than sick fascination. Scot uses minimisation and footing shifts to construct his use of pornography as generalisable to the wider public ('sort of', 'its on the rise') to work up the account of neutrality in this morally charged area (Goffman, 1981).

> Like something I've been watching kind of recently is kind of transsexual porn. It's like, it's big, it's on the rise, you know. And yes, that's not something I ever thought I would find interesting when I was kind of growing up I don't think. Like I never had interest in men, I never like liked the male form or penises, like I never had any kind of desire to sort of do anything with those. But now, after watching some of this and it's like, actually I could sort of see myself in some scenarios with these women, who just happened to have cocks... And that's, you know, I think that's all, and that's actually all quite healthy I think, for me that's quite healthy. Because it's, I'm quite interested in gender roles and transsexuals are very interesting when it comes to gender roles. Yes fascinating really. (Scot 351)

In contrast to the patient-type discourses of sex addicts, which provide possible action orientation of passivity, non-addict discourses appear aligned with consumer-type discourses, which provide the dual orientation of both acceptance and resistance to sexual desire (Speed, 2006). Non-addicts constructed negative elements of sex similarly to addicts, in discourses related to over-preoccupation, abuse and risk. For example, Daniel outlines bad sex as risky sex. However, in this depiction 'badness' is presented as easily remedied, with Daniel outlining ways of minimising risk within his account. The use of 'they' appears to distinguish this type of sex from Daniel's own sexual behaviour.

> I mean a good versus bad, are they putting themselves at risk would be, of HIV, would be a way of thinking about, is this bad sex or good sex? If they're putting themselves at risk of HIV, then that's probably quite bad sex. If they're behaving in ways that are physically quite dangerous for them or they're putting, you know, they're cruising in deserted spaces,

> they're going off to meet people where they don't leave their contact details or they don't know who they're meeting and they don't communicate this with anyone, you know. (Daniel 197)

It appears there is moral value in safety and wellbeing in both addict and non-addict accounts, although there appears little value contingent on sexuality, sexual interest or desire within non-addict accounts. Non-addict discourses around pleasure, curiosity, flexibility and privacy appear to enable the non-addict to explore sexual behaviour without it overwhelming or defining them. Privacy and independence to explore were constructed as basic rights, and independent of the moral priorities or judgment of others.

> But the other thing, which I feel very strongly about, is that my sexuality is my own and it is not to be owned or given to anyone else. And so, therefore, part of the secrecy was that I felt like I needed to retain an aspect of my sexuality and just, simply because of the fact that I was in a relationship, a long standing intimate relationship, it didn't feel to me that I necessarily have to share all of my sexuality with him. So there's definitely, part of the secrecy was an attempt, I suppose, to retain an aspect of myself. (Jonathan 149)

> Like I'm not sure but it's almost like whatever you're doing in that room alone when the door's shut, kind of stays in that room. And it's a free space, it's a free space to explore anything you want. And if someone was to think about those things, you can think about anything you want, like that's OK. (Scot 314)

However, in addict accounts privacy and autonomy were subjugated by the dominant have/hold discourse of sexuality (cf. das Nair & Butler, 2012). Positioning as an addict appeared to reduce discourses of healthy independence, and instead facilitated constructions of pathological isolation. Non-addicts and addicts therefore constructed freedom and independence as both good and bad respectively.

> Certainly that was a bit fear, you know the isolation, and just being on my own I guess, and not achieving anything with my life and just being a dirty old man I guess. (Chris 494)

The positioning of addict modifies narratives around power, and increases an individual's physical and/or psychological vulnerability to being overcome by their desire (Frank, 2000). Here their drive was something that impeded this and which should be managed in order to achieve the culturally accepted goal of intimacy within a monogamous relationship.

Sex Junkies

An extract from Gay Talese's novel *'Thy Neighbor's wife'* (1981) is used to introduce Carnes' second chapter. The extract describes Hugh Hefner as a "sex junkie with an insatiable habit"*;* junkie being a pejorative term typically used to denote a person with opiate dependency, most famously coined by William Burroughs in his novel of the same name (1953). The term junkie originates from the association of the drug user with rubbish and criminality, and continues to reference a residual group that is associated with both dirt and danger (Radcliffe & Stevens, 2008). The term sex junkie therefore utilizes existing constructions of 'othering' of drug addicts, in constructing sexual addicts as dirty and dangerous others (Johnson et al., 2004). The sex junkie appears to correspond with a patient-type construction of mental ill-health and insanity which position the addict as prone to dangerous or dirty behaviour.

> So my risk profile got greater and greater over time, in terms of unprotected sex, I considered unprotected sex with prostitutes which is, well I look back at it now and it's just, well its just such utter madness, but I genuinely considered it, and came very close to doing it. You know I am a scientist, I know the risks, it is insane the risks . . . (Alistar 177)

Alistair outlines how he is now able to reflect on his previous behaviour as insane from a rational position of science. Neither risk nor insanity are neutral terms, but carry clear moral implications. Carnes constructs the insanity of the addict to eventually destroy the addict, as well as harming the wellbeing of others. Again extreme case formulation was common in presenting the

consequence of addictive desire, in both Carnes and sex addict interviewee accounts (Pomerantz, 1986)

> I think the worst case scenario is that you end up killing yourself either by you catch something or you commit suicide or you have a heart attack. I have heard about that a lot, particularly with people who use other substances erm as well to manage it. And I know of cases where people have caused themselves physical harm through things like exhaustion… But obviously just before that is that you harm other people. (Chris 455).

The practice of sexual addiction is constructed as incompatible with safe sexual behaviour. Indeed, Carnes describes one way in which the sexual addict "increases their dosage of intoxication" is through "risk, danger and even violence" (p.21).

> "When you are a person with AIDS and you have unprotected anal sex with others every time you use cocaine and yet you continue to use" (p.2)

Arrest, illness and injury, and death are constructed in several places in the text as risks of sexual addiction. Again Carnes' uses his vignette of Carrie, a schoolteacher who has multiple sexual partners, to build an extreme case formulation:

> "The consequence that brought Carrie help was an unexpected heart attack at the age of thirty-three… it was a miracle she had not contracted venereal disease or HIV/AIDS or been injured or even murdered" (p.27).

There is an integrative overall construction of the addict as increasingly isolated from others and reality, and decreasingly healthy and safe. The constructed contexts of risk and danger of the sexual addict are transparent within the SAST.

> Q. 26) Have people in your life been upset because of your sexual activities online?
>
> Q. 39) Have you engaged in unsafe or "risky" sex even though you knew it could cause you harm?

> Q. 44) Has your sexual behaviour put you at risk for lewd conduct or public indecency?

Again these constructions present sex addiction as based on objective outcome criteria of the risks and dangers of sexual addiction, aligned with biomedical discourses of diagnosis and symptomology, rather than idiosyncratic or subjective states.

Sin and Shame in Addiction

Both Jonathan and Daniel, who identified as non-addicts, constructed the states of guilt and shame as the central feature of their construction of people who identify as sexually addicted, and in differentiating their own subject positioning. Daniel constructed sexual shame using psychological discourses, mirroring sex addiction diagnosis, whereas Jonathan outlines sexual shame as a changeable concept for him based upon social context.

> And I've been putting together a kind of alternative diagnosis called, Sexual Shame Disorder…. it's more often that what people are presenting with is sexual shame. And sexual shame can be treated and, you know, psychologists and therapists have been treating shame for a long time, it can be treated very well. But it's not necessarily going to change their sexual behaviour, it's more treated in the way in which they relate to their sexual behaviour. (Daniel 515)

> I think what the shame actually reflects to more, is more of a societal construct of what is considered acceptable within society. And I think the clearest example that I can give of that is, I have quite a number of gay friends, and I quite happily and openly speak with them about my pornography use. I've gone with them to sex clubs and they have seen me have sex with other men and sometimes more than one man in a night and that's fine. And there's no shame attached to that, because within that context, sex and the frequency of partners and the anonymity of it, is seen very differently, than if I was to have exactly that same conversation with, for instance, my siblings. (Jonathan 670)

In both of these accounts sexual behaviour is constructed as capable of generating shame and embarrassment within the sexual addict, though sexual behaviour per se is not seen as the cause of the shame. Instead it is the context, and the individual's relation to their sexual behaviour, which generates shame. Contrary to these accounts Carnes conceptualises shame as immutable within the addict, presenting this conflict as an internalised diagnostic marker of the addict's opposition to the omnipotence of wider institutions.

'Vice' and 'sin' are discourses used by Carnes to construct this inherent shame in addiction, and to highlight the judgment discriminating the addict and the power of broader institutions. For example Carnes paraphrases Exodus, in describing the sexual "sins of one generation being visited on the next" (Carnes, p.5). This evokes the Judaeo-Christian notion of original sin, whereby Adam's rebellion in Eden led to a punitive expulsion from paradise, predisposing mankind to implicit embarrassment and shame (de Botton, 2012). Drawing on the institution of religion to disempower the addict is supportive of Carnes' links between sinful sex, shame and social judgement. As Rubin (1984) outlines, those individuals who practice 'sinful' sexual behaviour are subjected to a presumption of mental illness, disreputability, criminality, restricted social and physical mobility, loss of institutional support, and economic sanctions.

