

**UNDERSTANDING THE FEMALE CONCEPTUALIZATION OF SEXUAL
ADDICTION AND THE ROLE OF ADDICTION TREATMENT**

by

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ABSTRACT

Beginning with the diagnosis of nymphomania in the 19th Century, there has been widespread and continued interest across the mental health and bio-medical realm of what constitutes normality of female sexual behavior, and of the boundary at which sexual desire is deemed to be excessive, and thus abnormal. However, research questions that specifically investigate the subjective female voice and perspective in considerations of so-called hypersexuality or sex addiction remain understudied. This research project proposes to examine the cultural pathways and systemic foundations which have historically in the West problematized female sexuality by investigating women's own perceptions of sexual addiction and their experiences in seeking (or not) addiction treatment. In addition, this research project proposes to investigate the perceptions of therapists (psychologists and psychiatrists) who treat hypersexual female patients, in order to examine their beliefs about the cultural and biological genesis of the disorder, and its appearance in female patients. Theoretically, this project aims to move away from the concept of individualized bodies suffering singularly from (dis)ease and "abnormality," and investigate the ways in which Western cultural notions of "normal" female sexuality shape women's self-perceptions and notions about sexual "deviance."

To K.I.R

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TABLE OF CONTENTS

LIST OF FIGURES	x
INTRODUCTION	1
The Cultural Construction of Sexuality.....	1
Investigating the Topic of Female Sexual Addiction.....	7
Preparing for the Research Process	10
The Evolving Research Design	12
BACKGROUND AND LITERATURE REVIEW: FEMALE SEXUALITY, PATHOLOGY, AND THE RISE OF SEXUAL ADDICTION	14
The Problematic Female Body	14
Defining Sexuality.....	16
The Western Relationship between Commodity and Being	18
Women and Sexuality: The Tumultuous Relationship Throughout History.....	20
What is Sexual Addiction?	23
Medical Intervention	27
METHODOLOGY	33
Research Design and Methods	33
Interview Methods.....	34
Research Setting	35

Recruitment and Inclusion Criteria	36
Recruitment Methods	37
Sampling.....	38
Data Collection and Management	39
Data Analysis	40
Data Limitations	41
Outline of Chapters	42
CHAPTER ONE: CONCEPTUALIZING NORMALITY: WHEN PERSONAL MEANING-MAKING MEETS THE BELIEFS OF OTHERS IN DEFINING THE BOUNDARIES OF APPROPRIATE SEXUAL BEHAVIOR AND HYPERSEXUALITY.....	44
Personal Meaning-Making in Definitions of Normality	44
The Malleability of Social Norms	46
The Role of a “Community” in Shaping Beliefs about Normality.....	53
The Role of "Others" In Defining the Boundaries of Acceptable Sexual Behavior .	58
Religious Beliefs about Appropriate Sexuality	59
Media Messages and Beliefs about “Appropriate” Sexuality	62
Family and Beliefs about Appropriate Sexuality	64
The Role of Caregivers in Fostering Beliefs of Sexual Normality.....	66

Friends and Partners and Beliefs about Appropriate Sexuality	69
Discussion: So What <i>Is</i> normal?	73
CHAPTER TWO: RECONSTRUCTING GENDER ROLES: THE INTERPLAY BETWEEN CULTURAL DISCOURSES AND FEMALE CONCEPTUALIZATIONS OF SEXUAL ADDICTION AND APPROPRIATE SEXUAL BEHAVIOR	
	76
Sexually Addicted or Hypersexual?	80
Unrealistic Cultural Constructions of Sexuality.....	85
Masking Transgressive Behaviors: The Feminine Manipulation and Reinforcing of Heteronormativity	93
Discussion: Confronting Heteronormativity	102
CHAPTER THREE: THERAPIST AND FEMALE VIEWS ON SEXUAL ADDICTION, TREATMENT SEEKING, AND THE ROLE OF ADDICTION TREATMENT	
	104
Therapist Conceptualizations of Sexual Addiction	105
Cultural Misperceptions about Sexual Addiction and Treatment	111
Female Beliefs about Treatment Seeking.....	120
Female Views on the Benefits of Treatment	127
The Differing Views of Women and Therapist's on Sexual Addiction and	129
The Role of Addiction Treatment	129
Therapists Narratives on the DSM and Treatment Seeking	132

Discussion: The Role of Addiction Treatment.....	134
CONCLUSION.....	138
Applying this Study in a Broader Academic Context	141
Suggestions for Future Research.....	145
APPENDIX A: IRB APPROVAL LETTER	148
APPENDIX B: INTERVIEW GUIDES	150
Questions for Semi-Structured Interview with Female Sexual Addicts:	151
Questions for Semi-Structured Interview with Therapists:	152
REFERENCES:	153

LIST OF FIGURES

Figure 1 Theoretical Framework	2
Figure 2 The Interplay Between Cultural and Medical Discourses and Individual Behavior.....	77
Figure 3 Opposing Viewpoints of Women and Therapists.....	129

INTRODUCTION

"When we examine the construction of sexuality starting with structures visible on the body's exterior surface and ending with behaviors and motivations-that is with activities and forces which are patently invisible-inferred only from their outcome, but presumed to be located deep within the body's interior, we find that behaviors are generally social activities, expressed in interaction with distinctly separate objects and beings."

Anne Fausto-Sterling, "*Sexing the Body*"

The Cultural Construction of Sexuality

This study explores how and why it is that a woman¹ comes to see her sexuality as something different from a cultural norm, and whether or not this view leads a woman to seek medical intervention. Keeping in mind, that cultural activities rarely represent natural universals, the research conducted for this study is founded in the epistemological belief of reality as a cultural construction. Rather than view life and its emanations as static and inevitable, in keeping with the tradition of some anthropological scholarship in the past, I conceptualize of human behavior, the production of knowledge, and modes of belief, as the product of intertwined cultural and biological influences. The theoretical cycle below depicts the various philosophical paradigms that I engaged with as I sought to create a

¹ While I seemingly use the term "woman or women" monolithically throughout this paper, I am by no means suggesting that these terms can or will in fact pertain to all "women." Indeed, much of the present medical history that exists about female sexuality has been based largely on the study of women who had enough money and status to access health care professionals, or later on those who were initially willing to participate in studies (such as the sex worker populations used in Masters and Johnsons clinical trials in the 1960's. (Masters & Johnson 1966)

holistic understanding of female sexual addiction in the West². Presenting them in a circular fashion highlights that interaction between these categories is fluid and that each can be affected by and affect the other.

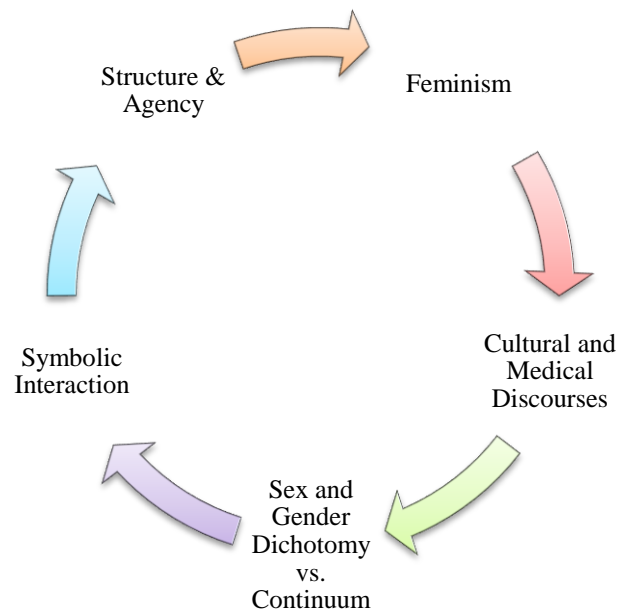


Figure 1 Theoretical Framework

Each point on the cycle represents one of the core epistemologies I believe provides a meaningful lens through which to examine the construction of sexuality in the West. Starting with the broad term of feminism, I have based my work on three principles which reflect a few of the goals of modern feminist scholarship. These include avoiding the structural victimization of women by instead framing women as active participants and agents in cultural meaning-making (Damousi 2004), rejecting the view that the term

² For the purpose of this research, I take “West” and “Western” to be related terms which speak less about geography and more about ideology. These terms should be read as referring to late capitalist/post industrialist societies.

“woman” equates to a monolithic view of femininity (Stansell 2004), and providing academic research which seeks to include the perspectives and voices of women as salient to any attempt to gain knowledge about women (McNamara 2009).

Moving to the next location on the cycle, I engage with the concept of cultural and medical “discourses.” Focusing on the work of Foucault, I examine the ways in which a person’s words may conflict with his or her actions. Throughout this thesis I engage Foucault by troubling instances of discourse brought in by both sets of research participants and by exposing the ways in which lived experiences are not always reflected in popular parlance.

Third, I attend to the biologically deterministic idea of a sex/gender dichotomy which states that men and women are different because of their innate biology and that, because of those biological differences men and women enjoy certain activities. I borrow here from work done by feminist and anthropological scholars whose work has exposed the fallacy behind such essentialized visions of sexuality (Kulick 1998, Goldstein 2003, Taylor & Rupp 2004). For example, in her philosophical work, *Gender Trouble*, feminist scholar, Judith Butler (1990), highlights the performativity of gender. Butler (1990) shows that because people are able to “trouble” gender identity and effectively disrupt the notion that only certain bodies can and should act in certain ways, we must be able to rethink gender as something more akin to a social construction and not a natural universal. In conjunction with the idea of gender performativity, I use the work of feminist and gender scholar, Anne Fausto Sterling (1993), who argues that sexuality ought to be viewed on a continuum. In this view, a person is able to act out his or her

sexuality in myriad ways according to personal desires, attractions, and biologies without effectively essentializing and delimiting any one expression as correct, natural, or acceptable.

The next theory I incorporate into my work is that of symbolic interactionism. I lean heavily upon the work of two sociologists, Viktor Gecas and Roger Libby who pioneered the concept of sexual scripts in the late 1960's. I underscore throughout this thesis the power that information exchange between persons, and individual interaction with various cultural ideologies holds over the ways people think about their own sexuality and the sexuality of others. However, the concept of symbolic interaction also posits that there are innumerable variations in the ways in which a person will experience encounters with others and with various ideologies. Ultimately, these variations in perceptions or interpretations lead to a wide range of ways in which those moments will be reflected in individual thought and behavior.

Finally, the category of structure and agency is evoked throughout this thesis. At times, it is discussed explicitly and at other times it is an implicit part of the theories that I incorporate and have outlined above. I challenge the notion of arranging structure and agency as diametrically opposed and instead seek to investigate the ways that people live within structured realities and, at the same time, use their agentic capabilities in negotiating new meanings within and outside of seemingly hegemonic social constructions.

In his classic work *The Methods of Ethnology*, Franz Boas (2001:125) writes:

The history of human civilization does not appear to us as determined entirely by psychological necessity that leads to a uniform evolution the world over. We rather see that each cultural group has its own unique history, dependent partly upon the peculiar inner development of the social group, and partly upon the foreign influences to which it has been subjected.

Through my research, then, I sought to make a contribution to the growing body of literature on sexual addiction, using the long-established anthropological lens which calls for ethnographers to view a culture in its own context, and which sees culture as flexible and changing. In addition, borrowing from William W. Dressler (2001:3), a medical anthropologist concerned with broadening the scope of anthropological undertakings, I find it salient to recognize that "at a basic level, it is the inclusion of the human body in our subject matter that forces us to take seriously th[e] relationship between structure and construction, because the disjunction between what happens to the body and how those happenings are culturally constructed is often too readily apparent."

While it would be a mistake to refute that our biology plays a part in human behavior and organization, or that scientists are able to uncover natural universals, there are compelling data that demonstrate the decisive nature of culturally specific constructions of behaviors and its meanings. Cultural influences also play a major role in shaping what are considered medical conditions. All too often, data about medical maladies is presented to us in a way that obscures the role of cultural assumptions, judgments and misconceptions in creating the disorder in the first place.

Philosopher Michel Foucault, in his writings on the insertion of medicine in sexual matters, best conveys this concept in *The History of Sexuality*, (1978:67):

The sexual domain... appeared as an extremely unstable pathological field: a surface of repercussion for other ailments, but also the focus of a specific nosography, that of instincts, tendencies, images, pleasure and conduct... sex would derive its meaning and its necessity from medical interventions: it would be required by the doctor, necessary for diagnosis...

Thus, this research sought to investigate how, in the West, an individual's subjective epistemologies interact with cultural and medical conceptualizations of the body in the production of “hypersexuality” as a self-identifying concept. Furthermore, I was interested in investigating the ways in which human beings situate their bodies and behaviors in relation to those of others, and to those structures, which form the basis of group interactions.

As a guiding principle, I sought to organize data collection in a way that not only accounted for the manner in which certain women understood their bodies, but also examined how medical structures might shape and inform the ways in which those individual conceptualizations may be expressed or concealed. It was important for me to find a culturally relevant site through which to expose the ways in which relationships of power, cultural meaning-making, and ideas about valid and invalid formulations of individual personhood interact to produce what seem to be intrinsic and inevitable paradigms for identity formation. This site is sexuality. Despite the fact that sex and gender are often popularly constructed as limited domains for individual expression, as

conventional gender roles dictate that men are expected to act one way and women another, in actuality, the range of sexual behaviors and beliefs are in fact far more numerous than a dichotomous gender and sexuality framework allows. Again Michel Foucault (1978:105) spoke to this issue when he stated: "There is no single, all-encompassing strategy, valid for all of society and uniformly bearing on all the manifestations of sex (Foucault 1978:105)."

Undoubtedly, there are innumerable ways in which sexuality and gender are experienced. Furthermore, as evidenced by the attention given to the topic by almost every academic field, sexuality is central to human constructions of reality. Anthropologists have long recognized sexuality as a key element to understanding broader bases for social organization as well as individual subjectivities that ontologically order the world.

Investigating the Topic of Female Sexual Addiction

I stumbled upon the topic of sexual addiction while researching issues of sexual dysfunction for a project I was considering in a Medical Anthropology course. As I searched, an article about sexual addiction would pop up from time to time, or an author would mention the term in passing. Intrigued, I began to focus my inquiry, and soon realized that though there is a plethora of information available about the topic of sexual dysfunction (on both men and women), much less is known about sexual addiction. The existing literature about female sexual addiction specifically is narrow (for example, Ferree 2001, Roller 2004), whereas a much wider body of works focusing on male sexual

addiction exists (for example, Bostwick & Bucci 2008, Reid et al 2009, Giugliano 2008, Levert 2007, Salisbury 2008).

I soon came to realize that a few things were at work in this apparent gap in the literature. First, female sexual addiction is more commonly referred to as “love addiction,” and is often seen as co-morbid with other disorders (which may take precedence), or may be reduced to “co-dependence” (Briken et al. 2007, Ferree 2001, Roller 2004). As my interest piqued, I set about searching for academic literature that provided narratives from female sexual addicts and provided a map of a woman's journey from normal and healthy to sexually deviant and in need of treatment. However, research like this is extremely rare, and I could find only one study that spoke of "highly sexual women" (Blumberg 2003) through women's own voices.

This study was extremely helpful in helping me to understand how women feel about the perception of their sexuality as something at odds with normality. Indeed, many of the trends revealed in Blumberg's (2003) research were paralleled in the narratives women provided to me in my study. These included women's belief that their sexuality was not something to be ashamed of, despite their constant struggle with feelings of difference; that friends and partners were often a source of negative judgment; that women who desire frequent sex or feel highly sexual are afraid of being labeled as "sluts," and that women will often hide their sexual behaviors from others in order to avoid stigma. However, what was missing from this study, and what I attempted to provide through my own research, was an in depth discussion of the sociocultural and subjective forces at work behind a woman's decision to pathologize her behavior.

Blumberg (2003:153) did discuss the term sexual addiction, but only to assert his opinion that he did not feel that the women he had interviewed did not seem to meet the diagnostic criteria required to label them sexual addicts. As his research was singularly focused on the voices of women there was no discussion of how the diagnosis is accessed by therapists and therapist beliefs about the disorder, or about women's views on treatment.

Most importantly, this was only one study, and I soon realized that while much of the literature sought to legitimize and uncover female sexual addiction as a diagnosis, only the above study attempted to pursue female narratives as a primary source of knowledge. Furthermore, most literature that does attempt to include female populations in discussing sexual addiction is either theory driven, or speaks generally about the evolution of treatment paradigms (Carnes et al. 2010, Kasl 2002).

Anthropologists have largely overlooked the topic. Though much anthropological research has been done on addiction in relation to substance abuse, and related to sexuality and culture in general, little knowledge exists about the topic of female sexual addiction. Given the importance that anthropology places upon providing a space for understudied and marginalized populations, I found it apt to begin my examination of female sexual addiction from the anthropological belief that there is no better way to understand something than to speak directly to the people whose lives the issue encompasses. In addition, it is crucial to be able to broaden the literature on a topic which reveals that ultimately there is no monolithic version of female sexuality.

Preparing for the Research Process

The topic of sexual addiction is a sensitive one, and so I had to make sure that I not only accounted for this sensitivity in my research design, but that I familiarized myself as much as possible with extant literature on all sides of the issue. I began this process by conducting an in-depth literature review so that I would be comfortable talking about the various dimensions of addiction in general. Subsequently, I engaged with the world of sexual addiction by joining a website which deals with sexual health, and provides a community based forum where members can interact with each other as well as with medical doctors. I made clear to the members that I was an anthropology student who was there merely to understand more about the community rather than to collect information, and that I would be a passive member of the website.

I soon came to learn that "12-stepping," the process of completing a series of 12 steps on one's way to alcohol or drug sobriety, a method first utilized by the organization Alcoholics Anonymous (AA), is an integral experience for patients who seek psychological treatment for sexual addiction. Early in my research I had the opportunity to attend an open meeting of AA; this experience helped me to better understand the 12-step process and its underlying reasoning. Though AA is geared mainly towards substance abusers, 12-step programs developed for sexual addicts are modeled directly after the AA format. Though I did not take notes or collect data, this experience offered me a chance to observe how group meetings are organized, what information is given to group members, and how members discuss their addiction. My access to this meeting was facilitated by two friends who are AA members and who graciously invited me to

attend along with them and because the organization allows attendance of non-addicts at open meetings.

While I would have liked to visit a meeting of Sex Addicts Anonymous, or Sex & Love Addicts Anonymous (both are on-going groups in Central Florida areas), 12-step meetings have been designed to be spaces for confidentiality and security, and as I am keenly aware of people's need for privacy and stability, especially in areas of medical health, I felt it best not to attend a meeting where my presence as an anthropologist could potentially disturb any treatment seeker. Additionally and as noted by many of the therapists I have interviewed, Orlando has very few meetings of groups such as these. While through the Internet, I did find two groups meeting in the Central Florida area, I was told that both were comprised solely of men. So given limited access, I did not pursue this avenue for long.

Later, during my data collection, I was invited to attend a support group run by one of the therapists who had granted me an interview. The group mainly functioned as a support group for the female spouses of male sexual addicts. However, the two therapists who ran the group mentioned that a few women present also struggled with sexual addiction. Being at this meeting not only provided me with a wonderful opportunity to see how 12-step groups that tackle issues with sex are managed. My attendance also confirmed the highly sensitive nature of this topic—many of the women in the room were uncomfortable with my presence until the lead therapist explained why I was there and allowed me to briefly share my research goals with the group. I clarified that I had no

intentions of taking notes or recording names and emphasized that I was merely there to learn. After that, my status as an anthropologist seemed to be ignored.

While I will not be presenting any data from any of those meetings, per IRB and my own research protocol, those experiences helped me to feel more fully engaged in my own research experience. I was able to see therapists at work, and to watch how they apply their beliefs about therapy and sexual addiction in real situations. Additionally, hearing the various stories of women and substance abusers helped solidify for me the idea that my own research was on the right track. How can anyone feel as if they truly know a topic, unless they have heard from the voices of those whose lives ultimately give it meaning?

The Evolving Research Design

Originally, I had intended to speak only with women who identify as sexually addicted. My idea was to speak with 15 women from the college campus setting, and 15 women who were currently in treatment for sexual addiction. However, as I began fine-tuning the study design, I realized that accessing the population of women in treatment would be quite difficult and that it would require the assistance of local therapists. During preparation, I reached out to a local therapist in order to get his feedback. As a practicing therapist, he made some salient points leading me to believe that many clinicians might be resistant to the idea of assisting me with participant recruitment that called on them to supply patient referrals for the study.

First, he noted that many people work with high-profile patients who may have felt nervous about the idea of an anthropologist/researcher invading the private world of therapy. Second, he reminded me that therapists are acutely interested in maintaining their patients' stability through a graduated process of evaluation and treatment. Perhaps, he cautioned, therapists would be worried that participation in my research might "trigger" a patient into an episode of sexual "acting out." It became clear to me that perhaps a beneficial compromise would be to interview therapists directly. Thus, instead of using therapists merely as gateways to patient participation, I decided to include them as an integral and extremely informative part of this research. This decision, which triangulated women's and therapists' perspectives, was perhaps the best I could have made. Inclusion of their perspectives, I believe has made my research more holistic, relevant, and, hopefully more useful to a wider audience.

BACKGROUND AND LITERATURE REVIEW: FEMALE SEXUALITY, PATHOLOGY, AND THE RISE OF SEXUAL ADDICTION

The scholarship on female sexuality in relation to sexual addiction or hypersexuality is scarce. This necessitates a broader review of topics that relate to this issue including, addressing the problematization of the female the body, examining different understandings of sexuality, investigating the relationship in the West between commodity and being, discussing the place of female sexuality throughout history, defining what constitutes sexual addiction, and illuminating the role of medical intervention.

From a historical perspective and beginning with the diagnosis of nymphomania in the 19th Century, there has been widespread and continued interest across the mental health and bio-medical realm of what constitutes normality of female sexual behavior, and of the boundary at which sexual desire is deemed to be excessive, and thus abnormal. However, my literature review shows that research questions that specifically investigate the subjective female voice and perspective in considerations of hypersexuality or sex addiction remain understudied.

The Problematic Female Body

Current scholarship on the problematic female body reveals interesting Western normative and discursive considerations as well as important historical trajectories. In popular Western notions of health and stability, the role of addiction in denigrating an

individual life has generally become accepted ideology. 12-step programs, self-help groups, Internet forums, countless books, therapy, and medicines, which are aimed to suppress, eradicate and prevent what are perceived as excessive behaviors are all available to those seeking treatment. While perhaps these resources and the ails they attempt to treat are not new, it seems that with time, more and more behaviors get characterized as harmful, and more and more people find themselves seeking professional help.

