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Is Sex Addiction an Addiction?

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Introduction

In the past decade or so there has been a development for the addiction paradigm to be applied to sexual behaviors. An increasing number of people are reporting excessive thoughts or behavior that is sexual in nature, and that they claim causes them suffering. They attribute this suffering as sex "addiction" [1]. Diagnosing sex addictions implicate narratives of a compulsive obsession with behaviors of a sexual nature. It also needs to obstruct everyday living [2].

These classifications seem to integrate problematic sexual behavior to diagnostic classifications. Some patterns of diagnostic classifications include dependence on drugs, or "OCD" (Obsessive-Compulsive Disorder), and abandon timeworn public conceptualizations of "nymphomaniac", "oversexed", "horny", and other such classifications. Mirroring this increasing clinical concentration, there has been an increasing quantity of clinical and research work affirming the necessity to incorporate "hypersexuality" as a diagnostic category [3]. Including this category in formal diagnostic manuals like the DSM-5 [4]. Nevertheless, addiction is a complex concept.

The complexity of addiction lies in the model of sexual addiction holding different descriptions and understandings [5]. Some clinical and academic communities have even doubted whether sex addiction is a rightful clinical entity. The doubt is based on the question if sex addiction merits a "diagnosis". The alternative is if sex addiction is a denouncing label for those who differ from a hegemonic sexual standard [6].

Dr. Patrick Carnes is a respected mental health specialist, who was the first person to circumscribe sex addiction and its undercurrents. This was based on a culmination of his own clinical work and experiences [7]. Carnes explained the addict's sexual behavior in a way not previously described. He posited that their behavior is qualitatively different from the norm, and not at the extreme of the normal range, as previously thought. Their behavior incorporates a pathological relationship to sex including symptomology comparable to alcoholism and that of substance dependence [3,7].

Consider his example that sexual addiction is discernable by advancement from sexual practices that are within the confines of the law, to illegal practices. Such behaviors cascade toward extreme and unsafe sexual activity, ending in sexual offending [8]. Portrayed this way, advancement of sex addiction is not just sexual nonconformity. Sex addiction can advance to dangerous, forcible and criminal behavior. This suggests that recognition and intervention with sexual addicts turn out to be a scientific, social and moral problem.

Under this light of data and understanding, the budding medicalization of sex addiction makes sense, as does the increasing amount of specialized screening tests to detect and diagnose sex-addicts. The identification and diagnosis of sex addiction, using these measures, are founded upon diagnostic measures established by Carnes' and colleagues, involving the Sexual Addiction Screening Test (SAST) [7].

Conversely, research proving efficacy of sex addiction intervention is limited and mostly based on anecdotal accounts. Reports supporting the evidence base and scientific consistency of sex addiction are nonetheless common. For example, asserts the proportion of sex-addicts to be nearly 3:1 men to women, notwithstanding a dearth of large-scale epidemiological studies [7]. These examples of difference between obtainable evidence and the frequency of scientific discussion underscore how the influence of the professional can function to concretize the concept.

Undeniably, some contend that the innovation of sex addiction as a verdict is constructed less on the "rigor of the arguments put forward by the clinicians and scientists than to the authority inherent to their social status" [8]. This expert authority is frequently expended to enable the addict to overcome supposed denial and acknowledge their addiction [9]. Addiction (especially behavioral addiction) is a nonconcrete notion, because it is socially demarcated. What this means is that views and therefore definitions can logically differ. As such, it cannot be assumed that one explanation is unequivocally correct [10].

The narrow agreement in academic and clinical literature, and broader nonprofessional discussion, interprets in the diversity of discussions utilized by different, various addict populations to validate or rebuff addiction constructions [11]. Likewise, it remains doubtful what the limits of normalcy are vis-à-vis sexual behavior, and specifically where and whom these limits have developed from. There is a continued need to prove how the collective structure of sex within addiction dialogue might function to help the sex addict.