Some addict interviewees constructed societal piety as a barrier between them and wider society, which directed their segregation further into addiction. Contrastingly, Daniel and others who adopted the non-addict subject positioning constructed religiousness as a reason some individuals may identify as addicted in the first place.

> I suspect she's getting a lot of people coming to her through the church. Who are sent by their ministers or their wives or self referring because their Christian beliefs say one thing but their sexual desires and drives say something else. And, therefore, they feel that they're wrong and that they should be brought into line with their moral values… I've met people who are having lots of sex and many who are sexually compulsive, but I wouldn't say they are sex addicts. But then I am not

> probably going to see lots of conflicted Christians, for example, who have got a problem with their moral values. (Daniel 349)

> I was Christian and possibly even more on the evangelical side… You know I sort of had this image of being married and that sort of thing, and wanting to be in a marriage, and probably looking back on it now from where I am, probably a very co-dependent view of what that should be like, and thinking that if I was gay that was going to stuff that up. (Chris 383)

It appears that the moral values Daniel constructs correspond to Chris' desire for marriage. Therefore, in several cases religion was seen as an institution by which individuals judged themselves to be addicted and maintained their addict positioning.

Intimacy and Addiction

Good sex was commonly constructed using combined discourses of intimacy and love (Laurenceau et al., 1998). Though there is a broad cultural discourse of sex as important within relationships (Elliot & Umberson, 2008), a relationship based purely upon sex was constructed by Carnes and addicts interviewees as a problematic prioritisation of sex over love and intimacy. The subject positioning of addict appears to negate potential for discursive resources of love; in fact the addict "routinely jeopardise all [they] love" (p.14).

> Think that people who go out with sex addicts – sex addicts are typically incapable of meaningful intimacy erm when they are in active sex addiction. (Alistair 514).

Modern Western society appraises sex acts according to a hierarchical system of value (Rubin, 1984). Marital, reproductive relationships, and the bond of sexual relationships based on love, headline this hierarchy, whereas purely sexual acts are positioned towards the bottom of this hierarchy. The moral conundrum of sex and love has long been debated (see sensual and affectionate currents; Freud, 2001). Carnes and addicts constructed sex addiction as both a barrier to initiating intimacy as well as a reason for intimacy, and monogamy, deteriorating. These accounts correspondingly construct the

sexual partner of the addict (presumably 'normal'), as desiring intimacy, and the addict as the source of unfair, degrading and even unsafe ('hardcore') sex. Contrasting construction of morally appropriate and intimate sexual behaviour, appears to involve subjugating your own desires ('I wanted to').

> It's becoming harder, it's becoming more degrading to the girls… It's moving further and further away from loving. I don't think it ever was loving, but it's really getting quite hardcore, you know. (Tony 179)

> So when I was in Europe I met a girl I was really interested in, and I wanted to start a relationship with her, and sort of was very keen, but thought 'you need to knock this on the head before you do', because I thought this isn't fair on her. (Chris 267)

> "When you seen a person on the street you have been anonymously sexual with in a rest room" (p.2)

Non-addicts, such as Jonathan, reject the construction of intimacy and polygamy as mutually exclusive, and instead constructed intimacy within polygamy in relation to this dominant discourse of intimacy. Below Jonathan uses stake confession to acknowledge the difficulty of constructing intimate polygamy, and present his account as honest and objective (Potter, 1996). However, he then goes on to outline how sex with others can heighten intimacy, as it involves in depth personal understanding, and caring and validating partner-responsiveness (Weingarten, 1992).

> So I do also think that non-monogamous sex can distract one from being intimate. I definitely think that's possible. And it can work as a defence against intimacy. On the other hand, I don't think that it is necessarily counter or contra to intimacy. I think it's a very intimate experience for two partners together to have sex with a third person or to share sexual fantasy . . . So within that situation, it would almost be a heightened intimacy, rather than something that would threaten intimacy, you know. (Jonathan 301).

A crucial assumption of constructions of intimacy is commitment (Leslie & Morgan, 2011). While passion and desire are important initially, most

constructions involved excitement inevitably and suitably fading, as more morally healthy intimacy builds. Mature love, an aspiration for many addicts, appeared to be fulfilled through commitment, marriage and family life.

> I felt like I was losing myself. Because my dream and my goal had always been, and still is, to eventually have a family and to find love because I'd never been in love, you know, with a woman. And have kids and have the life that I had growing up. But meanwhile, I still haven't ever committed to anyone, I'm binging on this kind of porn and I'm now going to visit these kind of prostitutes and, you know, literally, what the hell is happening to me? I feel so miserable and so lost and I can't tell anyone. (Tony 351).

When lovers 'fall in love', lovers are constructed as helpless, passive and vulnerable to the unpredictability of 'cupid's arrow' (Leslie & Morgan, 2011). Conversely, when 'the right one' appears lovers are empowered to actively 'follow one's heart' (Shumway, 2003). However, it appears that following one's heart in constructions of sexual addiction involve sacrificing intimacy.

> Q. 43) Has your sexual behaviour kept you from having more long-term intimate relationships?

Monogamy and commitment are clearly highly valued in Carnes constructions of love and intimacy. This is congruent with the title of his earlier text "Contrary To Love: Helping the Sexual Addict" (1989). Ending relationships is therefore constructed as morally problematic feature of addiction.

> "When you break off another relationship that you had no interest of being in in the first place" (p.2)

The addict is moreover constructed to threaten and endanger the family. The addict's children are repeatedly constructed as suffering from the addict's dishonesty and their choices. For instance, in one almost Dickensian example of a 'moment', the addict prioritises spending money on prostitutes over the new shoes needed by their child.

In line with interviewee accounts, drawing on psychological discourses and common discourses of parental conduct, Carnes' constructs the risk of addicts mistreating and potentially abusing their children as cyclical, i.e. linking experiences in childhood with behaviour as a parent (Gough & Reavey, 1997). In line with the Carnes' conceptualisation of sin as being visited on generations, there is a construction that through abuse, inappropriate learning, or hereditary affliction, future generations are at risk of addiction. Correspondingly there is an amplified cultural imperative to intercede the sexual addict, for their own sake, but also to protect future generations.

3.5. The Cultural Imperative to intervene in Sex Addiction

The discourses defining sexual addiction outlined above offer little possibility for the addict to manage their sexual addiction alone. Their positioning as addicted appears to limit their role as responsible social actors due to reduced awareness and control of their morally and socially problematic desire. The active addict subject positioning contradicts the subject positioning of the 'free-agent' positioning associated with careful deliberation and consideration of the effects and consequences of action on the self (Willig, 2008). The addict therefore becomes a legitimate subject of interest to experts and wider society (Willig, 2011); that is this subject positioning carries a corresponding construction of a cultural imperative to intervene in sexual addiction, i.e. for science and society to identify, formulate and intervene to help sex addicts, as they cannot help themselves. Indeed, the disempowerment of addicts over their behaviour was often tied with an unawareness of their position.

Precontemplation

Many addicts constructed a definite point of conflict, between behaviour and desired self, at which they identified as addicted. As Alistair describes below, at this point they were said to be unable to change without help (i.e. they had lost control). Prior to this point they may have been able to successfully tackle their behaviour, however they were unaware of any problem and so were unmotivated to change.

> People can be addicted long before they know it, or long before they suspect that something is wrong… I'm sure there are many people who have gone way past that stage where they would find it, without help, impossible to do so, long before they realise it, long before they suspect it. (Alistair 377).

The transtheoretical model of change is a heuristic commonly applied to the 'process' of addiction (DiClemente & Prochaska, 1998). In the model the addict progresses through a number of motivational stages, which begins with 'precontemplation'. Here the individual is not concerned about their behaviour and so is not thinking about or motivated to change. This conceptualisation endorses the promotion of management of the 'precontemplator' by experts, for example by increasing their motivation to change. Reconceptualisation of the behaviour from good (harmless, pleasurable etc.) to bad (dirty, dangerous etc.) is one way in which expert input could promote change. The aparent power differential between the passive addict and empowered expert to identify addiction and guide intervention appeared fitting for some non-addicts though was more critically questioned by others.

> Like maybe that's for other people to decide, maybe that's for other people to notice, the change in you. So often, sometimes when you're stressed you don't know and it takes people around you to say like calm down, you know, you're not the same, do you realise? And you don't often because you're just sort of going straight, doing one thing. So maybe that's what, maybe addiction comes into other people having to tell you that you're addicted or having a problem. Porn intervention. (Scot 429)

> If someone else has a problem with your sexual behaviour, then you are a sex addict. And it's like, who decides that, you know, just because I don't like how much time you're spending wanking or looking on the Internet, looking at porn or whatever, I can diagnose you. (Daniel 333)

Incongruity between awareness and values of the addict and professionals was a common construction. Daniel uses extreme case formulation to construct the expert's power in this inconsistency as purely partisan (just because…).