Many Western nations are consumed with the idea that all bodies are problematic, and that each person benefits from the notion of a generalized standard of “health.” In these climates, individual experiences can become overshadowed by a reductionist impetus for biological determinism where perhaps other factors may be at play in producing certain disorders. Compounding this issue is the tendency in the West to accept a dichotomized gender, one which constructively essentializes sex (genitally based) differences as tantamount to identity, and which, at its patriarchal core, often devalues the female voice in discussing experience (Bierema 2003, Gimenez 2005, Groneman 2000, Hubbard 2000, Rogers 1998).

Given this understanding, it may be that in order to move away from the idea that all bodies are in some way defective, it is necessary to take into account how people come to see their bodies as diseased, and from where they receive these messages. Although sexual addiction is a contested and no longer medically recognized diagnosis in and of itself,³ there still remains a somewhat large contingent of people² who seek help for what

³ “Sexual Disorder Not Otherwise Specified (NOS) is included for coding disorders of sexual functioning that are not classifiable in any of the specific categories. One of the three examples given for this disorder is “Distress about a pattern o[f] repeated sexual

they consider to be problematic sexuality. This contradiction is what eventually drew me to the field of sexual addiction. What for me is important in undertaking an anthropological review and study of how a person comes to label herself as unhealthy is the provision of research which seeks to prioritize individual conceptualizations of disease, in light of the cultural forces theorized to bear upon the feminine place in the West.

Defining Sexuality

A critical body of literature that is central to sexual addiction pertains to the ways in which sexuality has been defined. The popular conception of sex often relies upon essentializing rhetoric about gender. Starting at birth, most Western children are indoctrinated into the binary culture of gender, where boy has penis, girl has vagina. Indeed the first question often asked when a new parent meets their new child (which could be as early as 3 months with ultra-sound technology) is “boy or girl?” Label intact, most parents move forward to choosing a culturally acceptable name, to purchasing “gender appropriate” clothing, toys, paint for the bedroom, and planning gender-gear activities for the child. As stated by Margaret Mead (1967:267) in her classic treatise on gender roles, *Male and Female*, “...American practice leaves no room for attained sex; the child is absolutely and completely named and identified from birth.” More than forty

relationships involving a succession of lovers who are experienced by the individual only as things to be used" (DSM-IV. 638). This diagnosis has historically been the most common one to be used for patients identified as sexual addicts" (Irons & Schneider 1996).

² The Society for the Advancement of Sexual Health (SASH) estimates that between 3-5% of the U.S. population seeks treatment for sexual addiction of compulsivity ("Welcome to SASH", 27 June 2009, www.sash.net.)

years later, though much has been done to challenge outdated assumptions about sex and gender, Mead's (1967) assertion is still visible in Western culture.

Though seemingly innocuous, the formulaic assertion of gender norms generally ignores the immense variety of ways individuals may choose to identify themselves, and the ways they may choose to express that identity. Unfortunately, the lingering specter of biology as sole determinate of societal roles still haunts popular and often biomedical ideology (Lowy 1999). This understanding makes expanding definitions of sexuality increasingly important in the attempt to combat dogmatic belief in an essentialized sexuality. The argument by Mead ([1928]2001:73) that "our [Western] attitude is a compound, the final result of many convergent lines of development in Western civilization, of the institution of monogamy, of the ideas of the age of chivalry, of the ethics of Christianity..." highlights the fact that pathways of sexuality cannot be separated from their cultural contexts. In this spirit then, I will follow anthropologists Anne Bolin and Patricia Whelehan (1999:4) in proposing that "sex is a part of our biology [but] it cannot be separated from the cultural context in which it occurs incorporating meanings, symbols, myths, ideals and values."

The World Association of Sexual Health recently stated that: "sexuality is influenced by the interaction of social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors ("Progress" 2004). All of these categories clearly implicate the systems governing a person's life as paramount in how they develop ideas about what it means to be sexually healthy. Thus, in discussing the topic of sex addiction, it becomes exceedingly important to keep in mind that if sexuality is inherently a

byproduct of culture, reinforced by group pressure to conform (Curtis 2004), then any of its expressions also have the potential to illuminate the underpinnings of said culture, and which things members of that culture value.

The Western Relationship between Commodity and Being

Social science scholarship makes it clear that although many contemporary Westerners are comfortable with the language of addiction, it has taken years of medical, political, and social analysis of the individual body for this to be possible. Many Westerners are now comfortable discussing any behavior as potentially addictive or compulsive. In order then to examine the link between cultural forces and the rise of sexual addiction, it is necessary to first understand how addiction, *sui generis*, has come to dominate such a large part of western rhetoric. Much previous research into the rise of an addiction saturated society (Bjerg 2008, Reinerman 2005, Reith 2004, Weinberg 2000, Zinberg [1975]1997) has shown the intimate connection between the socio-cultural setting in which people find themselves and their immediate values and subsequent actions. In the West, this setting is one that increasingly places value upon consumption over production. As this post-industrial phenomenon becomes more and more commonplace, many Westerners are left in a vulnerable position of unlimited access, even as old notions of moderation still inform cultural norms.

In his article *Addiction as Accomplishment: The Discursive Construction of Disease*, Sociologist Craig Reinerman (2005) addresses the historically Protestant

tendency in the West to prioritize notions of morality and production, both of which he states are paradoxically linked to their polar opposite of addiction. He argued: "The ancient Bacchanalian drinking traditions that persisted from at least classical antiquity through the Middle Ages began to be contested by ascetic Protestantism and early capitalism, each of which helped create the modern Western 'individual' and at the same time demanded the renunciation of pleasure for the sake of piety and productivity (Reinarman 2005:310). It was in this climate that a space for addiction was created. Those individuals who were seen not to be producing, contributing, or participating on the same level and in the same ways as their fellow industrialists were deemed immoral, unhealthy and in need of change, be it physiological, mental or both.

In a similar vein, Sociologist Gerda Reith (2004), in her article *Consumption and its Discontents: Addiction, Identity, and the Problems of Freedom*, highlights the modern paradox that exists between the core neo-liberal values of "freedom, autonomy and choice" and the "discourse of addiction." Reith (2004) argues that in a consumption-based society, which is also founded upon the ideals of free will, the consumer is continually engaged in a battle between individual desire and market-controlled options. Those things which the Westerner is supposed to desire are offered up laissez-faire with the caveat that consumption outside of this market is dangerously unregulated and ultimately at odds with freedom. This twisting of the truth in favor of neoliberal economic values paves the way for excessive consumption to be seen as a threat to Western ideals, and throughout time this notion that there is some natural limit to what one human being should desire has come to dominate discussions about appropriate levels of consumption.

Addiction thus which was once seen as the force of a substance and then as a moral or biological failing of the individual, has become so entrenched in our discussions of use and misuse of any product or behavior that the fact that there is really no solid evidence for either biological or moral failure, has become moot. Westerners no longer need any more than the subjective belief that they suffer from some sort of addiction, to diagnose themselves with one of the most prevalent "diseases" the West currently faces.

In a culture mired in the presence of addiction, it is important to understand how our basic understandings of health and disease have been influenced by this compulsory compulsivity. It is within this context then that I will move forward to examine the case of female sexual addiction.

Women and Sexuality: The Tumultuous Relationship Throughout History

Historical scholarship on female sexuality demonstrates a profound social anxiety focused upon female sexuality, even when women themselves were comfortable with their sexual choices. Throughout history it seems the sexuality of the woman has been treated as a scary "beast" that needs taming. Eve, the "first mother of the West" forsook peace, quiet, and ignorance, and in so doing, she thrust women into an unending cycle of shame and societal retribution. This cycle today is often acknowledged in academia under the guise of heteronormativity. Far beyond the simple idea of "one man, one woman," heteronormativity encapsulates and underlies what have come to be seen as healthy sexual roles in a Western setting. Women and men are mothers and fathers respectively (or

should aspire to be), with women generally seen as inhabiting a passive/domestic position in opposition to the active dominance of her male counterpart. Furthermore, these distinctions are extended to notions of how one's sexuality is supposed to be displayed both in public and in private, where the false expectation is for feminine modesty and anxiety in issues of sexuality (Groneman 2000, Hubbard 2000, Roach 2008).

In an attempt to explain the genesis of a womanhood tied to an expectation of shame, modesty and denial of her desire to be sexual, it is vital to understand where these ideas gained popular credence. In his classic treatise, *The History of Sexuality*, philosopher Michel Foucault (1978:12) builds a picture of a sexually repressive culture founded upon a 16th century Christianity-based "increasing incitement" to confess not solely the sexual sins of deed but those of thought as well. In his chapter "Scientia Sexualis" Foucault (1978) claims that once confession had become linked to a notion of truth, it became a handy tool for medical professionals who sought to incorporate therapy into theory, and who found the practice of telling on behalf of the patient, and diagnosis on behalf of the doctor to be an easy fit. In discussing the relationship of the medical professional to sexuality, Foucault (1978:68) argues that:

The scientia sexualis that emerged in the nineteenth century kept as its nucleus the singular ritual of obligatory and exhaustive confession, which in the Christian West was the first technique for producing the truth about sex. Beginning in the 16th century, this rite, gradually detached itself from the sacrament of penance, and via the guidance of souls and the direction

of conscience...emigrated toward pedagogy, relationships between adults and children, family relations, medicine and psychiatry.

Foucault's work is important for understanding sexual addiction because it reveals the intricate and intimate relationship between supposed individual subjectivities about health and medical discourses about the body. Sexuality in the West is attached not only to a relationship with the heteronormative, but also with a medicalized vision of health. It is here at the junction of socially constructed sexual norms and medicine, where the desire to uncover the "truth" about human nature through biological sexuality found common ground. It is also here where female sexuality throughout the nineteenth, twentieth, and now twenty-first centuries would be and is often dictated by at times perverse conceptions about what it meant and means to be sexually healthy.

Governed largely by Victorian ideals about feminine chastity and virtue, popular and medical ideology often vilified overt feminine sexuality and deemed it largely a product of flawed biology (Foucault 1978, Groneman 2000, Roach 2008, Studd 2007). As such, the ideal for Western feminine sexuality became one of constraint, intolerance, and the denial of various sexual expressions including, but not limited to, flirting, initiating sexual activity, masturbation, and sex outside of marriage. Due to the belief that women (of all ages, though primarily middle and upper class elite and white women) who displayed these behaviors were mentally ill, biologically flawed, and in need of moral and medical treatment, many women's bodies were subjected to cruel and inhumane processes in attempt to rid them of their nymphomaniacal ailments. Some of these processes

included surgeries such as clitoridectomy, unnecessary removal of the ovaries or hysterectomy, the application of fire hot poker to the genitalia in order to cool their “passion,” institutionalization, and public scorn (Groneman 2000, Roach 2008).

Essential to understanding early treatment of female sexuality is that many women sought out professional help for what they perceived as sexual deviance, and often went along with their doctors prescriptions, as many truly wanted to be "cured" of their "unseemly" sexual desire. This highlights the power of medical and cultural scripts to influence individual conceptualizations of ill health.

One such display of sexuality that has been particularly denigrated throughout the last two centuries is hypersexuality. Despite gains made in the accession of sexual, health and reproductive rights during the 20th and into the 21st century that women have benefitted from, the notion of hypersexuality remains a problem for many women. Nymphomania, promiscuity, sex addiction, and any other terms that may be applied to pathologize female sexuality carry with them not just merely a diagnosis, but also a heavy history.

What is Sexual Addiction?

In medical literature, sexual addiction has had a history rife with debate and has many names: out of control sexual behavior, excessive sexual desire, compulsive sexuality, hypersexuality, and up until recently nymphomania (Schneider 2004).⁴ What

⁴ Though the 1980 edition of the "DSM-III" identified nymphomania and Don Juanism as 'distress about a pattern of repeated sexual conquests with a succession of individuals who exist only as things to be used' (Groneman 2000:143) these terms were dropped in the

they all share in common is the immediately identifiable implication that there exists a cultural and medical belief in the West about the supposed limits of sexual behavior (Irvine 1995).

Most medical definitions of sexual addiction rely upon some combination of compulsive or impulsive behavior⁵ and forces external to the individual in judging whether or not a person is truly a sexual deviant. For example, according to Psychologist Michael Herkov (2009:1), "sexual addiction is best described as a progressive intimacy disorder characterized by compulsive sexual thoughts and acts." Psychiatrist Aviel Goodman, on the other hand, suggests that "[s]exual addiction is defined as a condition in which some form of sexual behavior is employed in a pattern that is characterized by two key features: 1) recurrent failure to control the sexual behavior, and 2) continuation of the sexual behavior despite significant harmful consequences" (Goodman 1998). The Mayo Clinic's definition shores up Goodman's observation of harmful consequences and proposes that "[i]f you have an overwhelming urge for sex and are so intensely preoccupied with it that your health, job, relationships or other areas of your life are affected, you may have compulsive sexual behavior" ("Compulsive" 2008:1).

While these definitions seem to provide a grounded understanding of sexual addiction, psychotherapist John Giugliano (2008:145) argues "the usage of the phrase sexual compulsion is not consistent with the DSM definition of compulsion as behaviors that 'do not provide pleasure of gratification.'" This caveat of "pleasure" has created a

revised 1987 version of the DSM III R, when the term "sexual addiction" first made its debut as a medical diagnosis. The DSM IV dropped the category of sex addiction all together, and it is still unclear as to whether or not it will return in the soon to be released DSM-V, under the heading of "hypersexual disorder."

⁵ Compulsive and Impulsive disorders are those in which the untreated patient has a strong and uncontrollable urge to do something.

situation where many medical professionals who are attempting to diagnosis a patient who has come to them complaining of hypersexuality, will deem the behavior as "out of control" or "atypical," in order to get around the popular conception that sex is always intrinsically pleasurable.

Psychologist Marnie C. Ferree (2001) critiques the mainstreaming of the definition for “sex addiction” as one set up to exclude many female “sex addicts” from the equation. Ferree’s (2001) article highlights that the systemic devaluation and negation of female sexuality is based upon long-developing myths about the nature of women’s interactions with sex. Through this understanding, Ferree (2001) exposes the paradox that has been established surrounding female sexuality. Women went from being one of the most scrutinized members of the hypersexual class, to the least, within 100 years, within the medical field. This situation has left the door wide open for a real discussion of why it is that female hypersexuality is not given more attention in recent medical discourse, and whether this is because fewer women suffer from sexual addiction, seek treatment less for sexual addiction, if there really just are less women affected than in the past, or if there has been a change in the way that medical practitioners approach and diagnose female hypersexuality.

Interestingly, some scholars studying sex addiction note the high prevalence of co-morbidity that hypersexuality in women has with other disorders, namely alcoholism, neurotic disorders, eating disorders and depression, and which may go unnoticed or undiagnosed as the hypersexuality is given precedence in treatment(Cosgrove et al. 2007, Ferree 2001). Given a cultural climate that stigmatizes overt and “excessive” sexuality in

females, some women being treated as sexual addicts may truly be suffering from other disorders and vice versa.

Conversely, it seems there is a culture bound syndrome of expecting women to feel guilty about their sexuality, so we are more likely to hear about women's frigidity or "sexual dysfunction" than we are about their inability to control their sexual impulses (Cosgrove et al. 2008, Irvine 2005).

This finding makes the article *The Lives and Voices of Highly Sexual Woman* (Blumberg, 2003) a particularly refreshing piece of academic work. Guided by the principle that the only way to dispel the cultural imperative that a woman who enjoys sex "too much" must have a problem, sexologist Eric Blumberg (2003) set out to interview and record the stories of women who understand that their sexual patterns do not fit into the Western norm, but who also staunchly defend their right to sexuality on their own terms. These women whose "ages ranged from 20 to 82... had diverse educational and professional backgrounds, [and] with careers ranging from janitor to corporate CEO" (Blumberg 2003:147), often noted that their sexual lives had negatively influenced upon some aspects of their social, relational, and personal lives. However, they were not compelled to seek treatment for the problem. Furthermore, they had been able to carve out an identity around their sexuality that did not relate to disease, but rather to empowerment. As they often felt excluded from social groups for what they perceived as fear from other women, they had also developed their own capacity for self-sufficiency.

Blumberg's (2003) conclusions highlight the necessity and importance of assessing just what exactly is taking place when a woman decides that her sexuality has

become a problem, that rather than normal variance she is experiencing a problem which is beyond her control and which may require medical intervention.

Medical Intervention

A review of health-related literature suggests that currently there are three main forms of therapy for the patient seeking to cure themselves of their sexual ailment. A sex addict can visit a psychologist or sexologist, seek out psychiatric treatment (which invariably entails a prescription of medication), attend one of the various self-help Addicts Anonymous groups, or participate in some combination of the three therapy options. Most seem to pursue more than one option at a time, especially initially.

Each of these three methods are touted by the various professionals working in the field to be a crucial key on the path to sexual salvation and much like the rhetoric of alcohol addiction, they all seem to say that without treatment the problem will not go away and may, in fact, get worse. Additionally, though each of these professions recognizes the power of culture in shaping patient concerns, there is still, sometimes, the deterministic tendency to view individual bodies as problematic.

The question then becomes, is the biological basis for sex addiction stronger than the cultural influence? Scholars argue that although there is no medication tapped exclusively for the treatment of sex addiction, scientific experimentation may be coming close to determining the physiological basis of sexual addiction (Bostwick and Bucci 2008, Martin et al. 2005). In a case-study conducted on a man with a severe Internet

pornography and cyber-sex addiction, which eventually led to sexual encounters with partners met through the internet, two Clinical Researchers in the field of psychiatry and psychology, Michael J. Bostwick and Jeffrey A. Bucci (2008), have shown that biologically, all addictive behaviors may be governed by a malfunctioning of the mesolimbic reward center in the brain.⁶ The patient in this case was given a drug by the name of Naltrexone, which is commonly used for patients with alcohol addiction. The fact that this drug worked to reduce the patient's impulses (though he admitted they still existed) may be further indication that the expression of addiction through sexual behavior is less about biology and more about culturally derived pathways for types of behaviors. Indeed, if all addictions manifest themselves in the same region of the brain, then what is important is not that humans have the ability to be addicted, but to what it is that certain people, in certain cultures become addicted. In this case, sex.

This idea is supported by Reinarman (2005) who contends that the "common pathway" argument only provides at best a nebulous connection between addiction and specific biological loci for the genesis of addictive behavior. He reminds the reader that much of this research was borne out of a proverbial "cart before the horse" given that long before any evidence of biological bases were established for addiction, many people in the West had already begun to conceptualize of addiction as disease. He warns "at present, it is not clear if there is a site of pathology in the brain that distinguishes repetitive drug

⁶ It has become common scientific knowledge that all drugs activate an area in the brain known as the mesolimbic dopamine pathway. "This pathway is a system of neurons that operates primarily on dopamine and extends through several regions of the brain." (Thombs 2006:39)

taking from, say, sex, sailing, symphonies, and other activities people learn to repeat because they provide pleasure (Reinarman 2005:309)."

Furthermore, scholarship review of "sex addiction" as a cultural phenomenon turns up the information that those seeking medical intervention for their problem are often prescribed the popular anti-depressants Prozac and Anafranil (Briken et al., 2007, Ferree 2001, "WebMD" 2007). Though some research suggests that the anti-depressants work to control compulsive/impulsive behaviors (Cosgrove et al. 2007), others propose that in fact the "sex addiction" may simply be a function of the depression and thus "cured" when the depression itself is diagnosed and treated (Ferree 2001).

Given the lack of available data, however, about how many women are actually taking anti-depression medication to control a sex addiction, or how many women have come to find out (either through personal research, medical intervention) that their sex addiction was a function of depression, it seems that this area remains a compelling area for research. This is especially salient given the knowledge that Prozac sales, once the main breadwinner of the Pfizer lineup, lost substantial profits when the drug went generic. While there is no evidence that drug companies "fish" for clients, it would be relevant to explore whether a pharmaceutical company poised to gain new clientele, would seek to promote the use of medication for sex addiction in order to capitalize on a new diagnosis.

While there is no debating the good that comes of many pharmaceutical interventions in saving lives, within the field of sexology there is much debate surrounding what is referred to as the "pharmacologicalism" of sex (Tiefer 2008). It is a debate that seems unlikely to go away any time soon as pharmaceutical companies spend

more and more on the development of new “lifestyle” drugs, which are aimed at the treatment of non-life-threatening conditions, and as direct to consumer (DTC) marketing of medicine expands (Hunt 1998, Pacey 2008, Tiefer 2007 Waldinger 2008). What is important to note, given this reality, is the new culture that has emerged regarding ideas about sexuality. The pharmaceutical industry has become a major player in cultivating both wide scale societal discourse about sexuality and at the same time profitably appropriates acceptable beliefs about healing and health (Brezis 2008, Pacey 2008, Tracy 2004).

Leonore Tiefer (2008), a Clinical Psychiatrist, is one of the leading researchers in the field of sexology and founder of “The New View Campaign,” an organization of sex professionals designed to speak out about the problematic nature of medicinal control over sexuality. Writing about the role of Big Pharma, psychotherapist Leonore Tiefer (2008:57) has said “it is harder than ever to make the case for research and education on social determinants of sexual behavior and satisfaction against the constant drumbeat of biological reduction sponsored by Big Pharma.” The “biological reduction” to which Tiefer refers has frustrated those sexologists who are dedicated to the idea that the cultural and social construction of sexuality cannot be wiped away by swallowing a pill. These scholars argue that placing the locus of sexual control solely upon the shoulders of the individual complaining of an issue removes sexuality from its natural realm of shared experience and places it once again into an isolated and thereby often untreatable position (Cohen 2005, Pacey 2008).

Added to this general concern in sexology for the increasing dominance of therapy by pharmaceutical companies, is the real worry that people who previously would not have considered themselves as sexually un-healthy are being made to feel that perhaps there is something wrong with them. As considerations of “normality” are challenged by newly constructed medical models of sexual fitness, which function much like the “disease models” of health, sexual problems are often taken to be reducible to a single and biological origin that can be fixed solely with medical intervention.

What makes the advent of medical interventions doubly disturbing is the control that pharmaceutical companies have been able to exert over the research and development of pharmaceuticals aimed at treating sexual issues. With budgets that far exceed that of many sexologists dedicated to evidence-based research (Gagnon and Lexchin 2008), Big Pharma is able to dictate what is studied, what medicines are developed, and since 1985 with the government approval of DTC advertising, how the public is receiving messages about medications (Hunt 1998). A leading researcher in the field of medicalized sexuality and a practicing psychiatrist and neurosexologist, Marcel Waldinger (2008:182) has proposed “although we should be cautious not to generalize all pharmaceutical companies to be primarily...interested in enlargement of their consumer market, for some companies “medicalization” of relatively healthy people is much more important, than the development of sexual science and research of psychotherapy, whether conducted by sex therapists or not.”