The totality of discussions used to sanction or reject addiction constructions is probably augmented in sex addiction assumed the abovementioned debate contiguous to the validity of the diagnosis, and its historical spot in the "diagnostic wastebasket" of sexual disorders not otherwise specified [12]. The substance and role of these dialogues necessitate explanation, mostly because of their power in being able to enable or disempower persons who consent or reject the addict positioning. The debate and complication of addiction discussions in relation to sexual behavior, in both professional and lay interpretations, renders it valuable to investigate how sexual behavior can be

established as addictive or not. "Sex-addicts" can self-diagnose or obtain this diagnosis by a professional third party. "Non-sex-addicts" might possibly meet conditions to be formally classified as dependent on sex by existing diagnostic criteria.

However, they were considered non-sex-addicts founded on their self-identification. Thus, those who classify themselves as sex-addicts and those who do not identify their behavior with this diagnosis, might disclose enacting very similar sexual behaviors, fantasies and urges. However, they may categorize as unalike subject positions. It is valuable to consider and capture the cultural, situational and value factors critical in these constructions [13]. Individuals who identified as addicts utilized discussions of both struggle and an advanced loss of control over sexual behavior. This was an aligned position as comparable with other established addictions.

Two important factors were used to construct loss of control as problematic: desirability of control and self-restraint [14]. A related broad theme of "good" vs. "bad" sex formed the conduct of the sex addict as aberration from a sexual norm. In general, addicts' formations of bad sexual behavior included impressions of danger; capable of engendering in the sex addict fear, shame and guilt. This fostered their seclusion and secrecy, assumed a predictable judgment from an unaccepting society [15].

The experience of losing control was frequently portrayed through a personal narrative. Addicts summarized occurrences of intrapsychic or social struggle and concern [16]. A lot of addicts engaged discourses of illness to classify their conduct from an aspirational self. This was in order to cope with their conflicting "bad" sexual behavior and broader moral stimulus toward "good" sexual conduct. This purpose is to shield the ethical status of the addict, in addition to creating a shared positioning of the expert on this subject, allowing for identification and intervention of the addicts' sexual behavior. There are three central interrelating broad themes or topics: a loss of control; good vs. bad sex and the cultural imperative to intervene in sex addiction [17]. In highlighting the loss of control experience, it is a significant connection in separating those of addict and non-addict. This significant separation exemplifies likenesses between and inconsistencies within these positions of addict and non-addict [15].

A Loss of Control

A central apparent theme in addict accounts was a self-reported failure to control choice. Those who classified as addicts seemed to differentiate self-governed behavior and addictive behavior to be mutually exclusive. If there was a self-reported inability to self-govern behavior it was a construct indicative of addiction. If sex, or certain behaviors, are not optional for a person, if a person is controlled by the behavior, or cannot say no when no is appropriate, the person definitely has a problem.

What constructs this as a disorder, or problem, is this loss of control and options. Alistair uses a stratagem of a three-part list [18]. The three parts include option, control and ability. The "taking over" of libido permits agency to this apparently inner state. The impulse toward sexual behavior and advanced loss of control produces a dynamic discrepancy. This dynamic discrepancy places addicts as powerless to control the acceleration of their problematic sexual behavior. This is notwithstanding the discourse of health and moral value in self-restraint [15].

The Progressive Nature of Addiction

Addicts' report of escalation corresponds to substance dependence discourses of tolerance. For example, necessitating an evidently increased quantity of substance to attain a desired effect [19]. According to their research, interviewees explained an increasing risk and deviance ("bad" sex), instead of the amount of sex. This allowed for their sexual behavior to continue to accelerate. Discourses of tolerance to increasingly "bad" sex seem to be entwined with confessions of sex addicts seemingly open and honest in their account notwithstanding the morally charged positioning [20]. Discourse usually includes minimization ("probably", "kind of") and a passive interpretation ("over time") to show the absence of conscious blameworthiness the addict had in this behavior.

Most addicts described "end points" of this progressive increase of sexual behavior. This includes the degree to which other standard responsibilities and interests are subordinated or injured by sexual behavior [21]. Such dangerous case formulation adds realness to the damage that addiction can propagate [22]. Several different social positions seem to be utilized in creating a gap between addicts and non-addicts. Social positions and institutions, like religion, were referenced to establish and keep this distance. There are addicts that will delineate a divergence concerning their behavior and societal religiousness to be a block to talk about sex.