However, Carnes' uses extreme case formulation to construct preoccupation as unbiased and scientific, where the addict-patient is unable to appreciate their actions.

> "Preoccupation – the trance or mood wherein the addicts' minds are completely engrossed with thoughts of sex." (p.19).

Lechner and colleagues have argued that it might be useful to adapt the transtheoretical model of change to distinguish between *aware* precontemplators (people who know/identify their behaviour but do not intend to change) and *unaware* precontemplators (people who do not know that their behaviour is problematic and therefore experience no need to change) (Lechner et al., 1998). The aware precontemplation construction offers non-addicts equality in their ability to decide upon their goal and emphasises equality of perspective. However, this does not appear the case for addicts. Positioning as an addict appears to marginalize discourses of awareness and ultimately places the addicts' perspective as opposing actuality.

Insanity: The false identity of the addict

The discursive construction of the addict's "impaired thinking" is used frequently in the text. Carnes utilises the familiar psychological discourse of faulty information processing, inherent within cognitive models of psychological therapy (e.g. Beck, Rush, Shaw & Emery, 1979) to construct the addict as governed by "core beliefs that are faulty or inadequate, and consequently, provide fundamental momentum for the addiction" (p.16).

Carnes draws on these popular psychological discourses to construct the addict as inherently flawed in the way they appraise the world, and hence, positions them as detached from true reality; i.e. "the addict's world has become totally insulated from real life" (p. 25). This is sustained by dominant discourses of drug addicts and alcoholics as having impaired decision-making capacity in the fields of neuroscience, law, and bioethics literature (Andreou 2008; Caplan 2008). The sex addict is positioned as a disempowered victim of their faulty beliefs. This discursive construction can be seen as a way of reducing personal responsibility, while emphasising passive dependence upon expert advice.

Carnes supports insanity discourse, with the notion of “sincere delusion”. For Carnes’ rationalisation of behaviour is constructed as confused defiance. The convictions of the addict that they not ill, are often presented as from a position of unreasonable self-regard and hostility, which can further drive a separation between addicts and others. For example, Carnes describes the addict as “self-righteous, critical and judgmental of those around him” (p.19), unfairly placing fault with spouse, children, parents, work associates and bosses.

The discursive positioning of the addict as insane, severely limits their capacity for contrasting discourses and alternative accounts of their sexual behaviour as rational. Carnes’ construction of the addict as insane, is sustained by a tautological loop whereby “whatever the rationalization, it further cuts the addict off from reality” (p.18). A list of bullet pointed examples of the addict’s “arguments, excuses, and justifications” is given, which promotes a diagnostic discourse of predictable rationalizations as signs of their ‘insanity’. These points often include another person, who at face value is positioned as at fault, though in the wider context is subtlety portrayed as suffering through the addict’s behaviour, and absolved of accountability.

> “My husband is not sensitive to my needs”
>
> “If only my wife could be more responsive” (p.17)

As with the sex junkie construction outlined above, the addict’s insanity is constructed as harmful to both the addict and those within their “biological system… governed by definite rules” (p.5). The use of biomedical comparisons, again aligns this construction with institutions of science, and provides a means of constructing the addict as physically unwell, and the source of wider systemic suffering. This is also apparent in items of the SAST, where addicts are presented as having caused harm to the system rather than as an equal member of the system; i.e. the addict is the sole source of the problem, rather than problems being a product of the system (Dallos & Vetere, 2003)

> Q. 8) Has anyone been hurt emotionally because of your sexual behaviour?

Corresponding the discursive theme above, there is therefore a need for experts to intervene to correct the beliefs of the addict and bring them in line with a more rational perspective, not just for them, but also to protect wider society.

Necessity of Experts

Scientific, psychological and medical discourses were used to construct the need for experts and therapeutic interventions to support the insane or unwell addict (Foucault, 1977; Jutel, 2009). Borrowing from transactional analysis, the addict positioning appears comparable to the powerless victim role, making available the inter-reliant rescuer role to guide the addict's recovery, or a persecutor role to condemn the addict, for the expert (Karpman, 1968). The implied accuracy of expert accounts to identify sex addiction pathology is a form of category entitlement (Edwards & Potter, 1992), in which authenticity to help is warranted by 'expert' category membership (Johnstone & Frith, 2005). This parallels the discursive theme of the science of addiction outlined above. As well as disempowering the addict, the family and partner are also constructed as powerless to help given their non-expert status.

> "These people have in common the belief that it is in their power to stop the spouse's addiction… Ironically, efforts to control the spouse's behaviour unwittingly intensify the addiction process" (p.5)

At worst the partner is constructed as capable of catalysing the addiction. Carnes uses the descriptor 'spouse', emphasising the underlying assumption of normalcy being aligned with monogamous holy-union. The social contacts of the addict were also constructed as being inappropriate to guide recovery by addict interviewees. In this extract Alistair presents the construction of 'co-addict', who is also unhealthy ('a fuck up', 'in denial')

> I think that I have never met a sex addict, whose partner is not equally as fucked up as they are. It is very rare, and so I have just not found a situation. I have also unfortunately with sex addiction, and with addiction generally, I think it is very common that addicts are the identified partner,

> the identified patient, and that the co-addict is in denial about their own part in that. (Alistair 508).

Addicts appear limited to adequately describe themselves using everyday discourse, given the remedicalisation of their sexual behaviour using psychological and medical discourse (Conrad & Angell, 2004). Many borrowed from this discursive repertoire, for example in constructions of previous trauma experiences as the foundation of their addiction. Childhood abuse and overly strict parenting were also constructed as some of the pre-dispositional factors which left individuals vulnerable to sex addiction.

> Having said that, and having been around sex addicts in numerous therapies, for a long long time, I have never met someone who has had a perfect childhood and ended up a fuck up anyway. (Alistair, 263)

Both addicts as well as non-addicts constructed this previous trauma using psychological discourses. In doing so it positions those who have access to these discourses, i.e. mental health professionals, as able to identify and support the addict given their ability to comprehend their addiction, through a positioning of expertise. Similarly, non-addicts utilized psychological discourses to construct how an individual may come to identify as sexually addicted, for example through previous trauma and attachment issues.

> The thing that I think is common in all of these things, in my mind and my experience, is that it is linked with attachment difficulties. So in my understanding, it often has to do with either avoidant or ambivalent attachment. And so, in my work that I do, is the thing to understand is not the sex addiction or the triggers or any of that stuff, but rather what makes them more complex or more secure attachment rather difficult. (Jonathan 510)

> Then maybe if you treat the sexual trauma, you might be able to relieve the anxiety of the fetish. So, for example, if someone was sexually assaulted as a child, then as an adult they're only really interested in age play or are not kind of consensual, non-consent type sex play. And they can't get off in any form of play unless they've got something like that.

> Then if you can uncover the fact there was a trauma and deal with the trauma, and heal the trauma, then maybe it will give them a greater level of repertoire for other activities, or maybe they can introduce some other activities as well by recognising that this was one aspect. It was trauma induced but perhaps there are other ways in which they can start to increase their arousal. (Daniel 436)

Carnes also draws upon psychological discourse to construct addiction as founded upon established vulnerability such as trauma. One such vulnerability is constructed as childhood sexual abuse. The primacy of items addressing abuse in the SAST implies its importance in the expert making sense of addiction, and also bolsters the significance of sex addiction as a construct.

> Q.1) Were you sexually abused as a child or adolescent?
>
> Q.2) Did your parents have trouble with their sexual behaviour?

For Jonathan and Daniel, who are critical of the addiction construction, they maintain the necessity of the expert position to support people in distress. However, contrastingly they construct 'responsible' experts as those who help criticise/persecute the addict role and support the addict construct and identify alternative non-addict identities, without disregarding a 'problem' outright.

> The fact that a client comes in and says they're addicted, I think as therapists, we have a responsibility to say, well actually, there is no such thing as sexual addiction. So I can't treat you for something that isn't a disorder. Let's think together about what is happening in your life and how else we might frame this, because clearly you have a problem with your, you know, that's brought you here. (Daniel 509).

For Carnes the addict is constructed as both a victim and a potential offender. He presents sex addiction as a circular construction of the abused becoming the abuser. By amalgamating constructions of addiction and sexual offending there is an exaggerated and unified obligation for forensic and mental health professionals to protect vulnerable children from sex addicts, and so unravel this cyclical abuse/abuser pattern. Carnes' own forensic background, and so positioning as a category witness, serves to bolster the authority of his account

of the offending sex addict (Edwards & Potter, 1992). The use of the defenseless child in these constructions also serves to emphasize the helplessness of individuals to addiction.