Indeed, sociologists Marc-Andre Gagnon and Joel Lexchin (2008) found that although pharmaceutical companies claim to spend more on research and development

than on marketing, these numbers are often largely skewed by their unregulated ability to couch expenditures by using evasive terminology. Another way pharmaceutical companies skew results is through practices such as “ghost-writing,” where scientists place their name on a study even though the research was actually directed by the pharmaceutical company itself. Gagnon and Lexchin (2008:32) show that the amount spent on marketing (approx. \$57.5 billion) actually doubles that spent on “research and development.”

There is a wealth of scholarship on topics related to female sexuality. Studies abound, for example on the position of female sexuality as a problematic issue throughout history, and on the ways that sexuality in general is linked to economic, medical and cultural traditions. My literature review, however, shows that research questions that specifically investigate the subjective female voice and perspective in considerations of so-called hypersexuality or sex addiction remain understudied. This project addresses this oversight by providing women with the opportunity to speak for themselves about a topic which has long been a site for academic and professional debate.

METHODOLOGY

Research Design and Methods

While considerable quantitative data exist regarding sexual addiction, qualitative data is lacking. Therefore, this research sought to address this gap by using qualitative in-depth, semi-structured interviewing, with two groups: female sexual addicts and therapists who treat or who have treated patients for sexual addiction. Using the *grounded theory* approach with a continuous monitoring for emerging and unforeseen themes, I sought answers to a primary set of questions prepared in the form of an interview guide while at the same time allowing for discussion of unforeseen issues raised by participants (Strauss & Corbin, 1998). As one of the aims of this research was to explore the perceptions and experiences of women who identify as sexually addicted or hypersexual, it was important to gain a measure of rapport and trust with participants. Anthropologist Corinne Glesne (2006:105) states that "interviewing is an occasion for close researcher-participant interaction. Qualitative research provides many opportunities to engage feelings because it is a distance-reducing experience."

This research was approved by the UCF Institutional Review Board on October 28, 2009 (Appendix A).

Interview Methods

I developed two distinct Interview Guides (Appendix B) for each group of research participants. One guide aimed at understanding female conceptualizations of sexual addiction, the other aimed at understanding therapist beliefs about female sexual addiction.

Interview Guide I (Women)

The women in the study were asked questions that sought to uncover common threads linking the stories of hypersexual women, and identify dominant and less dominant themes in the narratives. Though each interview followed a slightly different path, the topics covered in every interview included:

- Conceptualization of sexual addiction
 - Defining sexual addiction and/or hypersexuality
 - Motivations in attaching the label to their behavior
- Attitudes regarding the influence of "others"
 - Discussing the role of outside influences (i.e. family, friends, partners, religion, media) in supporting or undermining sexual behaviors
 - Feelings about "culture-at-large"
- Beliefs about the role of addiction treatment
 - Explanation of decision to or not to seek addiction treatment
 - Feelings about field of treatment aimed at sexual addiction

Interview Guide II (Therapists)

Therapists were asked questions that focused on understanding how they conceptualized sexual addiction based on their experience working with patients. Interviews covered the following topics:

- Definitions of sex addiction
 - Accessing a diagnosis
- Male vs. female sexual addicts
 - Commonalities or differences in treatment models for men and women
 - Common threads in the stories of female sexual addicts
- Use of pharmacotherapy
- Lack of a diagnosis in the DSM-IV for sexual addiction
 - Impediment to treatment
 - Legitimization of sexual addiction as a medical disorder
- Perceptions about the public/"culture-at-large" in regards to sexual addiction

Research Setting

Women participants in this research were recruited from the campus of the University of Central Florida (UCF), which has a student population of 53,644 students. Though the bulk of UCF's student population falls between the ages of 19-26, current enrollment represents both a diverse mix of ethnicities, genders, and ages, with approximately 25% falling above the age of 25.⁴

⁴ See website: <http://www.iroffice.ucf.edu/character/current.html>. Accessed on February 28, 2010.

A large university campus setting is an appropriate place for data collection on hypersexuality given that, statistically, college-age students engage in frequent sexual activity. Statistics provided by the U.S. Census show that 20-24 year olds represent the largest group of college students, and data provided by the Kinsey Institute for Research in Sex, Gender and Reproduction state that by age 20 approximately 81% of all females have engaged in sexual intercourse, with this number rising to approximately 92% by age 24.⁵

Therapist participants were only recruited from professionals in the Orlando area. The decision was made to focus solely upon therapists in the Central Florida area due to time and funding constraints, which did not allow for frequent travel to distant locations.

Recruitment and Inclusion Criteria

Inclusion criteria for female sexual addicts only required that the woman be 18 years of age or older, and that she self-identified as sexually addicted or hypersexual. There were no exclusions made based on race, ethnicity, sexual orientation, socioeconomic class, or religion. Because heterosexuality was not part of the inclusion/exclusion criteria, sexual orientation varied for two women in the final sample. One woman identified as "pan-sexual" and the other as bi-sexual. For both women the identification was recent and the bulk of their narratives relied upon their experiences in heterosexual relationships.

⁵ See website: <http://www.kinseyinstitute.org/resources/FAQ.html>

Inclusion criteria for therapists solely required that they be licensed professionals who had, in the past treated patients, or who was currently treating patients for sexual addiction. There were no exclusion criteria for therapists outside of these requirements.

Recruitment Methods

Participants were sought by a variety of methods, detailed below, including *purposive* and *snowball sampling*, Russell Bernard (2006), describes these two sampling methods as appropriate for research which seeks to document the experiences of "hard-to-find" populations and to speak with people about sensitive topics.

To recruit women, I contacted numerous professors throughout the university to request permission to announce my study in their classes. In the classrooms I distributed an IRB-approved recruitment flyer, which detailed the study goals and parameters, and provided details about the length of the interview, remuneration for participants' time, confidentiality of the research and institutional contact information. I would then speak briefly about the aims of my research and allow a minute or two for any questions that students might have. Those interested in participation were directed to send an email to a separate electronic account that I established explicitly for this study, in order to arrange a meeting time and location. All emails were destroyed once a meeting date and time had been set.

In addition to this method, some participants for the female portion of the study were gained through snowball sampling, a method which relies upon word of mouth (by participants, interested parties and the researcher) in locating research participants.

In order to locate therapists for participation, I employed purposive sampling (Bernard 2006:189) to establish ten seeds and used snowball sampling to expand the sample to 13 participants due to the limited number of therapists treating sex addiction in the Orlando area.

Therapists were interviewed as "key informants" for the study. Anthropologist Russell Bernard (2006:196), whose scholarship focuses on research methods in anthropology, defines key informants as "people who know a lot about their culture and are, for reasons of their own, willing to share all their knowledge with you." Some participants were found through the Internet, where either they had their own website for their practice or were listed as practicing professionals in the Orlando area by professional organizations, including www.psychologyinfo.com, and the membership database of the Society for the Advancement of Sexual Health⁶.

Sampling

Data for this research came from 13 interviews with college women between the ages of 18-50 who self-identified as either sexually addicted or hypersexual, and 12 interviews with therapists in the Central Florida area who treat or who have treated patients with problems related to sexual addiction, culminating in a total of 25 interviews. Of the 12 therapists, seven were women and five were men. Five therapists were either already Certified Sex Addiction Therapists (CSATs) or in the process of gaining the certification, four were Licensed Mental Health Counselors (LMHCs) whose work

⁶ See website: <http://sash.net/>

focused largely on the topic of family or sexuality issues, three were Certified Sex Therapists (CSTs), two were Registered Mental Health Counselor Interns (RMHCs) and one was a clinical sexologist. There is some overlap of categories as one of the RMHCs classified herself as a CSAT, one of the LMHCs was also a CST, and another CST was also a Clinical Sexologist. All therapists were licensed professionals, practicing in the Greater Orlando Area.

Data Collection and Management

24 of the 25 interviews were audio-recorded. Only one therapist declined to being recorded. In this instance, careful notes were taken during the interview. The 13 interviews with women were destroyed immediately following transcription, according to UCF IRB protocol. Nine of the interviews with the women were conducted in the office of my thesis adviser, Dr. Joanna Mishtal, which provided a safe and private environment; four women felt more comfortable conducting the interview in a location of their choosing. 11 of the 12 interviews with therapists were conducted in their private offices; one therapist preferred to meet in another location of her choosing.

Given the sensitive nature of the topic, the UCF IRB decided that the consent process was to be verbal. No identifiers, including signatures, names or personal information about any of the women who participated were collected or stored. Consent from therapists was also a verbal process and though identifiers were collected, therapists were given the option to have a pseudonym used in lieu of their real names.

All names for both women and therapists have been changed to protect the privacy of individuals who participated in this research. All transcripts will remain confidential and will be destroyed per IRB policy once they are no longer necessary or within three years of the study's completion, whichever is first.

All interviews were conducted between the months of November 2009 and February 2010.

Data Analysis

To aid in data analysis, all recorded interviews were transcribed using the dictation software MACSPEECH. Transcripts were then printed out and coded by identifying central themes. Once coded, each interview was analyzed in order to discern which themes were dominant, which were less dominant, and which suggested common threads between the various narratives.

I made the decision to use the terms sexual addiction and hypersexuality interchangeable throughout writing in order to show that both terms ultimately carry the same meaning in professional circles, though culturally they may be perceived to have other connotations.

The majority of participants fell between the ages of 18 - 29, with only one participant, Shelley, falling outside of this block at age 50. However, this study did not seek to investigate how age differences affect women's conceptualizations of hypersexuality, and so, age data were not included in the final writing.

Data Limitations

The data used for this thesis should not be viewed as a representative sample. Although the college students participating in this study might be typical of a large public university, they are not a random national sample; therefore the generalisability of the results is limited.

In addition, given that female participants were culled from a university setting, the study sample is considered more educated than the national average. This may mean that they were better positioned to reflect upon issues of hypersexuality, culturally-based gender role expectations, and addiction treatment, in ways that may be buttressed by knowledge gained in university courses.

Another limitation to viewing this sample as representative is that all of the participants "self-selected" to be a part of the study. Because they volunteered, it could be inferred that the women in this study may be more comfortable talking about sexuality in general and hypersexuality in specific.

For the therapist population, a limitation may be the low level of diversity among the sample. As nearly half of the therapists were Certified Sexual Addiction Therapists, a large portion of the information comes from therapists in one specific treatment field, who adhere to a similar model and have similar beliefs about sexual addiction.

Finally, the sensitivity of the topic could, potentially, also be seen as a limitation. However, while hypersexuality may be a sensitive topic for some respondents, no respondent requested that the interview be discontinued, or contacted me after the interview to rescind her participation. In general, most women were comfortable

discussing the topic, and related their happiness about their participation upon completion of the interview.

Outline of Chapters

In chapter one, I will examine how women view the concept of normality as it relates to their personal beliefs and experiences with hypersexuality. I argue that because notions of sexuality are ultimately a cultural construct, they are open to varying interpretations based upon subjective experience and understandings. Women's narratives in this chapter highlight the role that friends, partners, and religious and cultural ideology plays in shaping women's beliefs about hypersexuality.

In chapter two, I focus upon the interplay between heteronormative ideals which mold cultural expectations for feminine restraint and passivity in regards to sexual desires and the ways in which women's own decisions to mask their behavior (i.e. only talking about sex with friends, or only seeking sex in committed relationships) works to create a false credibility for heteronormative ideals. Women's narratives reveal ambivalence about the labels of sexual addiction and hypersexuality, and, at the same time, suggest a cultural tendency to pathologize aggressive female sexuality.

In chapter three, I engage with therapist narratives and examine therapist definitions of sexual addiction, as well as their beliefs about patient motivations for treatment seeking. I also examine their views on the interaction of cultural, religious and popular ideology with the diagnosis and experience of sexual addiction. Female

conceptualizations about the role of therapeutic intervention are investigated as well. Narratives in the chapter underscore the subjectivity apparent, from both women and therapists, in discourses of sexual addiction and the role of addiction treatment.

CHAPTER ONE: CONCEPTUALIZING NORMALITY: WHEN PERSONAL MEANING-MAKING MEETS THE BELIEFS OF OTHERS IN DEFINING THE BOUNDARIES OF APPROPRIATE SEXUAL BEHAVIOR AND HYPERSEXUALITY.

Personal Meaning-Making in Definitions of Normality

The term "normal" is regularly used in popular discourse. However, what is usually left out of the discussion is what it actually means to be normal. Where does the idea of normal come from? How do people react to ideas about normality and how do they feel about their place inside or outside of those definitions? How does one go about accessing normality? When does a person know if he or she is "normal" or not?

Each woman who participated in this research had her own way of defining normality as it pertained to her sexual behavior. Still, there are many common threads which link their multiple conceptualizations of normality. This finding fits neatly with the concept of symbolic interactionism (Gecas & Libby 1976, Longmore 1998) by highlighting the notion that constructions of sexual normality are not immutable. Rather, as people attempt to engage meaningfully with the world around them, it becomes clear that there is more than one way to do so. Indeed, as scholars have shown (Berkowitz et al. 2007, Goldstein 2003, Groneman 2000, Kasl 2002, Simon and Gagnon 2003, Studd 2007) though cultural and official discourses might not always account for variations in conceptualizing sexual normality, individual ideas of sexual normality lend themselves quite readily to personal and inter-personal adaptation. Using the lens of what Debra Curtis (2004) deems "sexual subjectivity," it is important to consider that while certainly

part of the equation, beliefs about normalcy in sexuality do not solely result from biological sources. Instead by "emphasizing the constitutive process - how sexual subjectivity is produced - we can attend to the ways individuals attempt to construct their sexual lives within dynamic and particular social structures (Curtis 2004:96)." Thus, though some women defined their behavior in terms of personal deviance, most sought to highlight the fluidity of normality in the range of sexual behavior and noted that accounting for variations in sex drives and individual desires for sexual activity is an important factor in the ways in which they conceptualized normality.

The narratives of the women in my study make it apparent that even though these women considered themselves sexually addicted or hypersexual, they also conceptualized sex and their motivations for engaging in sexual activity in ways that were not inherently pathological. They identified boredom, enjoyment, connection with a partner, security, maturity, stress relief, feeling better about oneself, love, and learning more about sex and sexuality, among other factors, as their motivations for engaging sexual activity. If women did not view their behaviors as pathological, then why had they decided to label their sexuality as something outside of the "norm" and volunteered to participate in this research? The chapter explores the subtle contradictions formed when notions of normality are vague, and malleable to personal interpretation.

The concept of symbolic interactionism posits that human beings order their lives and identities around personal interactions with a wide variety of meanings/symbols i.e. ideologies and behaviors of others, differing vocabularies, and official structures, with which they come into contact (Gecas & Libby 1976, Longmore 1998). In their article,

Sexual Behavior as Symbolic Interactionism, Gecas & Libby (1976) show that individual sexual behaviors are both rooted in tradition, and personally meaningful inventions. Key to their discussion is the recognition that individuals living in a particular society will often come into contact with many of the same ideologies and similar symbols. However, varying individual motivations and experiences will lead to varying interpretations of those symbols.

Using culturally acceptable terminology to describe their hypersexuality, the women below reinvent what it means to be hypersexual. Though their identification as hypersexual signifies that they have been exposed to and on some level have accepted the idea that their behavior is "different," their "normalized" descriptions of what hypersexuality means underscores the malleability of meaning as both a product of societal influence, and personal exposition.

Through the voices of the women who graciously shared their stories with me, this chapter will discuss the ways that women conceptualized their sexual behavior as well as the role of "others" in shaping those conceptualizations. Their stories will reveal that everyone brings their own perspectives, ideals and desires to the sexual domain.

The Malleability of Social Norms

Vicky's long brown hair was pulled back in a loose ponytail and she gazed out the window as we spoke. When I asked her why she felt that she was hypersexual she broached the subject of cultural dogma in the United States:

I guess it's kind of funny, because I think in the United States things are tight. People aren't really sexually open you know? I have no problem with having had a lot of partners but a lot of people shy away from it because they think it's wrong or whatever, but I don't have any problem with it. (Interview, Vicky, January 20, 2010)

When I asked her to tell me how she came to be so "different" from her fellow Americans, Vicky touched on one of the main points that the narratives of the women in this study illuminated in conceptualizing what they described as normal and healthy sexual behavior. She doubted herself for a moment, which highlights the difficulty many people have in accessing and trusting ideas of normality, but quickly brought her argument back in line with her conceptualization of her sexual behavior as completely acceptable:

I don't know. I would like to say it's because I'm open-minded but then again I might be completely wrong and everyone else might have it right. I don't know. I feel like if you're responsible about things and have protected sex and do things that make you happy without hurting other people I see no problem in that...because sex is enjoyable...like there is no reason *not* to have sex. (laughs) (Interview, Vicky, January 20, 2010)

This idea that sex is fun and enjoyable was echoed by many women in order to eschew the notion that their "high" sex drives may be problematic. Shelley, for instance, complained that she had difficulties getting men to call her back after a few dates or so.

Though Shelley equated this on some level with her constant need for sexual attention from these men, when I asked if she wanted to change her behavior, Shelly's emotions rose. Her voice jumped an octave and she shook her wild mane of blond hair, emphatically declaring, "No! I really like sex! I enjoy sex! I am multi-orgasmic, and I just absolutely love it. It's just really, really fun! (Interview, Shelley, November 3, 2009)" Pamela, shared this enthusiasm when I asked her how she became so comfortable speaking openly about her sexuality with others. Pamela's answer rejected the idea that there is only one right way to experience sexuality:

I don't know, I just don't see a big deal in talking about it like some people do. Some people are very private, and I'm like, Aw! I had great sex last night! Let me tell you about it! This is what we did! (Interview, Pamela, November 5, 2009)

Although both Shelley and Pamela recognized that there is some standard or expectation for healthy sexual expression, they perceived these standards to be antithetical to their own conceptualizations about healthy sexuality. Furthermore, it is important to note that although Shelley and Pamela might say that they are having more sex, or desiring more sex than "normal" people, the statements "sex is enjoyable," and "sex is fun," represent neither foreign nor dangerous concepts. However, while many people would agree with Vicky, Pamela, and Shelly that sex should be enjoyable, popular discourses on female sexuality have not always been so forgiving. Rather, aggressive or at least non-passive female sexuality has long been considered dangerous and a site for

punishment (Bierema 2003, Finlay & Fenton 2005, Gurevich et al. 2007, Studd 2007). In linking enjoyment with hypersexuality, a label which automatically implies deviance, these women have, perhaps unconsciously, appropriated a medical term, in what may be an attempt to subvert popular conceptualizations of a (hyper)sexual woman as abnormal.

What is troubling about women equating sexual enjoyment with hypersexuality is the underlying implication that "normal" women don't enjoy sex. Have culturally disseminated ideals for healthy sexuality and "normal" sexuality become so convoluted that a woman enjoying sex and speaking openly about that enjoyment signifies deviance?

Kaylie spoke to the confusion inherent in popular conceptualizations of hypersexuality and normality when she stated:

When you say someone is sexually addicted, you automatically think they have a problem, and I don't think that people who enjoy sex a lot, more than normal people, should think that they have a problem. (Interview, Kaylie, November 4, 2009)

Kaylie's statement "more than normal people" highlights the ambiguity underlying many popular notions of normalcy in sexual desire. Her comment at once defies and reifies the impression that there is some general rule which can be applied broadly to individual desires and motivations for sexual activity.

If, indeed, it is the case that sexual "normality" for women is being popularly defined as a space where sexual activity is not enjoyable, and is not a space for sharing, it would make sense that those in my study who see sex as inherently pleasurable and a

worthy end in and of itself, speak of their sexuality as outside the "norm." It also explains why they perceive their sexuality as a site open for constant reinvention, not only of personal beliefs but ideas about "society at large" as well.

Melissa is very pretty. A satin white headband holds back her hair, and over her white tee, she sports a sharp looking pea coat. In my notes, I write "very traditional, almost looks like she could be a Kennedy." Though perched upon the edge of her seat, Melissa is as relaxed as she is confident about what she wants. She makes sure throughout the interview that I understand that her ideal would be to have sex multiple times a day, and that she expects her partners to feel the same. She told me that this has led to breakups with boyfriends in the past and that while she knows others may perceive of her desires as unreasonable, that she just didn't agree. Late in our conversation, when I asked her whether she ever considered therapy while formulating her feelings of hypersexuality, she said:

I mean, with one of my past boyfriends, he didn't come out and say it like, "you need help," but I guess he touched upon it like "why are you so into this? Like why?" And it made me kind of question it, and I was like "no. You know it makes me feel good, and it makes me feel closer in relationships, and I don't think that's a bad thing. Maybe we're just not on the same level with that." And that sounds like a trivial reason to break up with someone. You know, we didn't have sex enough that sounds like, "alright well did you like him?" But I think it is just as important as talking and going out places. I think it's a major aspect of a relationship and so even though it sounds like "oh you broke up with him because of

sex.” I don't know, it doesn't strike me as weird. I know it strikes other people, but I think it's a legitimate reason. His main argument was that it's not that big of a deal, but it is to me. (Interview, Melissa, December 4, 2009)

For Melissa, that each person has varying desires for sexual activity and that these should be accounted for in a relationship is a belief she holds to be completely normal. In her conceptualization, rather than falling outside of the norm, she is well within it. Instead of internalizing her sexual behavior as something in need of therapeutic intervention, she sees the problem as being one of poorly matched sex drives.

For Melissa, sex is also a way to know more about her partner and to feel better about herself. By framing her desire for sex in this way, Melissa seems to circumvent any feelings of insecurity that may arise when she is faced with the beliefs of others that don't match with her construction of sexual desire as malleable.

Other women shared Melissa's assertion that dissatisfaction with the frequency of sex in a relationship was a reasonable factor to consider when deciding whether or not to remain with a partner. Flora, for example, shared that in some of her past relationships, her partners had been unwilling to engage in sex, because of their desire to wait until marriage. For Flora, this was a deal-breaker:

There have been guys that I've dated that are religious... they'll be like "no I can't you know. Like my parents, what if they find out?" And I don't force it like, I'm not like, "I'm going to rape you." But I tell them how I feel and how I see it and if they're still uncomfortable that's fine. But it

gets to a point where, like, if it's not going to happen I tend to get bored. Like there's not that... sex kind of plays a part in relationships for me, so if there's not sex, there's a whole part of the relationship that I find lacking and that I need in order to know that the relationship is going to work. (Interview, Flora, January 27, 2010)

Other women in my study also emphasized the importance of sexual frequency in determining the longevity of a relationship. Pamela, for example, made it clear that for her sex was not only an important part of a relationship, but that her expectations for frequent sexual activity when entering a relationship were not something she was willing to compromise:

Pamela: I feel like I always want to have sex more than the guys I'm having sex with...like I would like to be doing it more than they even care.