A "salience" discourse, grounded on incorrect prioritization of sex, was used to summarize the person's identity as addicted [14]. Sex addiction as a construct, distinguishable through objective consequences, encompasses the type of sex, instead of on purely personal experience. The highlight was on the addict as not being responsible or accountable for their preceding sexual behavior, or the results of this behavior. Examples of such consequences include problems with the law, relationship breakdown, or health problems.

Science of Addiction

A lot of addicts mention the controversy and skepticism previously talked about involving the diagnosis of sexual addiction to create their explanations as socio-culturally informed. This was characteristically contrasting to make this disorder authentic. Comparing themselves to alcoholics and drug addicts was one of the clearest discursive strategies used by sex-addicts to join the positioning of "addict". A lot of people addicted to sex state that they are vulnerable to established addictions. Some sex addicts find this identification to prove uneasy, but others feel security in this identification. This is because the security that sex addiction offers lies in the use of medicalized and conventional discourses of addiction as a method of protection to avoid personal blame for their behavior [20]. The addiction medicalized construction of personal experience and social phenomena bears moral responsibility.

The addict was characteristically constructed as a sufferer of a genetic predisposition, or patient and therefore should not be held accountable for inhibiting or "bringing on" sexual addiction [23]. In this regard the description "addict" is also utilized to create a structure around their sense of losing control. Some addicts positioned themselves as ordained to be "addicts", or in some form, lose control. The language some addicts use, for example, is accepting powerlessness over certain behaviors. This seems to be a significant conversation of the recovering addict positioning. This corresponds to the language often utilized in the 12-step therapy model.

The use of the serenity prayer: "God grant me the serenity to accept things I cannot change", is a great example of how the addict position seems to disprove discourses around plausible healthy habit of "bottom-line" sexual behaviors. For example, "appropriate" or "sufficient" use of pornography. In its place the addict is morally determined to practice the compulsory self-surveillance to sidestep these behaviors totally. In addition to avoiding these behaviors totally, the moral determination is to lessen stress, cohesive with the second verse of the prayer encouraging "courage to change the things [addicts] can". Experiencing and controlling responsibility via the position as a recovering sex addict seems to be a complicated process of moral renewal ("courage").

Other issues of stake and ability include that they must accept culpability for their powerlessness to manage certain behaviors. While doing this, they must also accept accountability for other behaviors via self-surveillance, or other surveillance. Non-addicts also acknowledged a requirement for practiced self-reflection of sexual behavior [15].

Conclusion

This research paper endeavored to bestow a loss of control as a broad construction formulated by sex addicts. In addition, are the implication on subsequent available positioning's and self-reported subjective experiences of self-identified sex addicts. Clear moral connotations to this loss of control, are also sustained by socio-political and ideological discourses. These were constructed predominantly by means of psychological and biomedical discussions of illness, vulnerability and stress [24]. Collectively, these discourses put numerous sex-addicts as unaccountable in both the progression and etiology of their addiction. This is comparable to the docile patient discourses shared in medical illness [25].

Addicts exerted great effort to make their addiction as a valid disease. This qualified them to adopt a sick role with some benefits. Examples of these benefits include association with biomedical and health institutions. This is used to understand a loss of control and receive access to a communal "addict" identity. This incorporates the "currency" of the addiction discussion [11,23].

Conversely, there was irregularity in sex addict's constructions of sex addiction. Also, there is a gradation to which sex addiction was similar or different to other compulsions. Both addicts and non-addicts, referred to sex as an outlet for stress, or referenced neurobiology as a footing of inherent sexual behavior. Both people in these categories of addicts and non-addicts refer to sex as potentially being "bad". They also framed their control of sexual desire as defective. Conversely, non-addicts did not view this as morally problematic. In addition, non-sex addicts did not view their sexual desire as symptomatic of addiction [15].

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