Q. 29) Have you been sexual with minors?

The victim-addict positioning, being founded in early experience, strengthens the construction of many addicts as early victims of their environment. The cultural imperative to intervene is constructed not only once a person is addicted, but also to prevent such environmental factors that would promote vulnerability to addiction, particularly in the young and so vulnerable. As well as trauma and abuse, opportunity was also constructed as a clear vulnerability factor in addiction. Specifically, the ever-expanding quantity and accessibility of pornography via the Internet was discussed as a catalyst for sociocultural level sex addiction.

The Internet as a catalyst for Sex Addiction

In contemporary socio-political discourse there has been a rise in constructions of the "war" on Internet pornography (Guardian, 2013). Internet pornography within such discourses typically carries similar constructions to the dirt and danger of bad sex in the above theme. Internet pornography is constructed also as unnatural or supernatural, "flooding our senses with visual stimuli and sexual opportunities, beyond the remit of our evolutionary capacity" (Hall, 2013, p.27). It is constructed as freely accessible to all, and as capable of promoting sexual assault and violent crime. The notion of anonymity afforded by the Internet corresponds with the bad sex discourse of lessening intimacy. 'Cybersex' is constructed by Carnes as stimulating a loss of self and an insane disconnection with reality discourse. It is also constructed as catalysing a disinhibited loss of control since "Addicts view cybersex as having no consequence" (Carnes, 2001, p.81).

"People can be anyone they want on the Internet" (p.81).

Several items on the SAST construct the Internet, not only as catalytic but as the cause of sex addiction. Indeed, the power and omnipresence of the Internet is constructed to *create* addicts.

Q. 22) Has the internet created sexual problems for you?

An anthropomorphous discourse surrounding a singular Internet can be seen as an example of the transference of power, control and so responsibility from the individual to a singular 'the Internet'. Internet pornography is presented as a roaming danger, or omnipresent phantom, which through its accessibility can reach the vulnerable at any time or location (Foucault, 1975), and put them on the path to addiction. Addicts are constructed as passive and as almost completely trusting, unquestioning and compliant to the power of the Internet. Many addict interviewees constructed the Internet as permitting unlimited access to pornography, and constructed access to the Internet as the start of their 'opportunity-induced' addiction (Hall, 2013). Again, addict interviewees constructed the Internet as a real and very serious danger.

> I think it's a very real issue. I think it's an issue, which is going to become more and more apparent to society in the years to come… nowadays, you know, and it's because of the internet that my porn usage went through the roof, just the availability of it… I think for the kids of today, genuinely, for the kids of today, who are growing up in their teens, you know, they're aged ten/eleven/twelve/thirteen/fourteen, they're going to get access to all of this. And we couldn't get access to it until we were older but it's, you know, I think it's going to be a real, real problem in the future. My point is, is there's going to be a lot more addicts at a younger age. (Tony 15)

As in Tony's account, children and teenagers were often constructed as unable to manage their pornography usage. Internet pornography is presented as particularly overwhelming and damaging to adolescents. Interviewees drew upon the dominant discourse of adolescents as immature and naïve to position them most at risk of the danger of pornography (Stevens et al, 2007).

> And I mean there's been lots of, you know, documentaries and kind of crappy Channel 4 kind of things on these. They go into schools and they, you know, talk about, look at kids and how they view kind of relationships and what a normal penis size is and stuff like that. But I think I'm a bit older, so I don't think that's really a problem for me. I can see that being

> a problem for younger children certainly, to have unrealistic expectations. (Scot 378)

Exposure to Internet pornography in adolescence is constructed as leading adolescents off the 'normal' developmental path (Wyn & White, 1997), and onto more addictive (I.e. dangerous and dirty) sexual behaviour in adulthood, akin to the gateway theory of drug dependence where lesser drugs, typically used in adolescence, may lead to a future risk of using comparatively dangerous 'hard' drugs and/or crime, and away from more appropriate lifestyles (Pudney, 2002). Again the institutions of education, work and marriage are drawn upon to construct pornography users as neglectful of such 'normal' lifestyles and morally acceptable responsibilities such as work and education.

> And then that progressed to, when I was doing a PhD, that progressed to using porn regularly. So kind of probably four or five nights a week, going back to work and, you know, spending hours on the internet looking at porn. (Jake, 82)

A jumble of institutions and regimes of sexual normativity is therefore involved in positioning the Internet as detrimental to 'good' sex. Internet pornography is positioned as incompatible to the regular relational sexuality, and is associated with pathologically abnormal stimuli. Masturbation is constructed as wastage of sexual energy, or a wanton lust representing an absence of ethical agency on the part of the individual (a loss of control on drive). Accounts construct the necessitation of arbitration of Internet pornography as some kind of moral crusade (Becker, 1963) through which experts and state can help the addict, and future addicts, adopt a more appropriate lifestyle (Voros, 2009).

3.6. Summary of Analysis

Though addict and non-addicts appear to share a surprising amount of discourse in describing their sexual behaviour, there appear clear discursive repertoires in both text and interviews, which distinguish ways of seeing and ways of being available to the addict and non-addict. It appears that the constructions of sex addiction and the sex addict are reinforced by medical/scientific rhetoric, which emphasizes the sick role of the addict, and

related professional and political interests to examine and intervene. This arguably has the effect of creating and maintaining powerlessness in an already vulnerable group. Using discourses of insanity and unawareness of psychological and moral conflict undermines capacity for dissent and disagreement from the addict position and instead places emphasis upon society to intermediate the sexual practice of current addicts and those at risk. The constructions of sexual addiction used by Carnes are paralleled in contemporary discourse of those who accept or reject the position of sex addict, supporting the value of a broad FDA analysis in addressing this complex topic.

General Discussion and Reflection

4.1. Section introduction

This summary and discussion builds upon that in the analysis. It is organised into three subsections: a summary and discussion of the key themes; implications of the results; and an evaluation of the study light of my own reflection.

4.2. Summary of Findings

The findings of this study show that there are a range of expert and non-expert constructions of sex addiction, which impact on the positioning of the addict and non-addict, their available ways of being and subjectivities. These in turn carry implications for healthcare professionals working with people who identify as sex addicts or as having concerns about their sexual behaviour.

A Loss of Control

Those who positioned themselves as addicts constructed a loss of control as a key feature of their addiction. A loss of control has long been conceptualised as a core feature of addiction (cf. Weinberg, 2013), and appears to be receiving a growing amount of interest in contemporary addiction literature (Cote et al., 2013; Griffiths, 2013). There are several depictions of loss of control in addiction, which typically refer to either lack of ability to regulate or control behaviour; lack of ability to choose between behaviours; or lack of resistance to engage in behaviours (West, 2006). There is also debate as to whether this control should refer purely to observable failed efforts at control or should also refer to individuals who are incapable of control but have not yet attempted restriction (in line with constructions of ability) (Griffiths, 2013). For the latter group loss of control would only manifest as problematic over time, if at all (Koob & LeMoal, 1997). Therefore, loss of control appears to refer to several different objective and subjective categories of behaviour with negative, neutral and positive functions, in theoretically different types of addict (e.g. Rachlin, 2000; Skog, 2003). This may explain the difficulty in producing a unanimous conceptualisation of a loss of control in addiction within positivist biomedical or social science models (Voros, 2009; Weinberg, 2013).

Some have argued that early stages of addiction may even be marked by excessive control over the addictive behaviour, and consequent deregulation of other areas of life, and so denoted addiction as involving a 'loss of prudence', rather than a loss of control (Griffiths, 2011). Prudence is a morally loaded term and is dependent on cultural and societal priorities. Conversely, control is not a neutral term. To present with a loss of control, it is necessary to have possessed a form of control previously and supposes the ownership of free will over previous choices (Cote et al., 2013). This conceptualisation would imply that non-addicts have complete control. However, as arose in interviewees' constructions, individual capacity and control is heavily dictated by a sociocultural context, and features such as age, relationships, illness, and biology. Therefore loss of control as a diagnostic marker separated from chronology and social context appears hollow.

The use of interpersonal or intrapsychic 'conflict' as a representation of loss of control is also problematic when presented independent of critical reflection on social and psychological context. At the heart of this marker is a concern with spending *"too much time engaging in the activity"* (Griffiths, 2013, p.38). This prompts the question for whom is this too much? Such questions are pertinent to other objective 'components' of addiction (Griffiths, 2005); e.g. how severe do withdrawal effects have to be to count them as withdrawal 'symptoms'?; 'how strong does a desire or urge need to be to count it as a 'craving'? (West, 2006). This issue is further compounded by the apparent arbitrariness of sets of symptoms, or cut-off points in measures such as the SAST, in order for a diagnosis to be made. Defining addiction empirically can mean that two 'addicts' could have non-overlapping sets of symptoms, which draws into question whether these indeed are permutations of the same core addiction, or are qualitatively different.