Megan: Is that a problem?

Pamela: Um. Not really I guess. I guess sometimes it's hard for boyfriends to keep up and that's kind of frustrating 'cause I'm like you know you're my boyfriend and I want to have sex all the time, we should have sex all the time so.

Megan: How do your boyfriends deal with that?

Pamela: I think most of them are really happy about it but there has been a couple here and there that are like I just can't have sex that often. I can't do it. I can't get it up that often and I'm just like, *okay*, I'm not going to be happy long term like this (laughs) you know I can do it for a while but you're my boyfriend. Like that's the point. I should be able to be

comfortable and do it whenever I want." (Interview, Pamela, November 5, 2009)

For others, if sexual needs were not being met within the relationship, this was seen as a valid excuse to go outside of the relationship. Shelley explained:

I did have a transgression. A friend of mine came in from out of town and we didn't actually have intercourse, we had oral sex because my husband refused to do it. And it was like, okay, this is really good old boyfriend of mine coming to town, and he called, and I said 'okay,' and he did it. And yes, I was married, but it was one of those 'I really want that!' and my husband wouldn't do it. (Interview, Shelley, December 3, 2009)

Although the particularities of each of these narratives vary significantly, there is a common thread in their conceptualization that sexual fulfillment should be a given in a partnered relationship. When this fulfillment does not occur, considerations of whether or not to remain in the relationship may emerge.

The Role of a "Community" in Shaping Beliefs about Normality

For most women, the ability to have a group of friends, or to connect with a network of sexually like-minded individuals (either through the internet, written material, or popular media), allowed them to feel as if their identity as hypersexual was something not "abnormal" per se, but rather marginal to mainstream conceptualizations of female behavior.

Thus an important issue raised in a number of interviews was the notion that having friends or finding others who are "just like me" is a valid means through which to feel normal. For example, Melissa told me that because of the cultural stigmas placed upon women who talk about sex, she will rarely discuss her sexual behavior with anyone outside of her close group of friends. I asked her if this was because she had been directly judged in the past or if it was just because she felt this could potentially happen. Her answer highlighted the importance that women place upon their interactions with friends when they formulate ideas about their sexuality, as well as how some women may go about accessing normality in conceptualizing hypersexuality:

With my really good friends I feel like we're kind of on the same wavelength and that's what makes me feel it is not just me. I feel like maybe most women, like they just don't want to talk about it, because all of my good friends... we've talked about it and they're like, "Yeah, you know, I like sex just as much as guys." But I feel like I would only talk about that with my close friends. I wouldn't talk about that with my work friends or acquaintances, people I haven't been friends with for that long, because yeah, there is that fear that maybe they will judge me. Maybe they will think I'm promiscuous and dirty or whatever. They want to label you... So yeah I wouldn't talk about it probably with someone that I didn't feel comfortable with or thought felt the same way about it. (Interview, Melissa, December 4, 2009)

Other women discussed finding sources of sexual community in non-conventional settings that allowed them to re-conceptualize shameful behaviors and bypass or ease

worries about social stigma. The following statements by both Kaylie and Kitty highlighted how they were able to situate their behavior in relation to the abstract community of people "out there" who are "like me" in order to center their sexual behavior in what I refer to as alternate normalities. In these instances, women realized that a "norm" is only normal for the people who have subscribed to some particular set of value-based assumptions, and that these assumptions can be changed to suit new needs or new values. Implicit in their narratives is their understanding that generalized notions of sexual normality are based upon cultural constructions, rather than a biologically mandated expectation of feminine passivity.

Kaylie called herself a "big feminist." She recently realized that she prefers to date women though she has been challenging essentialized notions of sexuality for years. When I asked her why and how she came to think of herself as hypersexual, she identified a few things which helped her to realize that her sexual desires were not outside of the norm but perhaps part of a different version of normal than the one she had been exposed to:

I think I remember the first porn I started watching. I was in high school, and I was watching this show called "Bliss" on the Oxygen Channel, and it made me want that. So I think like porn really is what got me started on the whole sex thing. But then I started reading erotic stories and that connected it emotionally for me, to see people have these extravagant sexual experiences with these emotional connections. That like sealed the deal for me! That's all I read now, like porn stories. Like all I read!

(laughs) And I watch porn all the time, and I masturbate all the time, and so everything is about sex (laughs). But I think reading and watching porn opened me, allowed me to see things that I never thought you could do or were acceptable, and it made me realize that it was okay. Like stuff like BDSM [bondage and discipline, sadism and masochism] and umm... like two women together, two men together. Things like that that aren't just straight edge sex. (Interview, Kaylie, November 4, 2009)

Kaylie's perception that there is no one and fixed source from which people may receive information about their sexuality, thus stems largely from the fact that she was able to find a community of "others" who were "just like me". Kaylie's voyage into the world of pornography and her subsequent attachment to it as a conduit for "feeling normal" is made clear by her statement that "it made me realize that it was okay." Though the world of pornography is often seen as detrimental in mainstream conceptualizations of healthy sexuality, for Kaylie, it was an important source of confidence in reaffirming her sexual desires as normal.

In a similar vein, Kitty also referenced sex-related reading material and the Internet as two key factors in helping her access a feeling of acceptance and normality regarding her sexual desires. Kitty was quiet. She peered at me intently through the available peepholes offered by her mess of brown hair. Kitty seemed to really enjoy talking about sex and was very comfortable articulating her position. I queried her about the contradiction inherent in her expressed comfort with her hypersexuality on the one hand, and on the other, her acknowledgement that her sexuality has been problematic at times. In response, she shook her hair out of her eyes and stated:

I've done a lot of reading, and it was something I had to make myself okay with when I was younger because it seemed like a problem to me right way. So by the time I was in high school I was reading very sex-positive things like Betty Dodson, and all the things "Good Vibrations" publishes. You know, I had the internet, and I was very computer literate, so I had resources early on that showed me 'oh everyone around me thinks *this* way, but it's okay because *somewhere* there is a group of people that I could hang with, and it's okay. They're out there. I'll be fine if I just read and stay in my own little world for now. Live my life. Do what I think is okay.' (Interview, Kitty, November 6, 2009)

What is clear from Kitty's and Kaylie's narratives is that though both recognized their behavior as different and perhaps problematic initially, neither woman was willing to give up on what she perceived to be healthy sexual expression, and so she found others who just like herself were interested in sexually expressing themselves in ways not necessarily accounted for in popular discussions of "normality."

Each of these stories emphasizes the centrality that finding community plays in shaping the ways in which people conceptualize of deviance and normality. Finding a group of like-minded individuals can go a long way in reaffirming a person's belief that their behavior is justified. For example, in her article written about "bug-chasers", people who actively seek to acquire HIV/AIDS from "gift-givers," people who actively seek to infect another person with HIV/AIDS, Ellie Reynolds (2007), examines a community of people who subvert conventional ideals of healthy sexuality by actively seeking to catch

or spread a deadly disease. While to outsiders the idea may seem extreme and implausible, for those on the inside, this behavior becomes not only normal but desirable. These groups actively, though anonymously, transgress accepted beliefs about their sexuality (that, in general, semen is to be feared, that bodies with HIV should have no value) in order to reestablish themselves as healthy and normal. While my intention is not to equate hypersexuality with such an extreme view of sexuality, it is important to recognize that in the search for acceptance and a space to be "normal," the value of community and solidarity in human lives cannot be underestimated.

Moving forward, it will also be important to examine how the role of "others" who play an important role in a woman's life may conversely lead them to doubt their sexual behaviors.

The Role of "Others" In Defining the Boundaries of Acceptable Sexual Behavior

Though most of the women with whom I spoke saw their sexual desire as a good and healthy aspect of their identity, they also realized and acknowledged the ability of "others" to make them question their beliefs about the positive value of their sexual behaviors. Though at times they are extremely comfortable with their sexuality, these women are not immune to the judgments, opinions, beliefs, suggestions and ideologies of "others" who play important roles in their lives. These types of interactions lead women to doubt themselves and their sexuality (at least superficially or momentarily).

Furthermore, the interaction and clashing of varying cultural perspectives plays a large role in creating public spaces of ambivalence about what actually constitutes healthy

sexuality. However, rather than remaining caught in a cycle of victimhood, the narratives of the women in my study demonstrate that for many, the chance to eschew the judgments of others became an empowering paradigm. Admittedly, they do not do so easily. Their stories accentuate how difficult it can be to go against the cultural grain, and that for some women, ultimately, it is far simpler to acquiesce to societal pressures. In this section, I will show how the women in this study interpreted messages from outside influences including religion, family, friends, partners in relationships, and "society/culture." It will also then be essential to discuss how these factors have shaped their notions of appropriate sexuality.

Religious Beliefs about Appropriate Sexuality

Julia was full of energy. She bounced into the office, tossed her things at her feet, and, with a quizzical smile on her face, waited for me to begin. Julia was confident. She spoke quickly, loudly and had a lot to say. At one point, after, unprompted, she brought up her frustrations with the notion that women are not supposed to be as sexual as men, I asked her where she thought this notion of a gendered hypersexuality came from:

I think society and culture has made it a problem...I agree with my professor [of a class on sexuality] that religion was a huge part of it too, that with Christianity, like, its hidden in that girls should not be showing skin, and it's digressed [become less of a problem], obviously, but I think society and culture has made sex a completely bad thing. I'm Catholic, you know. I'm a Christian and Catholic, and I was brought up with those views, so when I first started doing it, I did think 'you know, I'm sinning'

and then I would go to confession, and I went to confession one time and I remember crying. I was just crying because, you know, I had had sex before I got married. (Interview, Julia, December 4, 2009)

For many women, religion is a major cause of insecurity about sexual behaviors. For example, Lisa, who seemed shy and mumbled most of the way through our interview, expressed being very uncomfortable with her recent sexual choices. Unlike many of the other women I spoke with who were generally loud and seemed unaffected by the idea of talking about sex, I had the impression that Lisa did not want anyone to hear what we are talking about, though no one else was around. At one points she stated that she didn't "believe in pre-marital sex." When I asked her what she meant by that, she sighed, "Well, religion. It's against my religion. I feel weird saying that because I do it, but, I'm saying, it's against my religion." (Interview, Lisa, November 20, 2009)

Though some research shows that religion has a declining influence on an individual's decision not to engage in sexual activity (Petersen & Donnenwerth 1997) more recent research asserts that for teens who adhere more closely to their religious teaching, waiting for marriage still plays a large role in their sexual decision-making (Helm Jr. et al. 2009). Lisa's assertion that she didn't believe in premarital sex, but that she still engaged in sex, exposes how difficult it can be for a person to reconcile his or her feelings of hypersexuality with conflicting religious messages, which make such a disorder not only shameful, but a sin.

Mari was also trying to reconcile her religious beliefs with her desire to be sexual. Mari shared with me that having had sex with 20 men since her first time in high school at the age of 15 was "pretty bad" and that about a year and a half prior to our meeting she had made a vow of celibacy. Though she had recently broken the vow and was unsure of how to proceed, she was really relying upon her religious values to help guide her to make the right decision. In response to a question about how she reconciles her religion with her sexual behavior, Mari replied:

Being Catholic, you try to be a good person. I mean, with every religion you want to be a good person, but it's really stressed in my religion to be monogamous and to take that stuff seriously... I didn't really care in high school, but I'm trying to be more open-minded now towards my religion.
(Interview, Mari, December 4, 2009)

Kaylie expressed a similar sentiment as she talked about why she always felt so bad about her sexual activity when she was younger. After her mother passed away, Kaylie said that her father became quite detached and that she was often left to her own devices. At the age of 14, after Kaylie had discovered her father's stash of Internet pornography, she began looking at Internet pornography daily. At one point during her story, she explained, "I mean, I watch way more porn now than I did then, but at that age, I was 14, 15 years old, and I think it was a problem then." (Interview, Kaylie, November 4, 2009) When I asked her why it would be a problem then and not now, Kaylie's answers encapsulated the difficulties of balancing religious beliefs with sexual desires:

Like, I would read Bible verses, and people from church would be like 'porn is bad,' and so I mainly listened to them, and other people made me realize it was bad. So a lot of people's guilt comes from, I mean, if they have a religion, it comes from disobeying something to do with that religion or disobeying your own moral standards, and I was doing something against my religion. I was really religious so it was a like a very strong dissonance with me. So that's why I was like I have to stop... and then I just kept doing it. (laughs) (Interview, Pamela, November 4, 2009)

While religious messages constitute a powerful force that aims to shape sexual behavior, particularly of women, and often succeeds in creating a sense of internal conflict between personal desires for sex and personal desires to be "good," they are not the only source of contradiction when it comes to women's feelings about hypersexuality. Media messages play an equally significant role.

Media Messages and Beliefs about "Appropriate" Sexuality

Many women in this study acknowledged being impacted and sometimes frustrated by media-driven messages about appropriate feminine sexuality. Here Vicky recalled her first encounter with the idea that her sexuality may border on addiction:

I watched the Tyra Banks show, and there was this guy who had slept with 72 women, but he was like 39 or something like that. And I was like wow, and they were saying that he was a sex addict and had problems, and I was thinking, 'Wow, if he is a sex addict, what does that make me?'

Because I don't think there's anything wrong with sex. (Interview, Vicky, January 20, 2010)

Melissa also talked about the role of the media in creating ambivalence and sometimes conflict for women about the acceptability of their sexual behavior. In my conversation with Melissa she revealed that while she had been able to move away from generalized conceptions of normality in sexuality, she nevertheless recognized the influence that television and public reactions to television can have in shaping a woman's desire and ability to speak openly about her sexual behaviors and desires.

Specifically, I didn't have any direct attacks on me like, 'Oh you need to calm down now' but just seeing my friends, seeing TV, news and things like that. Like, if you watch "The Real World," guys are going out and having sex every night, and if the girls do it, they're like 'oh my god, that girl is trashy.' There is so much name-calling for a girl who does the same exact things that a guy does, and I think that is the reason that a lot of women feel reserved about sex. (Interview, Melissa, December 4, 2009)

Lisa also argued that media messages had often lead her to question how, exactly, she was expected to behave as a woman. Here she discussed her own battle to make sense of what seem to be contradictory and at times negative messages:

On Saturdays, I usually watch America's Next Top Model. Then I really want to dress up and look cute, and so, it's like, the message is you're supposed to be cute and go after what you want. Or... you might just watch that and be like okay now, at the same time you need to be skinny

and do all this other stuff. So... one minute it's trying to build you up and the next minute it's tearing you down. (Interview, Lisa, November 20, 2009)

While each woman recognized that behind these messages were values and assumptions which may be at odds with her own understandings of healthy sexuality, the questioning of her sexuality in response to those messages, signals the sway that media personalities and popular conceptualizations of healthy sexuality and personhood can have over individual conceptualizations of appropriate sexuality.

Inarguably, media and religion are powerful sources of messages regarding normality. However, the role of familial beliefs and values cannot be downplayed in understanding how it is that women conceptualized their sexuality as either something normal, or something shameful.

Family and Beliefs about Appropriate Sexuality

At some point in most of the interviews, the notion of "being raised to..." was brought up. Women seemed constantly aware of the familial values that they were taught and the role that their ideological heritage played in their levels of comfort with current or past sexual behavior. When I ask Kitty, 29, to expound upon what she meant by "I was raised to" she had this to say:

You know, kids are checked for sexual behavior. I mean, I got the message pretty loud and clear that 'oh, that's not okay!' Like, there was this time I got caught playing doctor with my friend when I was six, and

we both got in really big trouble, and I wasn't allowed over to her house anymore for a while. And I know my mom definitely caught me masturbating when I was little, like eight or nine, and I got in trouble for that. And then I got in trouble again. Like my nana caught me [masturbating] when I was 12 or 14, and so I kept getting in trouble, and I'm like 'what the hell!' And meanwhile, you buy me these books that say oh, you should go. You should explore yourself, but at the same time, it's not okay, and I'm in my room? So, I definitely got mixed messages. But I had the undercurrent of "it's okay" because you're gonna buy me this book like "Our Bodies, For Girls" or whatever it was and that was sex positive but then the messages I got otherwise were not so. (Interview, Kitty, November 6, 2009)

Pamela also mentioned her family's role in leading her to feel ambivalent about her sexual behavior. When I asked her to talk about her feelings of guilt, she said:

I think a lot of it was probably how I was raised... I was raised to wait till you're married, wait till you're married, ingrained from little kid time, and then, I guess, I still feel kind of guilty about the choices I make sometimes... I think a lot of it comes from being raised that you're not supposed to. My mom called me a prostitute one time. A prostitute! (laughs) (Interview, Pamela, November 5, 2009)

Though coming from a different perspective, Kaylie also spoke specifically about the role of one of her family members in leading her to realize that her sexual behavior may have been outside of the norm.

My aunt in California, I talk to her a lot about it, and she has read some of my erotic stories that I have written and published. She was the one who helped me realize that I probably have a co-dependency problem 'cause I told her all about what happened with my last girlfriend. So, she has been down deep [depressed], she's hit rock bottom before, and so she knows what it's like, so she can help me point out my own problems. So, I talk to her and tell her everything. But the majority of my family, I'm not really comfortable telling everything to. (Interview, Kaylie, November 4, 2009)

While for these women, family could be both a source of ambivalence and security in contextualizing their sexual behavior, some women spoke of their families as crucial to their belief in their sexual desire as completely normal and healthy.

The Role of Caregivers in Fostering Beliefs of Sexual Normality

Research over time has shown (Crosby et al. 2009, Diclemente et al. 2001, Karofsky et al. 2000) that communication between parents and adolescents about sexuality is crucial in helping young people to form positive and healthy attitudes towards sex. In the accounts of a few women, parents were a source of confidence in women's belief that though their desires may be seen as different, this did not mean they were abnormal.

Flora and Melissa both felt that the lack of sex-positive sexual education, in school and in the home, engendered what they perceive as a cultural failure to embrace assertive female sexuality. They both pointed to the limitations of the generalized

association of teenage sexual activity in the United States with negative outcomes (pregnancy, STD, confusion of sex with love) and were quick to point out what they see as negative stereotypes about female sexuality. They emphasized the role of their parents in achieving realistic and manageable goals for dealing with their desire for sexual activity.

Flora credited her Latin heritage with having made her so open about her sexuality and speaks fondly of her parents, who she said gave her the confidence to feel that her sexual behavior was not only acceptable but normal. Flora was funny. She was never at a loss for words and spoke as though she would like to make it her personal mission to teach people about how wonderful sex can be. Her American best friend, she said, was not as accepting of her sexuality as her parents and had looked at her as if she was "going to go to hell (Interview, Flora, January 27, 2010)" for her sexual activity. Flora told me that she explained to her friend that for her, pre-marital sex was not a sin, a view bolstered by her parents' support:

Like my parents knew. I told my parents, I wasn't afraid to tell them. My Dad was kind of like "my baby, she's not a baby anymore," but my parents they were supportive in the fact that even now I'm not in a relationship, but my mom is always like "are you taking the pill? Are you always using protection?" because my mom knows that when you're in my age group, I guess your hormones are always like "I want sex" or "I want that feeling." (Interview, Flora, January 27, 2010)

Melissa also credited her parents with having provided her a home-based comprehensive sexuality education. She identified her parents' input as a major reason she was so comfortable with her sexual behavior. When I asked her what, specifically, her parents did to foster a home environment that was open to discussing sexuality, she said:

My mom, you know, I would come home and say "oh, we learned this" because they had to sign off on a little sex education thing and she pretty much sat me down after that and said "okay what did they teach you?" And we sat down at the table and had a big construction paper thing laid out and we wrote down what they taught me and what they left out. So it was pretty much just like...I guess she was kind of like... "Obviously, you don't want to go, you know, sex is an important thing, sex is something that you need to be ready for, something that you don't just hand out, but it's not bad. It's not something to feel guilty about. It's not something to be ashamed about. Sex is natural. Like you and your sister are here because we had sex." You know, they were just open with me and they didn't try to beat around the bush and be like "oh well you should just wait." You know they told me that. They also told me that "if you do have sex here's what you need to do." (Interview, Melissa, December 4, 2009)

The stories of both of these women illuminate the power of authority figures in aiding those in their care to access healthy and positive relationships with sexual activity.

Most interesting about many of the narratives provided to me by hypersexual

women is that on some level they all express a desire for others to understand why their sexual behavior is not just "different," but also okay and, ultimately, normal. Though all of these women by claiming the label of hypersexual had identified with a cultural space carved out for "deviant" bodies, they are also seemed to be well aware that this carving had been done with a culturally sharpened knife. Furthermore, their pleas for others to change their views and for a more holistic approach to sexual education, signals a real necessity for a re-examination of the ways that we teach Western citizens to relate with their own beliefs and the beliefs of others about sexuality.

Friends and Partners and Beliefs about Appropriate Sexuality

Most of the women who participated in this study addressed the role that friends and partners in relationships played in making them feel as if their sexual behavior might be something outside of the norm. A number of women explained that a friend or partner directly made reference to their sexual behavior as something abnormal.

Vicky for example recalled:

My old best friend... she once did say that she felt like I was too sexual. I guess she said that maybe I should go see somebody. But I don't know. I just don't feel... like, it's not a problem. (Interview, Vicky, January 20, 2010)

Flora also recalled an encounter with a friend, who required her to justify her belief in sexuality as something positive:

"My first friend that I got when I came here, she's like American, her parents are like *real* American. They're rednecks. Like, they love America, so... they're the whole, like, save it till marriage... They're very Christian. But, like, she's my best friend, so I tell her everything. She tells me everything, and when I first told her when I lost it [virginity] in Peru, and I came back and told her, like, this is what happened, blah, blah, blah, I was like, I felt happy, like, 'Oh my goodness, it was such a good experience!' and she was looking at me like you're going to hell. (Interview, Flora, January 27, 2010)

Julia who boldly proclaimed at the beginning of our interview, "I really, really, really like sex," also alluded to pressure she has received from her friends to conform to their beliefs about appropriate sexuality: "Some of my friends would say, would make me feel, my friends would be like 'Geez Julia! What's wrong with you?' But it's just like, I never felt like there was anything wrong with it. People may try and make me feel like that, but... (Interview, Julia December 4, 2009)"

What is salient to note in all of these women's stories about their friends is that each one decidedly eschewed their friends' judgments, and actively asserted that their own personal feelings about the acceptability of their behavior trumped their friends' ruminations about their actions.

However, what became clear in these women's narrative was that these events subtly worked to shape their conceptualizations of hypersexuality. Many women spoke of comparing their behavior to friends and that comparison having been central to the decision to label their sexual desire as hypersexual. For example, when I asked Samantha

how she decided that she was hypersexual, she stated "I guess it was more of just like a comparison of my friends and other people I've met, when we've had discussions about sex. (Interview, Samantha, November 19, 2009)."

While friends can serve as an important source of solidarity and community, they can also play a large part in fueling feelings of difference. In referring back to the concept of symbolic interactionism, it is important to understand that although symbols (read friendship networks) may appear to function in the same way on the surface, because each person brings their own values and interpretations into any interaction, no two friendship networks will work in exactly the same ways. Thus for some women, friendships become an important source of normalizing "deviant" behaviors, while others become a means of identifying "deviant" behaviors.

Kitty's conceptualization of her hypersexuality was especially illuminating in showing how some women may come to see their sexuality and "high sex drives" as something problematic. The following dialogue underscores the influence of multiple external sources on women's self-conceptualizations of healthy sexuality. At the beginning of our interview, when I asked Kitty why she thought of herself as sexually addicted, her answers reflected the tension she felt between her own sexual expectations and those of past partners in relationships:

Kitty: I guess I wouldn't have ever just thought about it. Except for the perception of it in the media makes it sound like its somewhat common,

and people have told me things before that would lead me to believe that maybe I'm not quite normal, quote unquote normal.

Megan: What kinds of things?

Kitty: Things like, I just needed to relax, like I was obsessed perhaps, not obsessed I guess in those words but just like, uh, I guess hypersexual would be the only way to put it.

Megan: What people are these?

Kitty: People that I was in relationships with, for whom it shouldn't really be a problem, you would think, or I would think.

Megan: Was that something that got in the way of relationships?

Kitty: ...it gets in the way of, I guess, relating because then if somebody perceives that you're not quite, like, average that adds to the perception of you as, not impure, but maybe not marriageable. (Interview, Kitty, November 6, 2009)

Kitty's consciousness of the fact that her feelings of hypersexuality have been largely influenced by the judgments of others is telling. She made it clear that she really didn't feel as if she has a problem, but her recognition that this may be part of her problem, underscores the difficulty discussed in the beginning of this section, that comes along with attempts at subverting conventional meanings. Kitty's perception that other's may not be willing to see a hypersexual woman as marriageable makes clear some of the "risks" involved when a woman does decide to openly challenge established norms.

What is important to note is that most women immediately identified "others'" conceptualizations of normal sexual behavior as important when reaching their own conclusions about their sexuality as something outside or inside of some monolithic

norm. However, what is also immediately recognizable was the reluctance of most of these women to frame their sexual behavior with what they perceived to be the limited scopes of their friends or partners. Throughout their interviews, most women oscillated between conceptualizing of their sexuality as merely different from the next person's to perceiving it as something deviant when conceptualizing it through the eyes of "others."

Generally, however, though each woman was able to rely upon her own formulation of normality in order to counter the opinions of friends or romantic partners, they did not do so effortlessly. As noted below by Samantha, the fear of judgment by others is a real concern, one that can lead to anxiety and self-doubt in the already vulnerable setting of a sexual relationship:

So, you think, "okay, I'm sexually aggressive, and that's who I am, it's okay." But then you're like, "Wait a second. Like, are they gonna judge me?" You know what I mean? So, it's much easier to [have one night stands] versus [be] in a relationship and be sleeping with [somebody] because they don't matter. You don't necessarily have to see the person. You know, you can have sex the way you want to. I can choose to talk to you again. I can choose to sleep with you again. But in a relationship, it's more like you want this person to like you, at least. (laughs) (Interview, Samantha, November 19, 2009)

Discussion: So What *Is* normal?

The above narratives demonstrate that for the women in this study sexuality does not lend itself easily to strict and easily identifiable formulations of normality. In fact,

the variations in the ways that women identify their sexuality, highlights the intensely subjective nature of sexual expression and experiences. Women's narratives also underscore the fact that abstract and rigid notions of "normality" embedded in popular, religious and familiar discourses exist apart from the actual experiences and perceptions of sexuality. As such, these abstract notions also serve to mask the realities of sexual lives in terms of their malleability and subjective nature.

At the same time, it is important to note the credence that these women give to the judgments, suggestions and opinions of others about their sexual behavior. Though sexuality is recognized in feminist and anthropological scholarship to be a malleable site for identity formation, popular conceptualizations about the range of appropriate sexual behaviors has not necessarily caught up to this idea. The stories of these women show, however, that some, at least, have been able to reorganize cultural beliefs about female sexuality and situate themselves at the nexus of subjectivity and normality.

Through a reinvention of what it means to be sexually acceptable, many women attempt to normalize their "scandalous" sexuality. Moreover, they are able to protect themselves from nebulous understandings of healthy sexuality by reframing "normality" itself. In these "alternate normalities," most of these women who label their behaviors as hypersexual or sexually addicted, are revealing that if there were no biased judgment about female sexuality, they would be perfectly normal. For many of these women, it is "society/culture," friends, partners, religion, and the media that are the sources of judgment that are responsible for their sense of "problematic" sexuality, and not their sexual behavior in and of itself.

In the next chapter, I will discuss why it is that women feel compelled to reorder their ideas about normality, in light of dogmatic beliefs about appropriate female sexuality. I will examine how women go about hiding their "true identity" while maintaining their image as acceptably feminine through their use of subtle gender transgression.

CHAPTER TWO: RECONSTRUCTING GENDER ROLES: THE INTERPLAY BETWEEN CULTURAL DISCOURSES AND FEMALE CONCEPTUALIZATIONS OF SEXUAL ADDICTION AND APPROPRIATE SEXUAL BEHAVIOR

Explicit in many of the narratives women provided was their feeling that cultural discourses about appropriate female sexuality often shaped the ways they expressed their sexual desires. While it is clear from the last chapter that many women do not feel as if anything is inherently wrong with their behavior, in this chapter I will show that this does not mean that they always openly attempt to challenge cultural constructions. Rather, many women talk about masking their potentially "problematic" needs, in subtle ways. The fact that women recognize and subtly attempt to subvert gender roles and rules, lends credence to the recent academic acknowledgement that gender and sexuality are not the polar constructions we often make them out to be.

In addition, this chapter also highlights the ways that women's masking behavior serves as a way to reinforce the idea of heteronormativity as something innate rather than socially produced. The diagram below provides a visual representation of the ways that cultural and medical discourses, biologically deterministic beliefs about sex and gender and women's own masking strategies all interact to inform social beliefs about appropriate behavior and reinforce discourses which rely upon those behaviors for meaning and support.

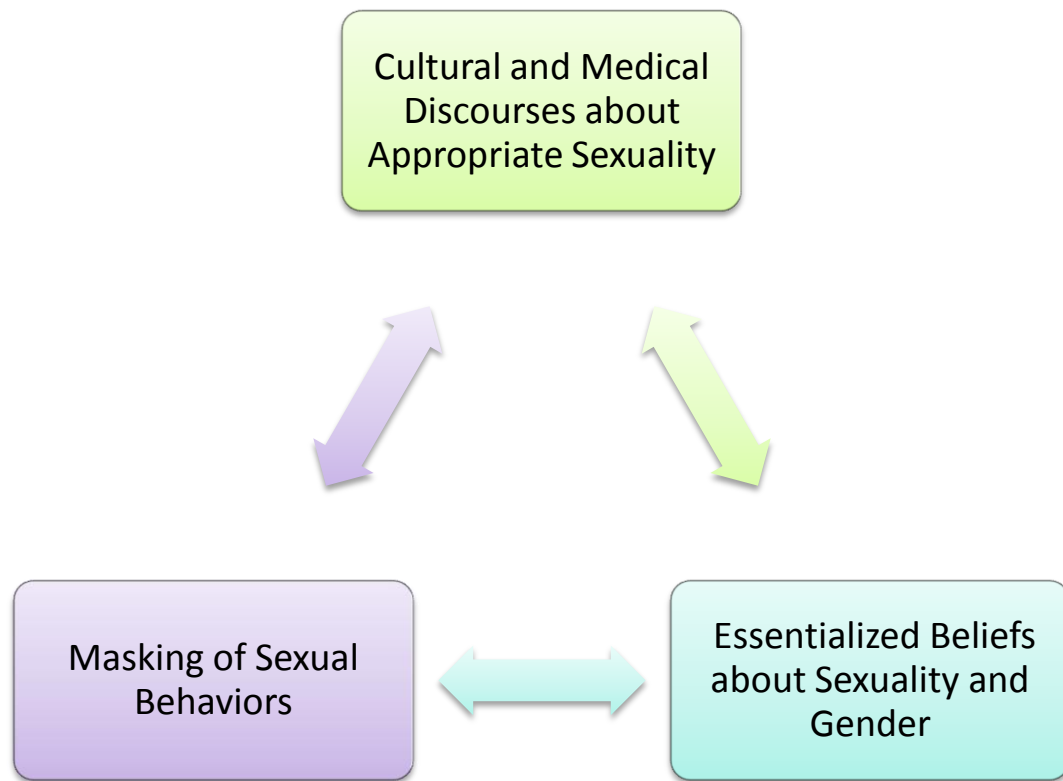


Figure 2 The Interplay Between Cultural and Medical Discourses and Individual Behavior

This quote by sociologists, William Simon & John Gagnon (2003:2) should serve as a reminder that it is generally impossible to divorce human actions from their social and historical contexts:

"Sexual drives, impulses or instincts struck us as misunderstandings of the socially acquired character of sexual life—for us the phenomenological experience of either sexual desire or the desire for sex was a learned way to label their interests within the context of specific interpersonal and intrapsychic conditions. In our view there is no sexual wisdom that derives from the relatively constant physical

body. It is the historical situation of the body that gives the body its sexual (as well as all other) meanings (Simon & Gagnon 2003:2)."

It is important to recognize that meanings change, can be changed, and are constantly changing depending on a multitude of various factors. In relation to the way in which people perceive the idea of gender roles, many scholars who write about gender dynamics have noted a shift in recent years. The overall view of gender roles is becoming less sharply focused on dichotomous interactions as men and women "queer," "bend," and "revolutionize" the genderscape. Feminist scholars, Verta Taylor and Leila J. Rupp (2004:116), who conducted an ethnographic study of Drag Queens in Key West, Florida, have highlighted the use of "'performative' gender transgressions such as drag, cross-dressing, female masculinity, and other boundary-disruptive tactics" in challenging essentialist and heteronormative constructions of femininity and masculinity." In addition, numerous scholars recognize the pervasiveness of instances in which people defy conventional gender norms and have called for a reconsideration of the inevitability of gender dichotomies (Bakshi 2004, Butler 1990, Fausto-Sterling 1993, Goldstein 2003; Kulick 1998, Schacht 2004, Taylor and Rupp 2005).

Through their work, these anthropologists, feminist scholars, sociologists, and others have been able to provide empirical evidence which supports the notion that though popular conceptualizations hold gender and sexuality as binaries, the reality is that they are merely abstract terms, with very little inherent meaning. As substantiated by the myriad ways individuals live their lives, sexuality and gender seems more likely to

represent a broad spectrum, which encompasses limitless ways that a person may express themselves, and interact with others. However, it has been rather difficult for academic conceptualizations to fully overcome popular beliefs about gender and sexuality. The idea of sexuality and gender as part of a continuum still remains marginal to mainstream dichotomous formulations of males as active and dominant and females as passive and submissive. Furthermore, though women in this study revealed that their sexual preferences were not part of a static reality, their tendency to mask their hypersexuality in order to “fit in” and avoid stigma is a discursive and behavioral production which works to bolster the idea that sexual desires that lie outside of the essentialized dichotomy are not normal and thus that they are deviant.

As revealed by Anthropologist Pamela Geller (2009:509), in her investigation of the enduring nature of heteronormative ideology in the discipline of anthropology as well as in culture at large, the "persistence of heteronormative presumptions is confounding because ethnographers detail humans' varied social arrangements (i.e., monogamy, polyandry, polygyny). Nor does mainstream scholarship or popular culture acknowledge feminist scholars' theoretical and evidentiary refutations." Her critique serves to remind the academic community that challenges to heteronormativity, while perhaps evident, are still considered the radical stepchild of tradition. Heteronormative behaviors are still the standard against which all other behaviors are judged. As such even though people may actually think and live in ways which are not reflected in popular heteronormatively shaped discourse, they often fall back upon conventional ideology in ontologically, discursively and behaviorally ordering identity.

Though one woman in this study identified as "pan-sexual" and another as "bi-sexual," interestingly their narratives did not generally deviate or suggest that their sexual orientation had precluded them from conceptualizing of their sexuality in relation to gender dichotomy. Though this is wholly speculation, this may result from the fact that both had only recently begun dating women, and so did not as have much experience with female partners as they did with male partners. Additionally, it may highlight that more than anything, women (and men) are socialized and expected to behave in socially proscribed ways, regardless of sexual orientation.

In this chapter, women discuss their view of sexuality as part of a hegemonic code about appropriate gender roles. Given the often limited public and private space afforded women to authentically express their sexual desires, I will demonstrate the ways in which women may be torn between the desire to satisfy gender conventions and the desire to transgress gender boundaries at the same time. Additionally, I will highlight the power of conventional gender dichotomies and show that while the women in my study conceptualize and experience sexuality in fluid ways that fall outside of an essentialized female-male dichotomy, they simultaneously are often reticent to afford similar sexual flexibility to their partners.

Sexually Addicted or Hypersexual?

Though the term "hypersexuality" has recently been suggested for inclusion in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), there is currently no official standard definition for this phenomenon. As such, the

decision to label or treat a person's sexual behaviors as something pathological or atypical often rests with an individual's subjective identification of their sexuality as problematic. As one of the main goals of this study was to understand how and why it is that a woman comes to see herself as sexually addicted or hypersexual, central to each interview was an investigation of how women saw their sexual behavior in relation to culturally pervasive ideologies.

Time and again, inadvertently or consciously, and in a multitude of ways, each woman attributed her notions of hypersexuality to culturally mandated heteronormative gender role expectations. Though each woman had her own reasons for doing so, what their stories conveyed was the very real, persistent, and often, subtle vestiges of biased gender values. Over time, women have been able to chip away at economic, educational, political, and social gender inequities resulting from unrealistic gender norms, and can now decide to marry or not, and even have un-partnered sex without facing past levels of judgment. Yet, an omnipresent expectation for feminine modesty and submission still remains and often vexes these women's decisions to express their sexuality in ways of their choosing that are not generally associated with feminine restraint.

Women who pursue sexual relations with multiple partners or who desire sex at a greater frequency than their partners seemed to conceptualize their behavior as stepping outside gender boundaries. Many of the women I spoke with said they often came back from having transgressed gender boundaries with the feeling that their femininity had been diminished. They often related this diminishment with simultaneously feeling more masculine. This conceptualization is not merely an internal process. Partners, friends,

media, religion, and even medical discourse all interact with individual conceptualizations of sexuality to suggest a picture of both feminine and masculine ideals.

Though some women identified with the term sexually addicted, the majority of women felt more comfortable identifying their behavior as hypersexual. Their preference for this term seemed to stem from the negative connotations often attached to notions of addiction in general. Many women expressed a general uneasiness about identifying their behavior with something as shameful and pathological as sexual addiction. Conversely, outside of the three women who did identify explicitly as sexually addicted, most women felt as if the term hypersexual did not carry such a heavy stigma, and that it did not pathologize their behavior. Here Vicky explained why it was that she preferred not to use the term sexually addicted:

I guess, like, for a woman to come forward and say she is sexually addicted that would be a big deal, but for a man, it's just, like, well, whatever, he's a man." But I feel like society makes a big deal if a woman has a lot of sex because we're still in some ways living in the [19]20s and [19]30s, where people just don't do that. It's always been okay for men to have sex. Like, it's always been very acceptable for men to go to brothels and to cheat on their wives, but it's never been acceptable for women to do that. And I feel like if we're moving towards more of an open world there is no reason a woman can't do the same things that men can do. I don't know. I could be wrong. People might feel just as bad when men do it as when women do it, but how I perceive [it] is that it is worse for women. (Interview, Vicky, January 20, 2010)

Vicky's comment highlights a number of issues at work when a woman decides that her sexual desire and behavior is outside of the accepted standard. First, her statement immediately discounted the idea that sexual addiction for some men is "a big deal." This static view of male sexuality as overactive and deviant, yet normal comes up in interview after interview, highlighting that not only are men and women forced to live up to strict gender role standards, but that the sexuality of men also embodies culturally-loaded expectations. Second, she noted that even though we are living in the "modern" world, there still remain many of the same gender boundaries that existed for women in the past. Third, she equated socially "deviant" behavior, "cheating men and men at brothels" with normality, by suggesting that it has always been acceptable for men to transgress sexually and seek sex outside of relationships, and that it should be acceptable for women to do so as well. While Vicky's comment draws attention to her feeling that her sexual behavior should not be considered problematic, it also suggests that there are only two ways to discursively construct legitimate sexuality. It is either feminine or masculine.

Kaylie who shared Vicky's reluctance to frame her sexuality as addictive spoke to the same issue. Her comments shored up the notion that many women, even those attempting to challenge the limited view of female sexuality, still at times view sexuality as part of a dichotomous framework. When I asked Kaylie to discuss what she perceived as the difference between sexual addiction and hypersexuality, she told me:

I think like one of my biggest issues and the reason I don't like the whole word sexual addiction or hypersexual is because there is such a different, such a double standard. Men can go and do whatever they want and having sex as often as some men have that might be considered sexual addiction or hypersexuality for a woman. And that's why I have a problem with terminology because there are so many standards...I think a lot of the reason that people are afraid to be like "I'm like this" is because they are afraid of what other people will think of them, calling them a slut, saying they are a whore or whatever, and they're just doing something that they love to do. You know, there shouldn't be anything wrong with doing something you love to do. (Interview, Kaylie, November 4, 2009)

Vicky's and Pamela's comments encapsulate why it might be that women reject equating their sexuality with addiction. The argument, essentially, is that if men can be "hypersexual," and that is acceptable to society, then by extension, women should be able to exhibit the same behaviors without negative judgment. If it is an addiction then by definition it cannot form part of a normal and healthy sexuality and is not so much revolutionary or empowering as it is deviant and problematic. By using the term hypersexual, some women are able to access what they feel translates to a more culturally acceptable interpretation of sexuality.

Indeed, most women who explicitly stated that they were "hypersexual" rather than "sexually addicted," often based their judgment on comparisons with friends who they saw as less sexually aware or active. Their reasons for preferring the term ranged from stating that their behavior only minimally interfered with their life, that they could stop if they wanted to, and that, in general, they didn't see anything wrong with their

sexual activity. For many of the women, the term "hypersexual," sounded less about problems, and more about being a person who enjoyed sex more than "normal."

Unrealistic Cultural Constructions of Sexuality

For many women, their conceptualization of their sexuality as something outside of the norm stemmed in part from their interactions with partners in relationships. The idea that boyfriends and other men should always want sexual activity, and the realization that they did not, factored largely in troubling women's conceptualizations of their sexuality as in-line with the cultural expectation for feminine passivity in regards to sex. Furthermore, their narratives highlight the existence of numerous falsely constructed expectations that both men and women hold to be true when dealing with partners.

Samantha described coming to the conclusion that she was hypersexual partly through her concerns about what was happening in her current relationship.

I've been dating a guy for six months now, and I want to have sex more than him! (laughs) And that's different because normally, guys just always want to do it. And he is like 'are you okay?' Yeah, I just want to have sex. I don't know. I think my drive is bigger than his. Which is weird. It shouldn't be that way. The guy is like in his early 20s. (Interview, Samantha, November 19, 2009)

Samantha's response shows a number of conflicts at work when a woman decides to label herself hypersexual. Her boyfriend's suggestion that she might not be "okay" was not the only reason that she felt she was hypersexual, however, it was one of the

first things she mentioned when we began our conversation and throughout the interview she continually referred to her fear that she was perhaps too aggressive in bed. However, while on the one hand she acknowledged that her frustration with her partner may stem from poorly matched sexual desires, she also referred to the notion that something may be wrong with her boyfriend. In her conceptualization normal men don't "just always want to do it," they *should* always desire sex.

Julia shared Samantha's consternation. When I asked her whether she identified as sexually addicted or hypersexual she claimed she was hypersexual because "I just really like it and enjoy it, but then I can not do it. (Interview, Julia, December 4, 2009)" Much like the contention of other women that hypersexuality is more about feeling as if they have an elevated desire for sex, Julia's statement highlights that for her hypersexuality is not something she saw as inherently problematic. However, in defending this decision, her story about her and an ex-boyfriend, revealed that on some level she did approximate her behavior with a biological "deviance":

I mean with my ex, him and I, I would call him a girl sometimes because he would deny me sometimes and I would get frustrated and ask like "What are you doing?" And one time he didn't want to do it because we were going to do it in the car and I said, "I'm 19 years old and I'm flexible. Twenty years from now, I won't be able to do this," and I said, "Why can't we do it?" And he said, "You're too good for this. We should be in a bed or whatever." And I was mad, or whatever. And some people, like, might not get mad because usually girls are doing it to guys, saying, "No, I don't want to do that," or using that against them. But I was never like that, never like that. I was always ready to go, most of the time more

than him. And I don't know, I just feel that, like, the other day, a professor said that guys have more testosterone, and, like, ten times more than girls, and I feel like I must have been born with more than the average than other girls because, seriously, when I was little, I started masturbating when I was really little, before most guys." (Interview, Julia, December 4, 2009)

Julia's story, about how she came to realize that her sexuality was something "different" unveils the way in which culturally and medically inherited assumptions about gender roles, can lead a woman to feel as if her behavior is outside of the norm. Her boyfriend's declaration that she "is too good for this," displays a number of assumptions about how "good girls" are supposed to have sex. That Julia, associates this event with her recognition that she is sexually more like a man underscores the power held by romantic partners in shaping a woman's conceptualization of her behavior as deviant.

Additionally, Julia herself relies upon cultural stereotypes in moving towards the conceptualization of her behavior as "deviant." By naming her boyfriend "a girl," she has reified the assumption that sexual restraint is a woman's domain, and, consequently, and has stripped her boyfriend of his masculinity. Furthermore, in sorting out what may be behind her own sexual aggressiveness, she deduced that the reason must be biological. In her conceptualization, then, females *are* supposed to be sexually restrained, since she was not she figured she must be more biologically masculine, even more so than most men. That Julia perceived her sexuality to be biologically different from that of most females, directly illustrates the way that nebulous medical conceptualizations can become part of popular parlance about sexuality and gender. Indeed, though biological conceptualizations of the body are important, Julia's final statement

that biology is to blame negates the scholarly understanding (Bolin & Whelehan 1999, “Progress” 2004, Mead [1928]2001) that sexuality is inseparable from its culturally manifested sources.