One possible differentiation appears to be location the conflict, i.e. within addicts or between addicts and others. "Happy addicts" are constructed as addicts, but as content with their behaviour (Skog, 2003). In line with the "precontemplation" theme above, it appears conflict between the individual and wider moral and scientific institutions is the basis of the description of losing control, which offers an account of this conflict. Here being unaware of conflict,

can be constructed as losing control, regardless of mood. The relative scarcity of recorded loss of control on 'gardening' or 'child-protection' is no-doubt a feature of relative societal values. Changing societal values, and also developments in theories of addiction, can lead to disjunction with past addiction research, in terms of prevalence and heritability estimates (West, 2006). It would have been fascinating to conduct a prevalence survey of sex addiction using the SAST in the era prior to the decriminalisation of homosexuality, and compare this to today's prevalence rates.

Together, this research and other accounts force the question of what value, and indeed credibility, there is in labeling individuals as addicts based upon control without critical reflection on what 'control' (and indeed other diagnostic components), represent for these individuals and prioritise within wider society. Further research into the interplay between prevalent discourses and experience of control, would be valuable in developing our understanding of control within constructions of addiction, and other psychological conditions demarcated by a its loss.

Good vs. Bad Sex

It is perhaps surprising that the historically dominant discourses of sexual monogamy and intimacy, aligned with institutions of the church and the state, appear to endure today in the sexual addict's constructions of their addiction (Foucault, 1990); particularly given the rise of more liberal alternatives (McNair, 2002). It appears that the dominance of these discourses is the foundation for conflict between the addict's sexual behaviour and their aspirations to the morally condoned 'have and hold' discourse, a happy marriage and family. Contrastingly, it appears that non-addicts do not place as much importance upon these institutions, and instead place value on the moral discourses of more localized societies including their peer group, online communities, as well as alternative construction of their sexual behaviour in a broad range of gender and sexuality discourses (e.g. Holloway, 1984).

Carnes' constructions of moral scaling of sexual behaviour in line with the institutions of church and state (Rubin, 1984) are arguably founded upon his own religious affiliation. In describing recovery Carnes pronounces, "*to establish*

a relationship with God is the first bridge to trusting relationships with others" (2001, p.172). In the preface, Carnes also describes producing the work as an "extraordinary pilgrimage", using religious symbolism to construct the work as virtuous. Carnes' writing and affiliation with 12-step organisations (cf. Hughes, 2010), promotes the spiritual entrusting of a higher power as a key factor in addiction treatment, or return to sexual "purity", of the sex addict today (Laaser, 2004). Discourses of pilgrimage, sin and purity denote clear Christian indices of morality. This means Carnes must work hard in his accounting to balance his religious principles and scientific neutrality (Chambers & Schilling, 2013). The result appears to be a complex mixture of Christian discourses in relation to sex, scientific discourses in relation to sex and, as noted in the analysis, on several occasions Christian morality is presented as science. The current work does not intend to dismiss these constructions, instead the analysis has emphasized the value of critically reflecting on the conflict of science and moral values within constructions of sex addiction, and how this may influence the available ways of being for the sex addict.

The Dr Jekyll and Mr Hyde discourse used by several addicts, encourages further reflection and investigation as to how sex addiction is distinguished from the 'true self', and what this means for recovery. The distinction of addiction from self appears to privilege a "restoration narrative" where addiction is seen as an interruption to normal functioning, which would suggest acceptance of the diagnosis would delay or suspend restoration to true self (Frank, 1995). That is, and as Carnes states "to preserve his integrity, Dr Jekyll had to kill Mr Hyde" (Carnes, 2001, p.30). However, as noted many addicts also privileged a seemingly contradictory "narrative surrender", i.e. their identification as a sex addict required adjustment and modification to their sense of self, including acceptance of things they 'could not change', or purposely limiting their access to forms of sexual behaviour such as masturbation (Frank, 1995). The inconsistent discourses of recovery identified across text and interview data, clearly have repercussions for the experience of being positioned as a sex addict in recovery. Particularly in terms of potential, as well as individual accountability and responsibility for change. Exploring the topic of recovery further with those who identify as in recovery would be valuable for future

research, but also appears an important topic clinically for healthcare workers to negotiate together with those identifying as recovering or recovered sex addicts.

The cultural imperative to intervene in sex addiction

The construction of a cultural imperative for expert support of the sex addict prompts reflection on how current services are set up to meet this need. Sex addiction is not normally treated by general addiction services, and individuals who present with sex addiction are often the cause of confusion for the therapist (Schneider & Irons, 1996). There is a suggestion that there are high levels of fear and discomfort for some therapists working with the topic of sex addiction (Herring, 2001; Hughes, 2010). Paralleling interviewee accounts, these practitioner concerns also suggest discussion about sex and sex addiction remains outside the realm of general practice, with available support being fragmented into specialist/private services. Several interviewees described experiences of feeling discussion of their sexual behaviour was inappropriate of unwarranted in some of the therapeutic work they had attended, despite describing having concerns at the time.

This division of sex addiction services from general healthcare services could serve to further reify sex addiction, as a distinct condition requiring specialist intervention. At a practical level this may also restrict many individuals' access to support for accessibility or monetary reasons. There appears a need to explore healthcare professionals concerns and discomfort of discussing sex and sexuality (Dyer & das Nair, 2012), and to better understand their health care professionals constructions of sex addiction in order to better meet the constructed need for services to support people in distress over their sexual behaviour. Interviewee accounts maintain that healthcare profesionals should remain mindful that discussing sexual concerns is often anxiety provoking, embarrassing and potentially shameful for many, and that blunt questioning or dismissive criticism is unlikely to ever be helpful.

It is hoped that this research helps elucidate the problems of healthcare professional passively complying with dominant reductionist constructions of sex addiction (such as the out of control or insane addict), within clinical practice. A narrow focus on the vulnerable individual arguably prevents looking

externally at the contextualisation of sex addiction (Boyle, 2007). As with other addictions such as alcoholism, a problem for theories conceptualising a disempowered, out of control addict, is that many addicts are able to stop without any outside help (Russell et al., 2001). Relative disempowerment is not a certainty following diagnoses, and as noted in the previous section, the sex addict label likely carries a combination of positive and negative implications to individuals, based upon what these discursive constructions limit and open up for each individual in turn.

The dominant discourse of the Internet as an inherent risk to wellbeing and decency necessitates further critical reflection on what this means for healthcare professionals guidance on the use (or not) of Internet pornography, chat rooms etc. There is an ever-expanding literature 'evidencing' Internet addiction (Griffths, 2000), and Internet sex addiction and Cybersex addiction, (and 'Sext Addiction'), in both academic and biomedical discourses, as well as a growing number of media stories and television programs with portray the dangers of internet pornography e.g. "Porn on the brain" (set to broadcast in October on Channel 4). The risk of problematic sexual behaviour has been argued to be 'turbocharged' by the internet through the "Triple A Engine" model of Accessibility, Affordability and Anonymity, or the "ACE" model: Anonymity, Convenience, Escape (Cooper et al., 1999). These factors are said to prove to be even more potent in disenfranchised groups (Griffiths, 2001).

Our analysis outlined that adolescents were one specific group constructed as particularly at risk from Internet pornography. This matches previous discourse analyses studies identifying dominant discourses of youth sexual health focusing upon mostly negative sexual health outcomes (e.g. sexually transmitted infections and teenage pregnancies) (Shoveller & Johnstone, 2006). The authors outlined how public health practice has followed suit, focusing on modifying sexual risk behaviour and lifestyle 'choices'. Committing to an unarticulated and underexplored set of discourses and assumptions about the overpowering dangers of Internet pornography, and the level of agency and control that is afforded to many young people, risks marginalizing and de-normalising sexual behaviour in a complex and transitory life-period, and in a group with restricted power. The creation of divisions based upon passive

consumers and empowered protectors from pornography increases the likelihood of many pornography users being 'othered' through the addiction discourse, and marginalizes possible discourses of 'healthy' or fluctuating sexual interest and activity. Again, it is hoped this research serves to highlight the need to acknowledge the powerful role of discourse, and to critically reflect on the various constructions that an imperative to intervene in sexual addiction involves.

4.3. Implications of the Study

Together the analysis could be taken as evidence of the confusion and contradiction which surrounds sex addiction, and the dubiety that the construct is reducible to an objective, empirical diagnostic category. Equally, the findings could be taken as evidence of the importance of discourse analytic methodology in understanding the construction of sex addiction, and acknowledging the controversy and wider historical and socio-political discourses within which sex addiction is constructed. The value of the discursive approach in facilitating critical reflection on mental health categories, whose reification is often taken for granted, has previously been shown (e.g. Harper, 1995), and is extremely relevant today given the outset of a range of new diagnostic constructions, and so subject positionings, within mental health in light of the updated DSM (APA, 2013).