For Shelley, being the active initiator of sexual activity also signaled a departure from typical feminine behavior and fueled her belief that she was hypersexual. As we discussed how she came to the conclusion that she is hypersexual, she mentioned her first marriage:

I'm one of those, you know, there's a lot of guys who say they have to chase their women around to give it up, and they won't give it up. And I was the opposite. You know, I chased my husband around trying to get him to give it up.
(Interview, Shelley, December 3, 2009)

Throughout our conversation, Shelley often discussed feeling that somehow the men she was with just couldn't handle her sexual prowess. When I asked her why she thought there may be tension surrounding her aggressiveness, she replied:

Maybe the guy wants to be the pursuer. You know, that caveman thing, like the chase and they have to conquer. And I'm the opposite. I take control. You know, I'm in charge. I'm really demanding, I guess you'd say. And maybe that's taking away their manly caveman "I have to conquer things." Because I won't let them. You know, I tell them what I want, and tell them what to do and really I know it's too much, and I would like to find a guy who could handle it (laughs). That would be nice, but I'm not finding that so to me it's becoming a problem. (Interview, Shelley, December 3, 2009)

Shelley's comments suggest that perhaps if her partners were more acquiescent or more understanding of her sexuality, she might not perceive of her behavior as problematic. However, the feeling that she was emasculating the men she was with, because she was not the typical woman, caused her not only to feel as if her sexuality was problematic, but also to recognize that there exists a standard mode of behavior for men and women that she just doesn't fit into. Finally, her desire to "find a guy that could handle it," suggests as well that even if Shelley has recognized that her behavior is problematic, in her conceptualization it is not because something was inherently wrong with her, it was because these men just weren't able to deal with a sexually open woman like herself.

Melissa's comments below also emphasized the role that sexual partners play in leading a woman to the conclusion that her sexual activity may lie outside of an accepted norm. As we discussed why she considered herself sexually addicted or hypersexual, she affirmed, "I would say hypersexual. I don't think it necessarily hinders me from doing things, but it has led to several issues in relationships (Interview, Melissa, December 4, 2009)." She went on to reveal that her breakups were often the result of fighting between her and her partner about the frequency of sex they were having (or not). Eventually, she brought the notion of heteronormativity into the picture when she spoke about the role of her partner's suggestions in fueling her conceptualization of her sexuality as something different:

I have been sexually active since I was 16 and a half, and I would say three major relationships that involve sex. And I know that doesn't sound like a lot, but it's the frequency with which I have had sex with those people... They're like, "God you're such a boy! Girls don't want sex as much. Girls shouldn't want sex as much! (Interview, Melissa, December 4, 2009)

These narratives show some level of having internalized the pervasive cultural belief that men are always seeking sex, and women always avoiding it. The frustration women expressed was not only frustration with specific partners, but with the failure of the men in their lives to live up to ubiquitous expectations of aggressive male sexuality. The resulting inversion of gender roles became the most logical way for these women to make sense of this situation. As active pursuers of sexual activity, women assert that they must have a more masculine gender identity and that their partners must be more feminine.

Key then to these interviews was asking women where the notion comes from that women are supposed to exemplify sexual restraint:

You know, T.V. and society tell you. I don't know. I guess growing up you always hear that the guy is the one that wants it all the time, and girls aren't supposed to pursue sex as much as guys, and I felt like I pursued sex just about as much as guys or more. (Interview, Pamela, November 5, 2009)

Pamela's answer above supports the argument that popular beliefs about sexual equality for men and women remain a site of ambivalence about feminine desire. Whether or not women have *legal* claims to their freedom in choosing to lead "unconventional" sexual lives, there

remains a stigma, which denies many women the ability to feel *culturally* justified in making such claims. Julia's comment below shows that sexual double standards often begin in youth and may be largely perpetuated by parents whose intentions may in other instances be applauded for displaying openness to their children's sexual proclivities:

I think men are more open just because and again I think that's more of a society thing because even as a little boy, like if you have a little boy your mom isn't going to be as worried. She's just going to say, "Just be safe," and hand you a condom. And I know so many guys that their mom gives them that. But then if you have a girl you know a lot of girls you know the mom will put them on birth control but my mom is against that too and you know it's like she knew what I was doing. But I feel guys, it's still just a whole that the guy is better than a girl and I feel that they don't get in as much trouble. (Interview, Julia, December 4, 2009)

This notion of "trouble" broached by Julia is taken a step further by Kaylie, Kitty, and Samantha. Each woman directly addressed the fear of cultural rejection and stigma that inhibit female conceptualizations of active sexuality as something normal or appropriate. They also pointed to the consequences awaiting women who decide to challenge heteronormative sexual traditions. Kaylie explained as follows:

I think this goes back to the double standard that men can basically do whatever they want, because they are men. Girls or women are supposedly inferior so if they do something that jeopardizes the men's ego then they get labeled something that is bad. (Interview, Kaylie, November 4, 2009)

Kaylie's answer not only suggested that culturally there is an expectation for feminine sexual restraint, but also pointed to an overarching devaluation of femininity. Kitty's answer below explored this idea:

Well, [because of] Patriarchy, obviously we've had a double standard for women for a long time. So we're not supposed to be sexual beings, and we're not supposed to have a desire generally. And so for a woman to want sex and to know what she wants is kind of not okay. (Interview, Kitty, November 6, 2009)

Finally, Samantha's comments, pointed specifically to evidence of continued expectations for female submission to patriarchal constructions. They also highlight how confusing it can be to be part of a society which has long negated the worth of female existence and desires:

Trying to be a woman now is I think really hard. Like it's really hard to figure out where we as women are in society. Like do we become the homemaker or do we get the job, you know what I mean? Like there's all these different things and then it's like they want the whore, they watch porn, but then you have to be the good girl that you bring home to mom. You know it's just so much that you think about, you just don't know if what you're doing is right in the eyes of the man. You know what I mean? Like they have these songs, like, "I want a lady in the street, but a freak in the bed." (Interview, Samantha, November 19, 2009)

At issue in the above narratives is that though academically we may be moving towards broader conceptualizations of gender, many people still struggle with the ability to reconcile those theories with their everyday experiences. Many women still feel as if their sexuality is under the control of others and that extant double standards make

freedom of expression a costly undertaking. At the same time, however, their own cultural indoctrination leads some women to result to the acceptance of gender binaries as they at times take on a masculinized conceptualization of their sexuality, in order to make sense of their hypersexuality.

In the next section, I will show how these gender imperatives often lead women to exploit gender roles as a tool to gain access to sex, while at least superficially complying with cultural expectations for feminine restraint.

Masking Transgressive Behaviors: The Feminine Manipulation and Reinforcing of Heteronormativity

The power that heteronormative ideals hold over female conceptualizations of their sexuality is evident from the narratives above. More subtle and only discussed directly by a few women, are the means through which women may attempt to mask their hypersexuality. Given the cultural stigma and perceived shame which many women confront in relation to their sexual desires within the context of pervasive heteronormative values, by exhibiting sexuality only in culturally sanctioned spaces, some women are able to circumvent public if not private judgment of their sexual behavior.

Some women spoke about masking their hypersexuality by only pursuing sex within the confines of a monogamous relationship. A few women explicitly noted however that this resulted in "serial monogamy," where they jumped from relationship to relationship. However, under the guise of a committed partnership their sexual activity

was less likely to receive public attention, and they could present the image of a girl who was not loose or "dirty." Other women spoke of seeking sex from men who formed part of their established network of friends. In this way, they could avoid engaging in relationships that they didn't want, while at the same time feel that their behavior was safe and acceptable.

The fear of being labeled a "whore" or a "slut" was discussed repeatedly in women's narratives and was emblematic of one of the central concerns underpinning their views of hypersexuality. The desire to be seen as a "good girl," or to be seen as a reflection of ideal femininity, factored largely in the way women masked their hypersexuality. Whether or not they had actually experienced having been judged, it was still a preoccupation that remained ever present in their interactions with others. Here Melissa described coming to the realization that overt female sexuality was not acceptable and something best to conceal:

I didn't experience any direct judgment. It was just that I saw what was happening and thought "Maybe I shouldn't be as open about this as I feel like I am." So yeah, I guess a lot of people expect that if you're hypersexual that you're wearing slutty clothes, that you're going out clubbing, and I do really well in school, and I'm home a lot of the time hanging out with my dog, and I'm not I guess the cliché hypersexual girl.
(Interview, Melissa, December 4, 2009)

The strength of heteronormative formulations goes far beyond merely restricting how it is that people must act in public. It also informs the ways in which people go

about structuring their private existences. Widespread cultural cues convey that participation in committed and long-term relationships is the most (and generally only) appropriate location for sexual behavior (Koborov & Thorne 2009). In the presumed "safe-haven" of a committed relationship, and with recent popular messages in the media which promote active "girlfriend" sexuality (Gill 2008), some women identify their "serial monogamy" as a means through which they could express themselves sexually, without having to face stigmas about their desire for an "increased" level of sex.

This comment by Pamela reveals the strength of heteronormative concepts in shaping female perceptions about normality in sexual preferences:

"I guess I feel normal when I'm in a relationship and doing it all the time with a boyfriend. Like when I'm just having random sex then I feel kind of guilty, because I feel like, I don't know, I want to have sex all the time. But it's just easier when I have a boyfriend to do it with, like I guess that would make me feel more normal. (Interview, Pamela, November 5, 2009)

Chloe's narrative makes the understanding that sex within a partnered relationship is a culturally normal way to seek sex explicit. Chloe is very put together. Her eyebrows are meticulously shaped, her nails are polished to perfection, and each strand of her long brown hair is in place. She tells me right away that she is very co-dependent, has an "addictive personality," and has been speaking with a psychologist on a variety of issues, including obsessive-compulsive disorder, and an eating disorder. She mentions that her therapist once told her that she would be the perfect stripper because she seeks to control

and manipulate men through her sexuality. Though she has not been diagnosed as sexually addicted or hypersexual, through her work with her therapist she has come to realize that she uses her sexuality to get what she wants from men, and that this may be problematic.

The fact that the opinions of Chloe's therapist factored largely in her belief that she is hypersexual is telling. Her therapist's equation of her sexual behavior with stripping, expose the judgments and assumptions that are often made about aggressive female sexuality, and which can confuse individual conceptualizations with broader medical understandings.

However, while Chloe expresses her disgust with the shame women are made to feel about their sexuality, she is also very affected by the threat of judgment for her behavior.

When we began our discussion, she told me that for as long as she could remember she had been in one relationship or another. Whenever she felt that one relationship was coming to an end, she would be sure to have someone on the side, so that she could end the current relationship, knowing that somebody was waiting to pick up where she left off. Chloe told me that recently she has come to the realization that she never wanted to be in any of those relationships in the first place and that they served mainly as way to have access to regular sex and affection.

I've actually been single for almost a year or so now, because I'm finally like I can't keep doing this, putting myself and hurting these people who, you know, are just for my own comfort. And in being single that's when I

started realizing I don't want to be in a relationship and never wanted to be in a relationship with these people. I just like the physical connection and contact without having society tell me you can't do that without being in relationship. (Interview, Chloe, December 3, 2009)

Later in our conversation, when she brings up the subject of judgment again, I ask her where she thinks the idea came from that she had to be in a relationship to escape judgment:

Just because culturally, it's always been so gender-based. Like for a man to do that has always been more accepted than for a female. And I'm more, sexually I'm more like a guy. I would feel like 'look at him, I want that,' but our society teaches girls we shouldn't be like that. We should just sit back and don't give it up and don't give it up until you are married. I don't know, I just think our culture especially is so ignorant when it comes to sexuality, because in Europe they don't care. People are sexual and people can express themselves and it's never really thought of as something bad. But here it's so religious and so man-based society [sic] that for a woman to do so is just looked down upon. And I do care what other people think about me, a lot. So I think that's what has always driven me to be in relationships, because that makes it okay, and that make me normal. (Interview, Chloe, December 3, 2009)

Chloe's comments uncover the discernible effects of abstract and opaque ideologies about heteronormativity. Not only does Chloe equate her sexual impulses with being "like a guy," but she realizes that in order to be normal or seen as "feminine," she

must play the game of acceptance, i.e., “being in a relationship.” While her work with her therapist has helped her to come to the realization that she doesn’t have to be in a relationship if she doesn’t want to, her therapists comments also reveal what some scholars have shown to be the incursion of moralistic dogma into the therapeutic realm as well (Foucault 1978, Groneman 2000, Irvine 2005).

Mari seems excited to participate in the interview. She has the look of fresh-faced youth, and is hopeful that her attempts to redefine herself sexually will be successful. Mari has told me that her sexual choices during high school led her to make bad relationship decisions and that she no longer wants to be the "sideline chick." Though she is trying to change, she is not embarrassed about her sexual struggles. In fact, Mari strode right up to me in front of a group of people who were well aware of my research intentions, and declared her desire to participate. She is going through much the same dilemma as Chloe, however, throughout the interview she frames her desire to be more conventional as a way to keep in line with her Catholic faith. Though she does so indirectly, Mari's story presents a picture of a woman who has resigned to the fact that in order for her to be viewed as a "good girl," whose sexual partners value her, she must only seek sex within a partnered relationship. As we discussed how she was handling her decision not to engage in sex until she is in a relationship, she said:

I would love to be in a relationship. I'm a girl of course, and girls always think with their hearts more than their vaginas. But yeah, I would like to be in a relationship with someone and to have sexual intercourse with

someone, but it's difficult to find the right person. So it's frustrating because you can't do it, but you want to (Interview, Mari, December 4, 2009)

Though her comments highlight her desire for sex and indeed throughout the interview she made constant references to her desire for sexual activity, her internal conflict calls attention to just how hard it is for a woman to buck the incursion of dogmatic heteronormative discourses into one's personal decisions. Additionally, the declaration that "girls always think with their hearts," falls in line with the idea that sex in and of itself is not or should not be seen as a worthwhile pursuit for women. Thus this masking is made necessary by dominant ideology which states that desire for regular access to sex should only come within a relationship, and constitutes a productive concealment strategy for many women who internalize or are concerned with the popular notion that women need or should need love to have sex.

For a few of the women I spoke with, judgments coming from partners or friends led women, to go "undercover" with their behavior or to seek new sexual partners. This included not speaking to certain friends about sexual encounters, finding new friends who felt the same way about sex, or breaking up with partners who were uncomfortable fulfilling demands for frequent sex. Julia, for example, stopped telling one of her best friends about her various sexual encounters; Vicky proclaimed toward the end of the interview that she spent most of her time with guy friends because girls over think

everything; Melissa broke up with a boyfriend who hinted that something was wrong with her sexual drive.

For these women, confidence about their sexual desires turns upon their ability to insulate themselves from the judgments of others. Rather than fully allow her sexual behavior to be pathologized, each woman accepts her desire as something outside of the "norm," while at the same time being completely normal as well.

Other women spoke of more subtle ways that allowed them to "act out" sexually without arousing suspicions. Some women discussed avoiding parties and alcohol because it would inevitably lead to a sexual encounter, while, for Lisa, getting drunk was identified as the perfect chance to mask her sexuality under the guise of lowered inhibitions. When Lisa mentioned that most of her sexual encounters resulted from a night out partying, I asked if drinking was involved and whether she saw that as having any effect on her actions. Lisa responded:

Yes, I'm very uninhibited. Some people say they get self-conscious, but it's easier when you're drunk, because you speak a sober mind or whatever. Because sometimes I want to do stuff, but I know I wouldn't because you're sitting there in your head saying, "No, I'm not supposed to do stuff like that," and then you drink or something and you can quote unquote be yourself. But everyone just thinks you're drunk. (laughs)
(Interview, Lisa, November 20, 2009)

For some women their gender transgression is presented as a means through which to change societal perceptions of female sexuality. Though their actions were bold

and direct, their intentions were subtly aimed at changing the way others think, so that their own behavior may no longer be considered "deviant." For example, Vicky, Pamela, Julia, and Kaylie all expressed a desire to either become sex therapists, or to teach women how to go about having more satisfying sex lives. For these women, rather than succumbing to popular notions which label them as "abnormal," if they can just change how people think about female sexuality, they may be able to retain their "femininity" within a new set of norms that do not punish female sexual desire.

While some women shrouded their intentions to challenge gender dichotomies in more subtle ways, other women openly and directly challenge these ideals. For example, when Kitty was in high school, she soon realized that her sexual beliefs were quite different from those of her friends. Instead of feeling as though she had a problem, or feeling compelled to hide her sexuality, Kitty got angry:

I have always been angry. Angry about it like it motivates me to subversive action... So like when I was 18 I bought all my friends vibrators for Christmas, and I haven't stopped. You know like now I buy them nicer ones. Somebody who I think needs one (laughs) you know, I'll put the Betty Dodson, like "Sex for One" book with it, like it's not just me. But you know it's like my personal vendetta, like my mission of education for the world. Because I don't think it's okay that I should have to feel like something is wrong with me because society has said that women should stay in the house and be faithful and raise children, and not worry about what they want I guess. (Interview, Kitty, November 6, 2009)

For each of the women, the very real possibility that someone might label them, judge them or make them feel abnormal about their sexual desires, was a prime consideration when they made sexual choices. Rather than merely transgressing gender boundaries, they seemed to actually be redrawing the gender map as they attempt to change cultural ideals for female sexuality by actively challenging socially constructed norms. In this way instead of succumbing to values which they did not hold, they sought to have their behaviors become considered a natural and normal feature of the genderscape.

Referring back to diagram 2, it is possible to understand that the actions of these women do and can play a large role in reshaping cultural and medical discourse about the nature of hypersexuality as well. In addition, through gendered subversion of heteronormative dogma women who speak openly about their sexual desire as normal may help to create a space for challenging essentialized notions about sex and gender roles.

Discussion: Confronting Heteronormativity

What each of the narratives above highlight is the continued existence of unrealistic cultural ideology which actively produces and reproduces gendered expectations for both males and females. In light of these societal assumptions it seems women spoke of their sexuality in ways, which sought to downplay deviance through the preference of the term hypersexuality. At the same time, heteronormative values factored largely in influencing how women saw their behavior. Many women spoke of role reversal, whereby, in their conceptualization, partners who didn't desire frequent sex became feminized and they who did have high sexual drives became masculinized. Though many women noted that cultural beliefs about passive female sexuality

were misinformed, their own narratives, which reinforced the idea that men should always want sex highlighted that these formations are pervasively ingrained in the ways many Americans discursively attend to sexual behavior.

Women's narratives also showed that transgressing gender boundaries through the masking of hypersexuality was a readily accessible means through which to maintain ones femininity by subverting gender role constructions. Women's use of culturally acceptable pathways including only seeking sex in partnered relationships, having sex with men who are part of established friendship networks, using alcohol to mimic a lowering of inhibitions, and remaining abstinent per the dictates of religion, These tactics highlight the performativity inherent in gender norms, and their availability as a tool through which women were able to pursue frequent sex without having to face high levels of stigma or shame.

Finally some women spoke of actively attempting to redefine gender boundaries through career choices which would give them access to a legitimate platform from which to challenge gender norms, and by educating friends about the variety of sexual choices available to modern women. What all of these women show is that the expression of sexual preferences is fluid rather than static by nature, which implicitly challenges the notion that discourses are tantamount to fact. While perhaps the masking behaviors of women effectively slow down the transmission rate of the idea that sexuality is not dichotomous and is in fact a site for constant reinvention, it is important also to recognize that by subtly and overtly challenging deterministic and essentialized notions of gender, these women claim their sexual agency in the face of structural convention.

CHAPTER THREE: THERAPIST AND FEMALE VIEWS ON SEXUAL ADDICTION, TREATMENT SEEKING, AND THE ROLE OF ADDICTION TREATMENT

In the last two chapters, women's narratives revealed that beliefs about female hypersexuality are not only diverse but often grounded in varying cultural conceptions and misperceptions about gender roles. In addition, though not always explicitly stated, the notion of sexual addiction is inherently a medical concern, and so, in this chapter, I turn my analysis to focus on both therapist discourses of sexual addiction and female views on the role of addiction treatment.

The perspectives of therapists are relevant for a multitude of reasons. As key informants, they are able to offer insiders accounts of sexual addiction, both as a diagnosis they use, and as a disorder, which affects many of their patients. Through their experiences with patients, they present professional and empirical knowledge of how and why it may be that a person comes to see his or her sexual preferences and behaviors as problematic. Finally, as members of the medical community, which has long been a prime source for popular understandings about sexuality, their insight into the topic provides a broader context within which to think about issues of sexuality and "deviance" in the West.

Therapist Conceptualizations of Sexual Addiction

"The old joke is that too much is one more time than you do.

(Interview, Stan Browning, November 23, 2009)

Recently, the American Psychiatric Association (APA) released its first round of suggested revisions for the next (fifth) edition of their Diagnostic and Statistical Manual of Mental Disorders, (DSM-V). Among the suggested revisions is a diagnosis for "Hypersexual Disorder." In the APA's rationale for suggesting this disorder they note:

"Such a condition has been clinically described for over 200 years in Western cultures...but a specific empirically supported and polythetic set of operationalized criteria, as proposed here for DSM-V, has not been validated...The adverse personal, relational and public health consequences associated with this affliction rank it as one of the more serious but still neglected contemporary psychiatric disorders.⁷

While this addition to the DSM-V is by no means guaranteed, many of the therapists with whom I spoke recognized that sexual addiction, as viewed by popular media and the public, is not given the full seriousness that they feel it deserves. Therapists claim that spouses of sexual addicts feel as if the diagnosis gives their partners a pass on bad behavior, and they recognize that people who do not truly fit into the accepted model for a diagnosis of sex addiction come in for treatment using the terminology of sexual addiction. Many therapists believe that the inclusion of a diagnosis

⁷ See website: www.dsm5.org for definition and further discussion of the suggested diagnosis of hypersexuality.

for "hypersexual disorder" would provide a means of legitimizing their field of work as necessary and evidence-based.

What is most interesting about this situation is that in keeping with the finding by Reinerman (2005), medical conceptualizations often play catch up to cultural beliefs about disorder. Though much of the work being done by therapists who treat patients for issues of sexuality does highlight that there may be something amiss in American beliefs and behaviors in regards to sexuality, it remains salient to recognize that many of these beliefs are founded upon the vestiges of Protestant constructions which viewed "deviant" sexuality as sinful and pathological.

Currently, however, there is no one official diagnosis for sexual addiction. In addition, there are a number of treatment and diagnosis paradigms that various types of therapists refer to when working with patients they feel may be sexually addicted. While all psychologists may potentially treat a patients for sexual addiction, there are three main categories of psychotherapists who treat patients for the condition: certified sex addiction therapists (CSATs), certified sex therapists, and sexologists.