There are important clinical implications of the current work, including the requisite for clinicians to critically reflect upon their own conceptualisations of 'normal' sexual behaviour and addiction, discourses which inform this positioning, and how this may influence their practice, particularly in light of the inherent power differential between client and therapist. Open and transparent discussion of the numerous and complex understandings of sexual behaviour, distress and addiction, and reflective challenging of dominant discourses in therapeutic work is likely to be beneficial in creating the possibility of positive change (Dallos & Vetere, 2003). This collaborative reflection could also serve to strengthen the therapeutic alliance, a factor associated with positive outcomes (Martin, Garske & Davis, 2000) and service-user satisfaction (Roberts & Holmes, 1998) across therapies.

Clinical psychologists working in this area, as both mental health practitioners and researchers, appear to be facing an important juncture our work—do we continue to operate within and contribute to a set of dominating discourses of positivist sex addiction, that risk pathologising and possibly disempowering those we purport to assist (Shovellor & Johnstone, 2006)? Or, do we acknowledge the powerful role of discourse, and use analyses such as the one described in the current thesis, to establish and empower new forms of discussion that critically appraise and challenge crude or obstructive constructions of sex addiction which have become taken for granted. Future research is invited to continue 'unpacking' the assumptions that are inherent in our existing knowledge of sex addiction, and extend this in developing our practices in more reflexive ways.

4.4. Evaluation and suggestions for future research

"Ultimately, the value of any scientific method must be evaluated in the light of its ability to provide meaningful and useful answers to the questions that motivated the research in the first place" (Elliott et al., 1999, p.216). It is felt that the present research has achieved its aim of improving understanding of the discursive world which sex addicts and non-addicts inhabit, though the discourses identified are not presumed as representative of the entire sex addict population or indeed non-addict population. Neither are the findings presented as regularities or even laws of defining sex addiction (Hammersley, 2003). The discourses identified are presented as some of the many possible constructions of sex addiction in circulation. To echo Orford "no definition of addiction or dependence, however arbitrary, will serve all people, in all places at all times" (2001, p.29). Though this may appear solipsistic, it is hoped that the strengths of FDA in taking into account matters such as history, and broader sociocultural context highlights that the discourses are established in social understandings, and as outlined in the analysis, commonalities may be drawn across comparable research, though it should be considered that each is grounded in the particulars of the interviewees and their situations (Rennie, 1998).

In line with the critical realist approach of this thesis the explicit, but not rigid, set

of guidelines for reviewing qualitative research outlined by Elliott et al. (1999) were seen as one of the most appropriate to review the research. Accordingly, I have aimed to present the work in line with common principles of psychological research through: addressing the relationship of the study to relevant literature; methodological appropriateness given research questions; informed consent and ethical research conduct; and presenting an aptly tentative discussion of implications of research data and understandings. In terms of the more flexible guidelines particularly pertinent to qualitative research, I have also sought to achieve each criteria set by Elliot and colleagues, arguably achieving differing levels of accomplishment.

Consistent with the idea of grounding the themes, several data extracts were included to demonstrate each theme's foundation in the data. Credibility checks were also employed, such as consulting with supervisors to discuss my analytical procedures and possible alternative interpretations of the data (Elliott, Fischer & Rennie, 2000). Similarly, I was able to check transcription with one informant and discuss their experience of the interview, reflecting on the resultant topics of conversation, and ensure they did not feel guided by me to certain topics. It is hoped this resulted in clear, coherent, and well evidenced, presentation of the discursive themes and the ways in which these interconnected.

The small scale of the project produces ethical dilemmas in fully situating the sample. Full descriptive information about the sample including, age, ethnicity, profession, sexuality, social class and path to addiction (including group affiliation etc.) would clearly reduce the anonymity of the sample. It is hoped the reader can appreciate the diversity of the sample, and the possible impact upon the analysis, despite this limitation. The sample size and use of a purely male sample, as well as the use of one, albeit significant, expert text and sex addiction screening measure limits claims of generalizability. There is clearly the potential for future work to investigate numerous other sources of discourse on the topic of sex addiction to expand understanding of such discursive networks.

It is acknowledged that my reflection on my own perspective has been limited

until this discussion section. Elliot's recommendation for full and open discussion of my own values, interests and assumptions at each stage of the work is somewhat limited by the available word count of the thesis. The work reported here undoubtedly reflects my own judgements and biases as well as my own positioning as a researcher and trainee clinical psychologist.

Interviews have long been the most popular method of generating data in qualitative research, though its alignment with ontological realism has been a source of some critique (cf. Madill, 2011). My role as a researcher, and trainee clinical psychologist may have affected what interviewees felt able to disclose in the interviews (Edwards & Potter, 1992). Equally features of the interviewee discourses may have been 'recipient designed' in that they were constructed to minimise tension of conflict between the interviewee and myself in the interview setting (Hutchby, 1995). Although this is not fundamentally problematic in the current critical realist research, it is likely the interview methodology will have impacted upon the data (Potter & Hepburn, 2005), implicating the themes produced reflect a co-construction between interviewees and myself (Hepburn, 2003). Examples of 'naturally occurring talk' within different contexts (e.g. group setting, psychotherapy), as well as from different texts would hopefully elucidate some of these idiosyncrasies of context. The use of discursive psychology (e.g. Potter & Wetherell, 1987) may help unpick such specifics, through a more detailed focus upon how language is used to manage stake in specific interactions (Willig, 2008).

4.5. Reflections on my role

From a Foucauldian perspective, the analyses presented are themselves discursive constructions and cannot be evaluated outside of the discursive framework (Willig, 2008). As an *author,* I cannot claim to have discovered knowledge about sexual addiction, but instead must see the analyses in light of my own reflexive awareness of how I have used to co-authored them with interviewees and Carnes. It is hoped that this reflexive awareness bolsters the quality of the work, in part by increasing its resonance the reader (Elliot et al., 1999).

It has been challenging, though extremely rewarding, to improve my

understanding of FDA, and by distinction other forms of qualitative research, in the present work. My lack of experience of using discourse analysis and relative experience of more positivist quantitative and qualitative methods (e.g. IPA, Smith, 2009), has at points in the analysis led to several redrafts, given the different focus and research questions of the current epistemology and methodology. Looking through my supervision notes, as well my own the reflective journal for the research, it is apparent at several points that I was drawn to compressing evolving analytic content into neat groups or models, and making broad claims about the generalizability and contextual consequences on what sex addiction *is* and *is not*, and the predicament of the wider sex addict (van Dijk, 1997). My reading of other FDA literature, supervision, and adherence to the quality criteria above has been invaluable in this process of getting to grips with FDA.

In particular it has been useful to acknowledge and reflect on my disposition to positivist assumptions in connecting existing theory to the understanding and representation of experiences and actions. 'Evidenced based practice' is sometimes referenced as a corner stone of clinical psychology practice, and as a trainee I am routinely requested to consume and synthesise research evidence to reason my practice (Spring, 2007). For me the use of theoretical models and summary reports which simplify and synthesise the intricacy and complexity of research are reassuring. I therefore had to work to resist temptation to seek out 'evidence' in the form of previous literature and research to scaffold my analysis, and instead aim to ensure the data was the source of the discursive themes.

Despite this effort, it is acknowledged that my previous experience of investigating drug-addiction (Briggs, 2012), and my learning experiences as a clinical psychology trainee will have influenced aspects of data collection, interviews, and analysis. I have therefore looked to evidence my grounding of the analysis in the data as much as possible, whilst acknowledging the role of previous literature and my own bias within the analysis.

For example, as the methodology outlines, I aimed to select text and interviewees to best meet the research aims. Interview methodology purposely

aimed not to impart interpretation, judgement, or otherwise impose on the interviewees account, and as far as possible to act as an attentive listener, interested in their story (Holloway & Jefferson, 1997). However, the language used by interviewees was often psychological or addiction based, which are familiar discourses to me as the listener. I may therefore have unwittingly restricted elaboration on such discourses as 'trauma' or 'tolerance' by taking for granted what was meant by these terms. It is also important to acknowledge that the participant information sheet may have itself may have primed interviewee to talk about topics. The information sheet introduced topics that might arise in the interviews, including "thoughts and behaviour" and how the individual "classified" sexual addiction. This information may have restricted interviewees to focus primarily upon psychological and biomedical language, as they felt this was expected of them. My own expectation is likely to have played a part in the emerging themes. I tried to remain open to a range of possible accounts and readings throughout the research, though did possibly expect a greater polarisation of addict and non-addict accounts. I expected many non-addicts to be vehemently dismissive of the addict label and distress of the addict, and to highlight their own sexual behaviour as unproblematic, though this clearly was not the case. Equally, despite the themes outlined above, some addicts were appreciative of the controversy surrounding the term, and many modestly outlined their understanding and what was helpful for them might not be for others.

I find the topic of behavioural addiction fascinating, I think in part because of the reflection it has triggered on my previous experiences of researching substance dependence, which is widely unquestioned as a 'true addiction'. My work as part of this research continues to change my perspective on addiction, and what it means to be an addict. I do not feel that certain addictions should be dismissed purely because of the subject topic, and am sure there are individuals for whom 'tattoo addiction' or 'shopping addiction' are helpful ways of making sense of their behaviour and distress. However, I find the conceptualisation of some addictions as perplexing, for example secondary addictions, i.e. those where the person "engages in behaviour as a way of dealing with other underlying problems" (Griffiths, 2013, p.1). I sometimes

struggle to see the value in classifying such behaviours as addictive, rather than simply using the ‘underlying problem’ as a way to conceptualise the distress. For example discourses such as grief addiction (UCLA, 2008) and anxiety addiction (Orloff, 2011), are beginning to emerge, which I fail to see as helpful. Though again this is my own reading of the research. I do think such work has helped me reflect critically on why I feel certain behaviours could be classified as addictive, and if and why this may add value.

Also in interviews, although ’why’ questions tend to elicit abstract and rationalised answers (Holloway & Jefferson, 1997), ’good’ and ’bad’ sex discourses would have arguably benefitted from further questions around why certain constructions are essentially ‘bad’ (e.g. isolation, selfishness). I feel at points in interviews these constructions were also taken for granted. The analysis of Carnes’ has helped highlight certain dominant discourses in sex addiction, and how they may have facilitated this process. These factors and co-constructions unavoidably contributed to constructing a particular framework for the interviewees' accounts and, as such, it is acknowledged that alternative findings might have been produced if the research was undertaken in a different context, or by a different researcher. It is hoped future work may explicate such alternatives.

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APPENDICES

SYSTEMATIC LITERATURE REVIEW APPENDICES

Appendix A: Literature Search

The following search terms were entered into PsycINFO, Medline and EMBASE independently. In each instance the individual terms were searched first, and then these terms were grouped using 'OR', into the four main themes relating to (i) Sexual addiction, (ii) Psychological Intervention, (iii) Efficacy, (iv) Methodology. The efficacy and Methodology terms were also combined with 'OR' given the likelihood that both would not be detailed. The focus of the final studies was therefore based upon some classification of sexual addiction, some psychological intervention, and some sense of the effectiveness of this.

Search Criteria:

1. Sex$ Addict$/ or Porn$ Addict$/ or exp Hypersexual$/ or exp Sexual Disorder Not Otherwise Specified/ or exp Sexual Compulsivity/ or Compulsive Sex$/ or Compulsive porn$/ or sexual impulsivity/ or nymphomania/ or Don Juanism/ or Satyriasis/ out of control sexual behaviour/ out of control porn$/ or hyperlibido.
2. Treatment/ or Therapy/ or Psychotherapy/ or Pharmacology/ or Cognitive Behavioural Therapy/ or Cognitive Behavioral Therapy/ or Cognitive Behaviour Therapy/ or Cognitive Behavior Therapy/ or CBT/ or Cognitive Therapy/ or Cognitive Analytic Therap$/ or CAT/ or Compassion Focussed Therap$/ or Eye Movement Desensitisation Therapy/ or EMDR/ or Behaviour$ Therapy/ or Behaviour Modification/ or Psychodynamic/ or talking therap$/ or Acceptance Therap$/ or couples therap$/ or systemic/ or psychodynamic/ or group therap$/ or Sex$ Addict$ Anonymous/or Porn$ Addict$ Anonymous/ or 12-step/ or twelve step.
3. Efficacy/ or Effectiveness/ or improvement/ or reduction/ or negative effects/ or iatrogenic
4. Randomised Controlled Trials/ or RCT/ or Random Allocation/ or placebo$/ or control group/ or comparison group/ or random$/ or Controlled Clinical Trial/ or Clinical Trial/ or Case Controlled Studies/ or Case Stud$
5. 3 or 4
6. 5 and 1
7. 6 and 2
8. limit to adult (18+)
9. limit to past 10 years (2002 – present)
10. limit to English speaking

Results of Search Terms (July 1st – August 10th 2012).

	Electronic Database		
THEME	**PsycINFO**	**Medline**	**EMBASE**
Sex Addiction	948	573	1436
Psychological Intervention	282727	2300710	3513693
Efficacy	162484	1040599	1747948
Methodology	127698	896649	1423360
Efficacy or Method	254827	1690422	2681736
Addict & Treatment	490	276	855
All Components	102	74	367
All Components + Limits	**57**	**57**	**275**

At the time of searching, PsycINFO was noted as containing over 3 million peer-reviewed articles dedicated to behavioural sciences and mental health; Medline contains around 20 million records and is dedicated to medicine and biomedical literature; and EMBASE contains over 20 million records from over 7,000 journals.

EXTENDED PAPER APPENDICES

Appendix A: PARTICIPANT INFORMATION SHEET

Participant Information Sheet

I am a Trainee Clinical Psychologist on the Trent Doctorate in Clinical Psychology programme, based at the University of Lincoln.

I would like to invite you to take part in my research about ways of understanding sexual behaviour and addiction to sex. This information sheet tells you about the research so that you can decide if you would like to take part in the study.

This research follows ethical guidelines set out by the Universities of Lincoln and Nottingham, and has gained ethical approval. This research is part of a research thesis and is funded by the University of Lincoln.

What is the aim of the research?

There has been a recent trend for the language of 'addiction' to be applied to sexual behaviours. Many celebrities and members of the general public feel they are addicted to sex, or pornography (though their thoughts, urges, and/or behaviours); or have been diagnosed as being addicted to sex, or as having hypersexual disorder.

This study aims to look into the things that are important in classifying addiction to sexual behaviours, and to explore important factors thought to play a part in how people make sense of, and experience their addiction. Equally, we are interested in exploring the same important factors and experiences of individuals who feel that they have high levels of sexual behaviour (thoughts, urges and/or behaviours), but do not see themselves as addicted.

Why have I been invited to take part?

I am asking you to participate because you have indicated that you would like to find out more about this study and/or offer your views and experiences about sex. We will be asking several people to come forward to tell us about how they feel about the amount and type of sex they are having, and whether or not this is a problem for them or their partners. I am interested in your perspective on your thoughts, feelings and experiences.

What do I have to do?

You will be asked to take part in an interview, which will last around 1 hour, at the University of Lincoln, or Nottingham; or a venue that is suitable for such an interview; including talking over the telephone or via Skype, whichever is most convenient for you. Questions will ask about your views on the concept of sexual addiction, and ask for you to describe how these fit with your own sexual behaviour. Before you start I will talk you through the interview and you will be able to ask any questions that you may have. When you are happy you understand what is going to be asked of you, and if you agree to take part, you will be asked to sign a consent form, or go through this consent form as part of the interview.

This interview will be audio-recorded so that I can write it down word-for-word at a later time. What you say will stay confidential with any names and personal information changed. All recordings will be stored on a password-encrypted computer, accessible by the researcher and the research team.

Will people know I took part?

All information that is collected from you during the course of the study will be treated in the strictest confidence at all times, and will only be used for this research. No names or identifying information will be printed which could tie you to the recordings. The only exception to this would be if at any point you tell the researcher you plan to harm yourself or harm others, or if you disclosed non-consensual sexual behaviour, or sex with a minor (child). In these instances the researcher would have to report it to his supervisor, who may have to inform the legal authorities.

If you join the study, other researchers at the Universities of Lincoln and/or Nottingham will look at some parts of the interviews to check that the study is being carried out correctly. At this stage personal information would be removed. These people will also be required to keep the information confidential.

Can I leave the study after I have started?

Participating in this study is totally your choice. You may pull out from the study at any time without giving a reason. If you withdraw from the study we will destroy all of your identifiable information. If following the interview you wish for your interview to be destroyed, the researcher will ask you to do so before a

specific date. This date will be made clear to you at the interview, along with the procedure for making this request. This will typically be two weeks after the interview has taken place. We will not be able to remove your interview data from the study after this date has passed.

Are there any benefits?

Although you are unlikely to benefit directly from the study, by taking part you will be helping towards improving knowledge about sexual behaviour and addiction. Time and location of the interview will try to fit around you as best as possible. Your involvement in the study will not affect your medical records or the quality of healthcare you receive in any way.

How will the results of the study be used?

The results of the study will hopefully help to improve our knowledge of sexual behaviour. Results could be presented to healthcare professionals, or published in academic or clinical journals. No information that links you personally to the study will be published.

What if something goes wrong?

There are no special compensation arrangements for this research project. If you are harmed through someone else's action, then you may have grounds for legal action, but may have to pay for it. If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this interview, you can complain to the research team and you can also complain to the researcher.

If you still have concerns about this research, please contact the Chair of the appropriate Ethics Committee:

Dr Patrick Bourke,
Chair of the Ethics Committee of the School of Psychology
Brayford Pool
Lincoln LN6 7TS
Telephone: 01522 886140
Email: pbourke@lincoln.ac.uk

I would like to thank you for reading this information sheet and for considering taking part in the study.

James Briggs

Appendix B: CONSENT FORM

Participant Checklist and Consent Form

Thank you very much for taking part in the study. This point of this form is to make sure that that you understand what is involved, and sign that you consent to take part.