CSATs rely upon a body of literature modeled from language and treatment protocols made popular by groups like "Alcoholics Anonymous." Much of the background literature for this type of treatment is produced by Dr. Patrick Carnes. Dr. Carnes, who has written extensively on the subject, is considered a pioneer in the field of sex addiction research, and in the 1980's authored the seminal book *Out of the Shadows* (2001), which many CSATs referenced as a core theoretical work guiding their practice. Carnes has long been a proponent of the idea that the disorder is an addiction like any

other addiction. Dr. Carnes currently runs a program for sexual addiction recovery known as "Gentle Path" at a well-known in-patient treatment center⁸.

Some in the field, however, including sexologists and some certified sex therapists challenge the notion that sex addiction works like alcohol addiction and instead pursue an avenue of treatment more akin to cognitive behavioral therapy. Certified sex therapist, Stan Browning, PhD, referred to the generalization of addiction as "pop psychology (Interview, Stan Browning, November 23, 2009)" and preferred instead to treat it using the DSM-IV diagnostic criteria for obsessive-compulsive behavior. Another certified sex therapist who was also a clinical sexologist, Bob Listen, PhD was wary of treating patients in conjunction with a 12-step model, which he likened to "a cookie cutter response" to diagnosis and treatment, and suggested that treating sexual addiction with a 12-step model implied a lack of a full understanding of human sexuality on part of CSATs (Interview, Bob Listen, February 22, 2009). Generally, sexologists, do not require a period of what is known as "sexual sobriety", as do most CSATs, and instead view sexual addiction as a manifestation of other issues, including anxiety, anger, boredom or loneliness that can be treated without requiring sexual abstinence.

Despite the array of approaches, both groups of therapists are primarily concerned with the health of the patient. Their narratives also show that they do, indeed, use many similar types of psychotherapy and similar justifications for their use. Therapists generally agree that the public lacks awareness of how devastating sexual addiction can be. Many therapists cite conflicting cultural messages and sexual double standards for

⁸ See website: <http://www.pinegrovetreatment.com/patrick-carnes.html> for more information

women, as at least partially responsible for the rise of patients seeking treatment for sexual behavior, though they construct differing meanings in relation to that theory.

Therapist beliefs about sexual addiction often relied upon the presence in their patients of compulsive or pervasive sexual thoughts or behaviors. Although each therapist had a slightly different way of conceptualizing sexual addiction, generally, they begin to suspect that a patient may be sexually addicted if he or she verbalizes a desire to stop a certain behavior but then is unable to do so. In addition, some therapists were aware that given the lack of an overarching definition for the disorder, there is great potential for misdiagnosis by those not trained to recognize sexual addiction, especially in women. Therapist Brandon Knight, PhD, LMHC, explained:

When people think “sexual addiction” they usually think pornography or prostitution or masturbation... and the women I've run into have been more around, not always, but a couple of people that I've heard from.... it's really around the sexuality but it was more about relationships, more on the relationships, kind of like love and relationship addiction which sometimes is misperceived as co-dependency. Or even people would misperceive it and call it borderline personality disorder or histrionic personality disorder... and they don't kind of tease it out as a female sexual addiction. (Interview, Brandon Knight, January 28, 2010)

For some, the use of the term "addiction" was merely a convenient term to use, which allowed people to quickly understand the idea of the disorder. For others, sexual addiction is treated just as any other addiction. CSAT Tina Jordan notes: "It's like

anything. If it's not sex, it's alcohol. If it's not alcohol, it's drugs. If it's not drugs it's eating. If it's not that it's gambling. So it's another form of soother for them to use.”

(Interview, Tina Jordan, January 4, 2009)

Many CSATs rely upon diagnostic screening tools, such as the Sexual Addiction Screening Test (SAST), or the Sexual Desire Inventory (SDI) and one CSAT even noted that "many of them [women] might not have self-identified" unless they had been given a psychological assessment. In fact, a few therapists explained that women in treatment were generally quite resistant to the idea that they may be sexually addicted, and that therapists often used a combination of techniques (including screening inventories, renaming the disorder to "love addiction," and helping patients to draw connections between their sexual behavior and loss of control over their lives, in assisting women to the conclusion that their sexual behaviors may be problematic.

It is not inherently worrisome that medical practitioners are often aware of diagnosis and treatment paradigms which may be new to their patients. What is troubling, however, about the acknowledgement by many CSATs that they may have to guide a patient to view their sexual behavior as “deviant,” is the lurking danger that sometimes behaviors are pathologized which may not be considered problematic by the patient. Though I do not intend to suggest that therapists wantonly ascribe labels to their patients, and indeed many noted not using labels unless their patients wanted to do so, it may be as Foucault (1978:105) suggested in his discussion of the “psychiatrization of perverse pleasure.” In discussing how it is that medical practitioners came to be seen as a

legitimate source of healing in relation to sexual matters Foucault (1978;105) noted that historically:

The sexual instinct was isolated as a separate biological and psychical instinct; a clinical analysis was made of all the forms of anomalies by which it could be afflicted; it was assigned a role of normalization or pathologization with respect to all behavior; and finally, a corrective technology was sought for these anomalies.

What this suggests is that although therapists may feel justified in assigning a diagnosis of sexual addiction to a patient, and indeed a patient may feel relieved to know that their behavior is accepted as a medical condition, careful attention must be paid to the reasons why people are looking to medical practitioners to sort out their feelings of hypersexuality. Below therapists discuss why it is apt to remember that cultural discourses often go a long way in shaming certain behaviors. Perhaps the accession of medical diagnosis, more than actually signaling disorder, represents a way for people to legitimize behaviors which are often heavily sanctioned in public. Thus in a circular fashion, medical discourse fuels popular beliefs that sexuality can be a site for pathology, and cultural discourses about deviant sexuality, fuel medical discourses about the legitimacy of diagnoses.

Many therapists recognized that individual interpretations of sexual addiction could range widely and often had to adjust their treatment strategies for people who did not necessarily fit the "sexual addiction mold." For example Knight, accounted for the

subjectivity inherent in patient impressions of their behavior as problematic. In his answer, using a model derived from the work of Dr. Patrick Carnes, he noted that there are varying levels of sexual addiction:

Level I behaviors are more like the predictable things, pornography, prostitution, masturbation, multiple relationships. Level II behaviors are those that are nuisance behaviors like peeping toms, flashers, frotteurism⁹, and Level III is incest, molestation, rape. So I'm usually with high level-one, level twos. But then there's a guy who says he looks at pornography once a week and can't stop, and once a week is not that much, but his conceptualization of sexuality is "purity" and he's tried to stop. So then once a week, for him, is addiction, and if it's causing that severe stress and interfering with normal living, then it does. (Interview, Brandon Knight, January 28, 2010)

Cultural Misperceptions about Sexual Addiction and Treatment

Almost every therapist recognized that because there was a lack of readily available and evidence-based information about sexual addiction, many people came to them reporting with "sex addiction," while in reality they might be suffering from culturally or religiously derived guilt, like the patient referred to in Knight's quote above.

Another interpretation of treatment seeking motivations pertains to the sway of popular cultural ideas about sex. For example, therapist Cindy Gray, MS, argued that

⁹ **frotteurism** /frot·teur·ism/ (frō-toor'izm) a paraphilia in which sexual arousal or orgasm is achieved by actual or fantasized rubbing up against another person, usually in a crowded place with an unsuspecting victim. (www.medical-dictionary.thefreedictionary.com)

some patients are "seduced by our culture" into the belief that a lot of sex is inherently a good thing:

Our culture is huge on influencing the accepting of sexually addictive behaviors... we look at a lot of the television shows... like a lot of the reality shows, it [sic] gives us a picture of normalcy that everyone is "hooking-up." [Everyone] wakes up with their make-up on, no one has to take a shower and it gives a certain picture that it's fun, it's exciting, it's normal, everyone's doing it so to speak. Especially when it comes to pornography a lot of people have such a normalization of pornography not realizing how it's going to hurt the relationship. You know, for example, men or women cannot just look at pornography and say "Okay, I'm going to masturbate and then just walk away from that." You're now going to walk outside and you're now going to be objectifying everyone you see because you now have that in your mind. But that's subtle because it affects them in a subtle way. Even with television we are what I consider a sexually abused culture... the things that our culture puts in our mind it seduces [sic] us and that's what I like to say, that our culture seduces us to be to be more vulnerable to sexual addiction. (Interview, Cindy Gray, November 17, 2009)

Gray's quote emphasizes how some therapists view the role of popular culture and shows that, like patients, therapists may also bring their beliefs about sexuality into treatment. Gray's narrative highlights that, for her, certain forms of sexual expression are inherently problematic. Additionally, she has located the genesis for the popular belief of sexuality as a space for abandon within mainstream media.

That we live in a culture that both glorifies and vilifies sexuality should come as no surprise to anyone who is exposed in any way to American culture. Feminist scholar Rosalind Gill (2008), as do other scholars, recognizes that predominant media messages emphasize the fact that women have been empowered to take control of their lives and are encouraged to be independent, while at the same time offering a limited purview of the ways in which a woman may appropriately do so. This contradiction is noted by feminist scholar Feona Atwood (2006:80), who observes that "Late modern cultures are characterized by a move to more permissive attitudes to sex, though sex is also a regular focus of public concern in the context of an apparent disintegration of moral consensus around issues of sexual propriety." Thus, while some see sexuality as a site for experimentation and identity reformation, others seek to maintain outdated beliefs about appropriate sexuality. For Gray, above, the cultural move away from conservative beliefs about sexuality has lead to a climate in which we are "seduced by culture" and in the process lose sight of what it means to interact sexually in a healthy ways.

The recognition that our culture does not necessarily provide healthy or positive messages about sexuality, coupled with the cultural, particularly religious, impetus to stigmatize people who may be "different," often leads to situations in which therapists, in addition to treating clients for sexual addiction, must also reeducate clients and loved ones about healthy sexuality. Some therapists spoke of the ways that misinformed and misleading religious messages may impede treatment and acceptance of a diagnosis of sexual addiction, Therapist Alicia Brewster, who is in training to become a CSAT observed:

I think religion can have a lot to do with it...Unfortunately, growing up in a rigid household or a disengaged household, which most Christian families are fairly disengaged and rigid, really lays a good foundation for sexual addiction. So unfortunately, sex addiction is rampant in the church. It's just not recognized because sex is so dirty. So, unfortunately, even though it's there, it's swept under the rug, and that's sad. Because you know, a lot of religions say, "Oh, you know, if you just pray hard enough, God will take the addiction away from you." Well, you know what? That's just not the case. That is not the way it is. So, unfortunately, a lot of people that are Christian think if they would just pray harder or be better that this addiction will go away, and it doesn't. (Interview, Alicia Brewster, January 12, 2010)

Brewster's analysis, which focuses upon Christian values of "sexual purity" as an inhibitor of treatment, could also be extended to question whether or not the view that "sex is so dirty" might also lead to false constructions of sexual addiction. In an article focusing upon Christian college-aged males who sought help for "sexual addiction," therapeutic clinicians Kwee et al. (2007) noted that religious beliefs often caused what they saw as unwarranted feelings that sexual behavior was pathological. Their study focused particularly upon masturbation and found that many of the males seeking treatment for "sexual addiction," were actually seeking treatment for what they perceived to be behavior out of line with the religious values. Thus, the arguments made by Brewster and Gray, may be troubled by the notion that perhaps the lack of healthy and

sex-positive messages about sexual preferences in mainstream religion and culture, may also lead people to feel, unnecessarily, that their behavior signifies disease.

It is important to keep in mind that these issues were also brought up in women's narratives about hypersexuality. Many women either directly or indirectly referred to moral obligations, religious teachings, and cultural values of "sexual purity" as salient to their constructions of their behavior as deviant. Even women, who stated that their families weren't necessarily religious, spoke of having been taught values which eschewed pre-marital sexual activity. It is also salient to note the power of religious ideology to sway popular views of certain forms of sexual activity as deviant, even for those who may feel as if they are unaffected by these messages.

While religion plays a large part in therapist beliefs of how patients come to see their desires as problematic and in their discussions of treatment motivations, therapists also discuss dealing with popular misconceptions about the nature of sexual addiction as a significant factor in therapists' perceptions that their treatment is being undermined. A few practitioners cited the partners of patients as potential sources of shame and disbelief. Partners wary of a diagnosis that seems to let their partner "off the hook," may be unwilling to engage in couples' therapy for something they do not see as a medical disorder. Therapist Mark Alvarez, MSW, argued that partners of patients should accept the real nature of these experiences:

I think people need to know this is real. I've had a woman come in here and when I started trying to explore the issue of sexual addiction, heading in

the direction of "I think this is what your husband struggles with," it's almost like I'm trying to just hang a label on him, and, now, all of a sudden, I'm giving him a pass. No, that's not what it is at all. This is a well documented dynamic, and these are the features of it, and these are the feelings he's going to experience. And you are going to experience. I think there is a certain conservative right wing that sees it as just putting a label on someone, and, now, it's just like another sickness. It's something I'd never be casual about putting a label on anyone, and I don't like labels to begin with. But I think as a society, we focus on things that are titillating stories and good gossip and whatever. But actually being healthy about our attitudes toward sexuality... we're just stuck way back in some place I don't even want to go. (Interview, Mark Alvarez, January 13, 2010)

Alvarez not only calls attention to what he sees as a misinformed sector of popular culture but also makes it clear that he found it troubling that his diagnosis was perceived by the partner as having the effect of letting his patient "off the hook." Yet Alvarez does not seem to consider that the wife of his patient may in fact have felt victimized by her husband's behavior and even been justified for her concern. For Alvarez not only does the woman's assessment betray what he sees as her ignorance about sexual addiction, he also seems to take her cynicism as an affront to his professional judgment.

Given the flexibility granted to definitions of sexual addiction, it is not surprising that some people would be skeptical about the validity of the diagnosis. In addition, as discussed in previous chapters, the popular cultural belief is that men have a long history of "getting away" with undesirable sexual behaviors, which, until recently, were

legitimized as innate to male biology. Underlying this wife's concern may be the acknowledgment that men are often lauded for their sexual pursuits instead of checked for their indiscretions. However, in moving away from this view of a static sexuality, the therapist above is asking for both patients to step outside of their culturally-loaded assumptions and see sexuality through a new framework of disorder.

Below therapist Darren Young, LMHC, made a similar argument, though in a way which recognized that a diagnosis of sexual addiction is vulnerable to manipulation. He also addressed what he considered to be an unaware public:

You know with Tiger [Woods], and that's for him and his therapist to decide, but like with David Duchovny and them, it's almost like they get caught, so they go and do this and sort of get themselves out of trouble. Whereas the truly destructive nature of this is the quiet stuff. Its stuff you and I don't really bump into. So the average person doesn't really understand it, you know? They don't get how pervasive in someone's life it might become. (Interview, Darren Young, December 21, 2009)

Many therapists highlighted the general misperception that sexual addiction is something enjoyable and desirable, rather than a disorder that in reality can be consuming and destructive. Indeed, one therapist noted that this view was not just a public misperception, but one which he encountered from professionals as well. Knight has made it his professional goal to see a definition of sexual addiction re-enter the DSM, so that he is no longer faced with questions about the credibility of the diagnosis, and so that

the general public might finally understand the pathological nature of this condition. He relates an interaction he had at a conference with a fellow psychologist as follows:

When I have done presentations internationally and nationally, there is still a lot of misperception about what it is. I've had counselors come up afterward and say, "You know, I wish I had sexual addiction. I can't get anything at home." And I'm like maybe you don't understand what [sic] the last 90 minutes of what I just said. It's not about a high sexual drive. It's about this hunger and this hollowness that people use sex to fill up. And it just leaves them more hollowed out at the end, and even educated folks don't understand that. (Interview, Brandon Knight, January 28, 2010)

Accompanying most therapists' frustrations with public misperceptions about sexual addiction was the sense that if only the general public could receive an accurate representation of just how damaging and emotionally upheaving sexual addiction is, there might not be so many people who attach a label to themselves or others for a disorder they do not have. Additionally, some therapists feel that a lack of public understanding about sexual addiction fuels intense and unnecessary stigmatization for those people who legitimately suffer from the disorder. Below therapist Deborah Smith, a CSAT in training, reacts to my question about public misconceptions of sexual addiction and whether or not these misunderstandings affected her practice of sex addiction therapy:

I think a lot of people don't understand what it means. I know, personally, my experience has been that when I say that I work with sexual addicts, people translate that to sexual offenders. They automatically think I work with offenders, and there's a huge difference. So I do get that. And I think it would do us some service if there were more accurate portrayals in the media of exactly what it is, and how devastating it is, and how disruptive it is to people's lives, and that it is an addiction, and it is a disease. To me there is just not enough coverage that is accurate and really does it justice. So I think there's certainly a social stigma. (Interview, Deborah Smith, January 13, 2010)

Though the narratives of many women in this study show that they may not view their behavior as problematic, their voluntary participation in this study highlights a cultural disconnect between our personal ideas about problematic behaviors, medical discourses about problematic behavior, and the tendency to pathologize behaviors which may merely represent part of the healthy continuum of sexual behaviors.

As noted by therapists, these public misperceptions and shaming tendencies often make treatment inaccessible for a large part of the population. However, an inchoate analysis is that misunderstandings of sexual addiction may also be fueling female conceptualizations that they are hypersexual. As noted by Young, this lack of understanding about sexual addiction, also leads to situations in which people who may have what he called "poor other skills, (inabilities to reconcile religious beliefs with sexual needs, unresolved sexual traumas which lead to patient perceptions of

mismanagement of sexual activity)” (Interview, Darren Young, November 21, 2009) are presenting in therapy with the idea that they are sexually addicted.

In the next section, I will discuss how therapists’ discourses about patient motivations for seeking treatment differs from women’s own stated impetus for care.

Female Beliefs about Treatment Seeking

"I have never thought that I have needed to seek out someone to cure me or anything like that. I just thought I needed more sex to cure me (Interview, Melissa, December 4, 2009)."

Though glib, Melissa’s comment above, as will be shown throughout this section, highlights that, opinions about the necessity and desire for treatment varied widely among women. A few women in this study were under a regular care of a therapist for other issues, some had seen a counselor in the past to discuss various issues, others had been diagnosed as hypersexual by a therapist in the past, and others completely disregarded the idea that their behavior was pathological. In general, most women felt that the need for therapy would only arise if their sexual activity got so out of hand that they could no longer control their behavior, and many perceived therapy as an automatic acknowledgement that their behavior was wrong. For most, in stark contrast to the medical conceptualization of sex addiction as wholly devastating and undesirable, hypersexuality was seen as something positive though perhaps culturally stigmatized.

When I asked Kitty, for example, what would make her decide to seek treatment, she stated:

It would have to intervene on my functioning in such a way that I really didn't feel like I could bring it back in check. Like, right now, it's just... that... it's not that it's not okay, it's just that it's not okay because it's something that I can't talk about. You know? It's like societally not okay. (Interview, Kitty, November 6, 2009)

Like many of the other women, Kitty vacillated between taking about her hypersexuality as something benign and as something problematic. Above, Kitty notes that her behavior is only "not okay" because it is stigmatized by society, but at various points throughout our interview, Kitty often stated that at times her behavior can be "out of control." She also continually spoke about her behavior as something normal and natural. Later, when I asked Kitty to expand on her feelings about therapy, she tied these ideas together in her response:

I think if I got out of balance, and I think I *could* get out of balance. I mean there is a potential for me to get out of balance, but yeah if I was in a place where I felt like it was unhealthy and it was contributing to other problems then I would certainly get help, like therapy. Like I don't think I would really go to a support group 'cuz I don't really believe in it. It's for some people, not for me. I would seek counseling if I thought that I needed it... I don't have a problem going to a counselor and being like, "Look all I want to do is have sex all the time and its getting in the way of

my life. What the hell am I supposed to do about it?" Like that wouldn't really bother me. It's just that they're probably just going to tell me not to have sex! You know, "Stop thinking about it all the time and go get a hobby!" And I don't need to pay a lot of money for that (laughs); I'm paying way too much for therapy in my life already. (laughs) (Interview, Kitty, November 6, 2009)

Kitty's statement reflects the ambivalence that many women felt about the idea that their sexual predilections necessitated treatment. In her estimation, seeking treatment would mean a cessation of behaviors that she does not believe she should have to relinquish. In addition, treatment would signal that Kitty was not able to control her behavior, which she speaks of being quite comfortable doing throughout her interview.

For Samantha, similarly to Kitty, the idea of seeking treatment related directly to her feelings about her capacity to control her behavior on her own. However, she tied this to her ability to be a stable participant in a committed relationship. At one point, Samantha told me that she used to be irresponsible with her sexual choices and that she had cheated on every boyfriend she had ever had. She also told me that with her current boyfriend, she was trying to avoid the types of situations that she associates with an inability to control herself, including drinking with friends in the absence of her boyfriend and going to parties with heavy male presence. She felt torn by what she referred to as her "animalistic side," which comes out during sex, and her desire to be considered a "worthy" girlfriend. When I asked her whether or not she ever thought about therapy when dealing with these issues, she said:

Not now. You know, I can't predict the future, but maybe when I turn 30 it will slow down or something. But I think it's just my personality and I don't know if I would seek treatment because I don't consider it bad. But at one point, you know, if I'm in a marriage or something, and I'm not seeking satisfaction sexually in a marriage. If I, like, ever went to look elsewhere for it, you know, or even like a relationship, if I felt the need to look elsewhere then I would probably consider help. You know, is me being above normal in a sex drive going to affect my relationship and the things that matter to me the most? Then it would become an addiction, I think, because it would have that negative thing to it. Then, I would think, if I needed to seek treatment I would. But right now it doesn't have any massive effect. I'm able to be in a relationship and not need to seek elsewhere. (Interview, Samantha, November 19, 2009)

Though Samantha's answer highlights her confidence in the fact that she perceived her behavior to be under her control and did not "consider it bad," it also illuminates just how difficult it can be for a person to admit that they may benefit from therapy. In Samantha's narrative, the gauge of needing therapy lies in the question of whether she felt compelled to seek sex outside of a relationship or not. However, during our interview she also revealed that she has never been faithful in a relationship, and that her unfaithfulness had not only caused her relationships to end in the past, but also made her suspect her partners of cheating. Admittedly, then, Samantha had already met her own requirements for seeking therapy, but, because she envisioned her behavior as

fundamentally normal and a part of her personality, to seek therapy would require Samantha to reconfigure her own understanding of “abnormal.”

Perhaps then, it is because people do not generally seek treatment for behaviors they consider to be normal, why "others," including friends and partners seem to factor largely in person's recognition not only of her sexual "differences," but also of her need to seek treatment.