Please circle YES or NO.

Have you been able to ask questions and talk about the study?	YES/NO
If you have asked questions have you had fair answers?	YES/NO/NA
Do you understand that you are free to end the study at any time?	YES/NO
Do you understand that you don't have to answer a question and don't have to give a reason why?	YES/NO
Do you agree to your answers being recorded?	YES/NO
Do you agree to the results of the research being published? (N.B. You will not be able to be linked to any published information)	YES/NO
Do you understand that the researcher has to tell someone if you share any intention to commit self-harm, harm someone else or discuss any illegal or non-consensual sexual behaviour? (please ask if you are unsure about this).	YES/NO
Do you give your informed consent to take part in the research?	YES/NO

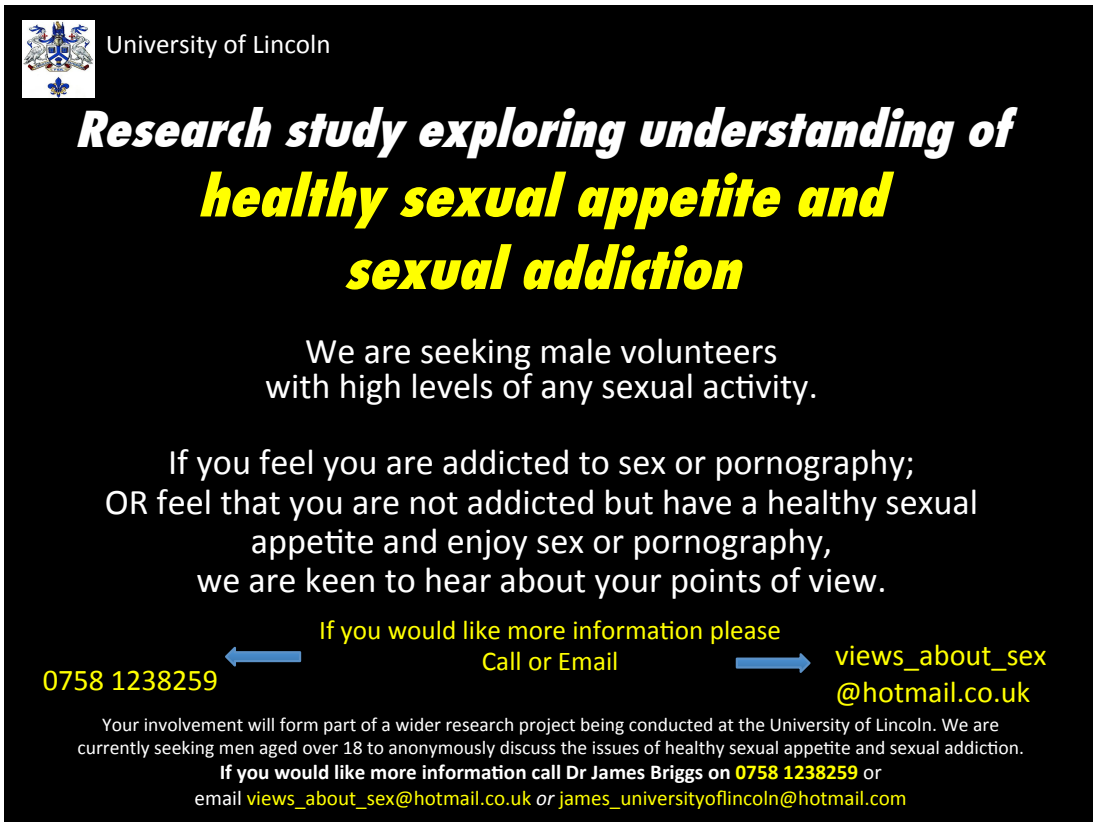
Signed _____ Date _____

Name in Block Letters _____

Signed _____

Researcher Name _____

Appendix C: RECRUITMENT POSTER



Twitter Account: @views_about_sex

Appendix D: INTERVIEW SCHEDULE

Participants will be invited to discuss their story as freely as possible, with minimum intervention from the interviewer. This is in order to provide highly contextualised accounts. Following the methodology of Benford & Gough (2006), the interview schedule will avoid 'why' questions, given that they tend to be answered with abstract, rationalised answers unconnected to experience. Also, as far as possible, moralistic or medical terminology was avoided, to minimise prompting these discourses. Prompts (e.g. could you say more?) and minimal encouragement (e.g. mmhmm, nodding) will be used during interviews, in order to supplement the questions outlined below.

For those who identify as sex addicts:

- Description of sexual behaviour:
    - How often do you think about sex?
    - How often do you have sex/masturbate/look at pornography?
- What, in your opinion, defines sex addiction?
- What is it about your current behaviour that you feel defines you as a sex addict?
- Can you compare sex addiction to anything else?
- Can you recall where you first heard of sex addiction?
- How does this differ to normal sexual behaviour?
- What, if any, support or intervention do you feel would be most helpful to you?
- How do you think sex addicts generally can best be helped?
- Have you ever sought help before?
- Do you have any concerns about your sexual behaviour?

For those who identify as having a healthy sexual appetite (non-addicts):

- Description of sexual behaviour:
    - How often do you think about sex?
    - How often do you have sex/masturbate/look at pornography?
- What, in your opinion, defines sex addiction?
- Have you previously heard of sex addiction?
- Do you agree with the term?
    - If so how does this differ to normal sexual behaviour?
    - If not, could you provide more detail?
- Do you feel there is any value in intervening, either psychologically or otherwise, with people who believe they are addicted to sex?
- Have you ever sought help before?
- Do you have any concerns about your sexual behaviour?

Appendix E: ETHICAL APPROVAL

UNIVERSITY OF
LINCOLN

21-11-2012

Dear James Briggs,

The Ethics Committee of the School of Psychology would like to inform you that your proposal 'A Foucauldian Discourse Analyses exploring expert and individual accounts of sex addiction.'

was:

☒ **approved**

☐ **approved subject to the following conditions:**

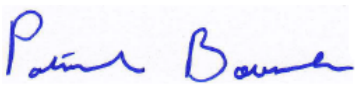
☐ **invited for resubmission, taking into account the following issues:**

☐ **is rejected. An appeal can be made to the Faculty Ethics Committee against this decision (cawalker@lincoln.ac.uk).**

☐ **is referred to the Faculty Ethics Committee. You will automatically be contacted by the chair of the Faculty Ethics Committee about further procedures.**

Could you address each of the issues raised by changing all relevant documentation, and by formulating a reply to each of the numbered issues in a separate document or e-mail? I may be able to approve after your reply by chair's action; if I have any doubts I will need to refer your application back to the School's Ethics Committee.

Yours sincerely,



Patrick Bourke, PhD

Chair of the Ethics Committee
School of Psychology
University of Lincoln
Brayford Campus
Lincoln LN6 7TS
United Kingdom
telephone: +44 (0)1522 886140

Appendix F: TRANSCRIPTION CONFIDENTIALITY STATEMENT

Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of _____ (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and _____ with principal offices at _____, (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by _____ which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of

_____

Signed: ..... Title: .....

Signed for and on behalf of the University of Lincoln Signed: .....

Title: ....

Name: .....

Date: ..... Version 1, August 2011

Appendix G: EXAMPLE TRANSCRIPT

Extract from Jake's Interview; lines 62-90

A: I would say I was masturbating differently because I was, in school I worked very hard so I was stressed a lot, and I was using it to deal with that. So that was my kind of outlet. I didn't drink when I was a teenager but I, you know, I can see now I was using masturbation as my way of controlling how I was feeling, rather than anything else. And I suspect other people don't use it like that.

I mean at that stage I wouldn't say, it wasn't, at that point it wasn't compulsive. So that's why I really don't, I don't count my real addiction as including that period because it was often, it probably wasn't more often than other people. But it was more how I was using it, that was the thing that I didn't see a problem with because that kind of, I had that way of dealing with emotional stress and, therefore, I just kept using that all my life, that was the problem. But at that point I wouldn't say it was effecting my normal life, in the sense it wasn't taking up large chunks of time, I wasn't having to lie about it or anything like that.

Q: So did that progress into, when did that progress?

A: So it was when I was, when I was an undergraduate, that was the early Nineties and the Internet was just appearing at Universities. So at that stage, there weren't really any images but I did, from time to time I would kind of get obsessed with reading erotic stories on the Internet. And then that progressed to, when I was doing a PhD, that progressed to using porn regularly. So kind of probably four or five nights a week, going back to work and, you know, spending hours on the internet looking at porn.

And then, after I got married it became more episodic, just, I would definitely say, so in the late Nineties, as I say, when I was doing my PhD, I had about two years, which were definitely compulsive, it was a compulsive issue then because it was starting to affect my work because I'd be staying up late looking at porn. During the next, the kind of the first eight years of, or ten years of being married, it was, as I say, every so