A few of the women I spoke with recalled partners or friends who had suggested that maybe they needed to speak with somebody about their sexual activity. For example when I asked Vicky if anyone has ever suggested that her sexuality was problematic, Vicky tells me, "I think my best friend did. My old best friend, who is a girl, she once did say that I was too sexual I guess. She said that maybe I should go see somebody. But I don't know, I just feel like it's not a problem (Interview, Vicky, January 20, 2010)." When I asked her why her friend would have thought that, Vicky said that it was because "she knew how many people I was having sex with at the time (Interview, Vicky, January 20, 2010)." Though Vicky told me that she does not feel that her sexual behavior is a problem, a couple of minutes later she stated:

Yeah she said I needed to slow down and yeah I did get a little promiscuous for a little while, but it's cooled down now. And that's where the numbers came from. It's like I just started having sex with a lot of my friends, but I think that was that. (Interview, Vicky, January 20, 2010)

Because she perceived that her behavior was situational and not a permanent factor in her sexual activity, Vicky did not see treatment as an appropriate response to her behavior. However, her friend's suggestion, that she may need to "go see somebody," calls attention to the ways in which cultural misperceptions about sexual behaviors may play a part in pathologizing the behavior of women who do not fit cultural molds for feminine sexual restraint.

In contrast women who were currently receiving counseling or otherwise saw therapy as viable had more nuanced opinions about therapy.

Kaylie claims she would be interested in pursuing therapy "not to change myself, but to help me get a firmer grasp on it... I feel like I don't mind if there is a problem within myself if I completely understand it (Interview, Kaylie, November 4, 2009)." Kaylie's sense of therapy as something aimed at changing a person, underscores the discomfort that she feels with giving up control and allowing her behaviors to be identified with deviance. Though she tells me on a couple of occasions throughout the interview that she recognizes that her sexual behaviors can be problematic, she is resistant to the idea that this means she should have to change.

Pamela stated that she would seek therapy for purposes that are "more so related to how it deals with relationships," and argues that although she has sought help in the past for "relationship issues," that she is not sure if she would "be comfortable rolling in talking about sex... with an adult figure (Interview, Pamela, November 5, 2009)."

Much like Samantha, who felt that therapy would only be necessary if her sexual activity were affecting a relationship, Pamela also thinks of therapy as something that

might only be necessary when another person is involved. Interesting to note in Pamela's answer is that though she tells me throughout her interview that she is extremely comfortable talking about sex, with anyone at anytime, her understanding of therapeutic intervention, which is often hailed as one of the safest places to talk about anything, is that it would potentially be a source of anxiety.

Shelley also discusses anxiety about the age of the therapist as being a factor in preventing her from seeking treatment. However, Shelley has the opposite problem. She is afraid the therapist will be too young:

Sometimes, though, I feel awkward... that's why I really had to think about calling you [to be interviewed], because I'm 50 years old you know? I'm not 20 and not 25 and a lot of people that work in those things [counseling centers] are they even 50 years old? Sometimes it's weird talking to somebody who's so much younger than you about sex. Like to me, sometimes that makes me feel weird. (Interview, Shelley, December 3, 2009)

What these narratives show is that the decision to seek treatment is not an easy one. Female understandings of therapy represent the myriad motivations that accompany a person's desire to seek or to not seek treatment. These included, feeling discomfort with what they perceived as an inability for someone outside of their age group to fully relate to their issues, wanting to understand more about their behavior and not necessarily change that behavior, and dealing with relationship issues in general and not solely focusing upon sexual activity.

While some women felt that treatment was not something they would totally benefit from, other women considered therapy to be pivotal in helping them to understand their behavior in a broader context.

Female Views on the Benefits of Treatment

Two of the women who were currently in therapy and working on issues with their sexuality, each noted that merely having someone to talk to had helped them to gain a better grasp on who they were as women and what they wanted out of life. Neither of them believed that therapy had caused them to change their desire for sexual activity, only that it had lead them to realize and accept it as another facet of their identity.

Jamie is a confident woman. She comes into the office with her midriff bared and tells me within the first two minutes of our conversation that she has been diagnosed not only as hypersexual, but also as bipolar and depressed, and that she suffers from Attention Deficit Disorder and Obsessive Compulsive Disorder. However, she believes that the diagnosis of hypersexuality is "just something else that explains another thing" about herself. Later in our discussion we come to the topic of what she considered sexually "normal" and how she understood that it in relation to her diagnosis of hypersexuality. She acknowledged the positive role of therapy:

See, it's weird because America is so hypercritical. Sex is taboo in most households, I guess you would say based on religion or whatever, but then they eat it up in any movie, magazine or whatever. Sex sells for everything

so it's like everyone knows that sex is important to everyone. Everyone is more sexual than they admit. I think that no one wants to share that information. So I have no problem admitting that I am hypersexual or whatever, and through therapy, I've been more open. Like, I used to be a very closed person, but now I can meet someone, like, that day, and I will tell them my life story with no problem. I think it really helps with any aspect of your life because it's like a release. (Interview, Jamie, December 3, 2009)

Chloe shared in Jamie's enthusiasm for the benefits of therapy and tells me that it has been great to have someone to share things with, because women are generally required to keep secrets. She was adamant in her belief that "there is no normal," and that she thought more people would benefit from the help of a therapist. At the end of our conversation she thanked me for "doing the research and talking about it," and said, "I think a lot of people don't realize they are [hypersexual] until they talk about it or talk to somebody about it. Kind of like when I went to the therapist and I was like "Oh yeah, I can talk about it."

For both of these women, while it is clear that their therapists played a significant role in leading them to the conclusion that they were hypersexual, each woman was also benefitting from what she perceives as an ability to discuss her feelings in a space free from judgment.

The Differing Views of Women and Therapist's on Sexual Addiction and
The Role of Addiction Treatment

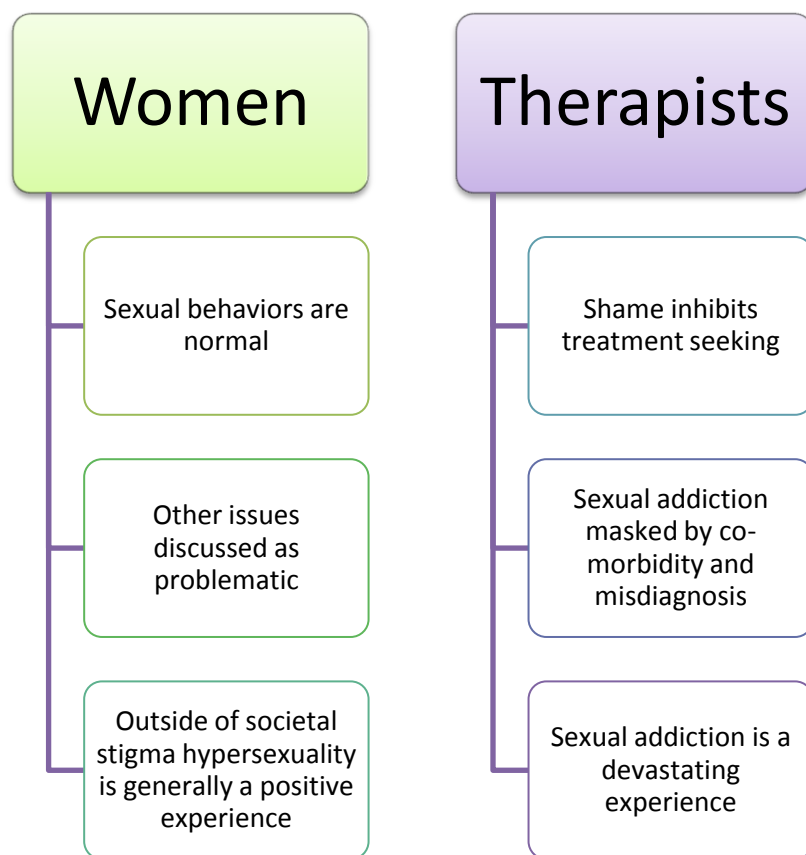


Figure 3 Opposing Viewpoints of Women and Therapists

Striking throughout my interviews with both women and therapists were the different ways that both groups spoke about motivations or impediments to treatment seeking. As the diagram above (which can be read from left to right) shows women largely viewed treatment as an admission of pathology, and thus generally did not deem therapy a largely worthwhile venture. Therapists however, constructed treatment seeking behaviors in ways which accounted for both cultural factors and medical considerations.

All therapists in my study revealed that the majority of their male clients who came to them seeking help for sexual addiction, had either been brought in by an infuriated partner or had come of their own volition because the consequences for their behavior had become so dire that therapy had seemed to be the only logical next step. However, many noted that when they saw female patients, the issue of sexual addiction was something that often surfaced later in treatment. Therapists often attributed this to a general masking of female sexual addiction by others disorders which may be deemed more socially acceptable for a female (i.e. co-dependency, depression, eating disorders).

Gray illuminated this point:

It is more common that men will come in and say, "I believe that I have a sex addiction," either because someone told them to or because their life has become so unmanageable. But women do not normally come in and say, "I have a sexual addiction." They will come in with something else: "I'm depressed," "I have an eating disorder," "I'm having sexual problems." They will say other things other than labeling it a sex addiction. There have been very few that actually have come and said that... and those women were already previously quote unquote diagnosed. (Interview, Cindy Gray, November 17, 2009)

It seemed to be a general consensus throughout my discussions with therapists that though women were more likely than men to seek treatment in general, those women did not generally self-identify as "sexually addicted." While most therapists recognized that men are not immune to high levels of shame and stigma, therapists were more likely

to attribute women's reticence in seeking treatment to culturally pervasive ideals about female sexuality, discussed in depth by women in chapter two. Here, in a narrative that conveys a common belief among therapists, CSAT Janis Neale, MA discusses why it is she believes fewer women are either sexually addicted or less prone to seek treatment for it:

There is so much shame, cultural shame. You know, you're not an addict, you're a whore. You know they are so intertwined with the story about that being a moral issue and I think it's common for men too... I can just say it's probably more extreme for women. You know, you can't be a person who acts out sexually and be a decent human being, if you're a woman. And men can get away with it because men are being men. But culturally we accept far more unacceptable behavior from men than we do with women. You know, what we define as unacceptable is usually sexual, so their shame, their core identity, they're not going to show up with that. They want to shoot themselves. They want to hide. They're scared of owning it, because it's a moral issue. Not only are they addicts, they are morally depraved, and they're whores. It's not good. It's not good. There needs to be a revolution! (laughs) (Interview, Janis Neale, December 21, 2009)

Much like her colleagues, Neale believes that more women do not seek treatment because there is cultural shame attached to the diagnosis. However, it could also be argued that women's tendencies to normalize as well as mask their behavior as revealed in women's narratives, are ways to protect themselves from totally accepting the notion that their sexual desires equates to medical pathology.

In addition, as discussed by women throughout chapter one and chapter two, most women constructed their sexual activity as something positive, something that they enjoyed. Key to many women's narratives was the idea that if they were not being judged by "others," or feeling pressured to conform to conventional notions of feminine sexuality they would not feel as if their sexual behavior was something outside of the norm, or negative.

Therapists narratives however, reveal that they generally see sexual addiction as something wholly devastating and denigrating in an individual's life. They often spoke of sex addicts as people whose lives were either on the brink of total chaos, or whose lives had already become out of control.

Key to understanding the contradiction between female and therapist beliefs about sexual addiction is to keep in mind the notion of discourses outlined in the introduction. This conflict underscores the Foucauldian concept of discourses that are constructed popularly (in this case women feeling as if they are sexually addicted or hypersexual) that don't match up with experience or behavior. Thus, while medical practitioners often treat patients whose lives have become essentially "out of control," this reality does not seem to be reflected in popular constructions of sexual addiction.

Therapists Narratives on the DSM and Treatment Seeking

The topic of whether or not "sexual addiction," or some classification which encompassed the symptoms of the disorder, should be in the DSM-V, brought forth a few different therapists' opinions on its usefulness. Some therapists believed that sex

addiction did not need its own classification because of what they perceived as the wholly subjective experience of the disorder. Others believed that since they did not accept health insurance coverage for their treatment, they found the issue of whether or not there is a diagnosis irrelevant. A few therapists said that even if there were to be a classification for the disorder in the DSM-V, they would still not use the code, given many patients' fears of being "discovered," by colleagues or bosses, and saw it as a hindrance to treatment.

However, a few therapists expressed concern that the lack of a proper diagnosis for sexual addiction in the DSM-IV made reimbursement from insurers very difficult, and consequently prevented many people, men and women alike, from seeking therapy.

For Shelley, the inability to access affordable treatment insurance factored largely in her decision not to speak with a therapist. While discussing this setback, Shelley explained, "Sometimes it's bad because you really need the help, but you can't afford the health care. So you have to live with whatever you feel is wrong with you because you can't afford to talk to somebody about it." (Interview, Shelley, December 3, 2009). As a single mother on a limited budget, Shelley couldn't afford the high hourly prices charged by most sex therapists, who often do not accept insurance because of the battles they have to wage with insurance companies to have their services recognized as medically necessary. However, it is also important to note that Shelley clearly stated that if it weren't for what she perceived of as cultural stigma for a hypersexual woman, she would not be interested in seeking treatment.

When I asked Neale, whether or not having a diagnosis in the DSM is something that has affected her as a therapist or affected her patients, she stated:

It speaks to me of the politics, because I don't think a lot of the people, so-called "laypeople," know that there isn't a diagnosis. They get it that they are acting out compulsively and if they are already an addict they don't need, you know, I've never heard anyone say, "It's not in the DSM-IV." You know, what they do say is, "I'm an addict. I get it I'm compulsive sexually." And it's not about being validated by a diagnostic. I think it impedes and inhibits financial reimbursement for therapist practitioners, so it creates a lack of access to effective and long-term treatment. And I think it's unfortunate. (Interview, Janis Neale, December 21, 2009)

What is interesting about Neale's comment is that it highlights the aforementioned ability of medical scripts to affect cultural scripts and vice versa. Neale notes that people don't even need to be guided anymore to the idea that their behavior may be pathological. This she stated, was a given. Given that notions of addiction arose from moralistic judgments about individual behavior, and then became a medical diagnosis, Neale's comment serves to remind the reader that Americans have become so indoctrinated into the discourse of addiction as disease that it has perhaps become the rule rather than the exception.

Discussion: The Role of Addiction Treatment

The idea that sexual addiction/hypersexuality is a disorder which affects many Americans is increasingly becoming a medical consensus, but what the above narratives

show is that there still exists popular confusion about the affliction. In addition, medical consensus about the best course of treatment, and the underlying causes of hypersexuality still remain field and therapist specific, which calls attention to the difficulty in essentializing a condition which ultimately relies upon an individual's subjective understanding (both of the therapist and the patient) of certain forms of sexuality as either problematic or healthy.

One contradiction that arose throughout interviews with therapists was how they perceived the role of cultural misperceptions in affecting both treatment seeking as well as individuals' beliefs about their sexuality. Some therapists argued that cultural messages which promote flagrant sexuality are fueling the rise in sexual addiction, while others realized that it was due to a lack of understanding about healthy sexuality that lead people to feel they are sexually addicted, even if technically they were not. What this inconsistency suggests is a need for more holistic views of sexuality that account for subjectivity in constructions of desires and needs as well as a recognition that outmoded beliefs about sexuality need to be reexamined if the diagnosis of sexual addiction and treatment are to be accepted as legitimate.

Female narratives uncovered a number of individual beliefs that impeded treatment seeking. These included the belief that treatment automatically equated to an acceptance that their behavior was out of control or deviant, that therapists would not be able to relate to their situation, and that treatment would be sought regarding relationship issues but not personal sexual behaviors. For some women, however, though they had not originally sought treatment specifically for hypersexuality, therapy was seen as an ideal

site for addressing their sexual "difference," and they welcomed an opportunity to be able to speak freely about an aspect of their lives usually kept private.

Significant to understanding how a majority of women in this study conceptualize of therapeutic intervention is an appraisal of the belief that seeking medical treatment would equate to acknowledging abnormality. Their prevailing perception remains that men have had centuries with which to enjoy unquestioned sexual freedom (although this may not to be exactly true, as many men experience high levels of shame and stigma surrounding their sexual desires), and that women should now be given the same privilege.

Additionally, the narratives of some of the women and therapists in this research show that it is also important for people to understand that therapy is not necessarily about changing someone into a different person, but that it is more generally geared towards helping people find comfort with who they are, or helping them to recognize and change behaviors which lead to chaos and distress.

Vital to note as well is that female sexuality has long been pathologized in numerous ways (Groneman 2000), and as revealed by the narratives of both women and therapists, there still exists the tendency for our culture to shame and stigmatize aggressive female sexuality. Couple this with the powerful influence that medical conceptualizations have on discourses on sexuality and an atmosphere is created, in which care must be taken to avoid problematizing perfectly healthy bodies.

In a climate where medical judgments of sexuality are rarely challenged, it must not be forgotten that, just like their patients, medical practitioners are not immune to the

effects of their cultures, "that their minds are located in sexed/gendered bodies...and that this fact may, and often does, affect the knowledge they produce (Lowy 1999:515)."

CONCLUSION

I believe that any time a person independently decides to label some aspect of his or her life, or body as problematic, that they are completely within their rights to do so. However, rarely do human beings, as social creatures living out lives entrenched in their cultural traditions, actually make independent decisions about how to interact with other members of their respective societies. As members of a Western culture, whose ideals about sexuality have been built upon conceptualizations of heteronormativity not solely as a theoretical construct, but as a practical means of interaction and mechanism of the discipline of conduct it is only natural that our ideas about sexuality and subsequent behaviors as well as one's sense of sexual and gender identity would be affected by and in turn affect cultural and medical discourse.

Chapter one demonstrated that while women's participation in this research suggests that they have on some level accepted the idea that their sexuality deviates from the "norm," their narratives also highlight that they believe that this is largely a problem with conventional ideology about normalcy and not inherently related to the fact that their behavior actually *is* deviant. Furthermore, they often situate their perceptions of hypersexuality within contexts which are not inherently pathological, including boredom, enjoyment, connecting to a partner, security, maturity, stress relief, love and learning more about sex and sexuality.

The most troubling aspect of the stories of women and therapists about sexual addiction is that many of the women, most of whom did not seem to fit the medical

criteria for sexual addiction/hypersexuality, felt the need to label their behavior as deviant, using medical terminology. There has been a long tradition in the United States (and indeed in many societies throughout time and place) to actively control and subjugate female sexuality in all of its manifestations, especially through the force of medical intervention. Beginning in the 19th century with the rise of psychiatry and nascent understandings about the ways biology worked to produce various behaviors, female bodies that acted outside of moralistic norms and displayed sexual interest were considered inherently damaged and diseased (Groneman 2000). Shaking this judgment, which associated femininity with an innate lack of ability for self-control while at the same time situating female sexuality as a space of passivity, still proves to be an inherently flawed and contradictory belief while at the same time it is a norm that is difficult to fully overcome.

It is salient for women to realize that perhaps their feelings of "hypersexuality" have less to do with being outside of some abstract version of normality, but instead reveals how difficult it is for a society to redefine the lines of its cultural and biological norms. Though many of the women felt that their behavior was normal and were uninterested in seeking treatment, the mere fact that they had decided to label themselves as something other than "normal," might be cause for concern. It highlights the tension that exists between our cultural ideals, which conversely treat each person as a valuable individual, while also expecting people to fit into a homogenous mold.

In chapter two women's narratives revealed that heteronormative constructions still factor largely in ordering the way people think about their own sexuality and the

sexuality of others and at the same time can be reinforced by women's use of sexual masking. While it is true that some men and women have rejected their places within the gender mainstream, many do so quietly. For many of the women with whom I spoke, it is much easier to cloak their transgressions by having sex only with established friends or within a committed relationship, by using alcohol to mask their desires, and by relying upon religious proscriptions for abstinence outside of a committed relationship, than to risk stigma and shame by openly declaring their desire for sex. In this way, though they recognize the unfairness and the inequality, they are able to remain culturally acceptable, and forego the cultural marginalization that meets so many who opt out of tradition. These narratives show that dominant ideas about gender and sexuality, though easily "bent," are not easily overcome. They also show that when a woman identifies a problem within her body or behaviors, that many times, they are identifying a problem that actually lies outside of their body, a problem whose origin lies in tradition, dogma, and culture.

In chapter three, I demonstrated that therapists are aware of the tradition in the United States to negatively label and judge certain expressions of female sexuality, which may merely represent another point upon a continuum of sexual behaviors and desires. In addition, I show that women's beliefs about the necessity for treatment reflect myriad considerations that may not always be explicitly attended to by therapists.

Interestingly, while therapist narratives uncover that they recognize a cultural reality in which women may face unacceptable levels of stigma, this does not always seem to translate to a therapist's discourse on the etiology of sex addiction, *sui generis*,

and whether some women feel they are sexual addicts because of those stigmas and not because their behaviors actually signify deviance. While some therapists did discuss attending to feelings of culturally-based guilt and shame and to general stereotyping that exists about a women whose sexual preferences lie outside of the norm, this idea still remains largely marginal to medical discussions about why sexual addiction exists in the first place, and how we go about assessing cultural causes of feeling ‘abnormality’ rather than individual causes in treating the disorder. To be clear, this is not to fault individual therapists who do note the power of cultural shame and stigma to shape the ways a person may act sexually and the difference between a patient who is feeling culturally infused shame versus suffering from a sexual addiction. However, these therapists must work within the diagnostic parameters of their profession and so this recognition should serve as a broad call for an increased and more accurate understanding of the epidemiology of sexual addiction.

Applying this Study in a Broader Academic Context

It is important to keep in mind that previous research that sought to specifically include the voices of women as central to the production of knowledge about sexual addiction is limited. The most in-depth example of research that incorporates women’s voices is that of the clinical therapist, Eric Blumberg (2003). Though the narratives offered by women in his study are often mirrored by the narratives of the women in my study, the conclusions we draw occasionally diverge in important ways. As a

psychologist, Blumberg (2003) seems to rely heavily upon what he considered to be a biological basis for his participants' high sexual drives. While Blumberg (2003:155) makes sure to point out that one cannot divorce sexuality from social construction, his statement that "the women here appear to have become highly sexual despite their interactions with society," seems to overlook the reality underscored by women's narratives in my study, that popular discourses are not static and that people can use discourse to mask "true" behaviors.

Indeed, my study shows, that although the women I interviewed do, at times face pressure to conform to sexual stereotypes, they also actively seek out alternative communities where they can speak about their sexuality openly. Some furthermore, were provided with familial support in perceiving their sexuality as a normal and healthy aspect of their lives, and others had friendship networks which helped them feel as if their label of difference was less about biological pathology and more about a cultural tendency to pathologize aggressive female sexuality.

Academic research exists not only to produce knowledge, but also to create a space for academic exchange. Thus, while differences between my conclusions and those of Dr. Blumberg's may exist, the similarities found help to establish a base upon which further research can be conducted.

As the formal diagnosis of "hypersexuality" looms in the medical near future, one CSAT's call for a more sex-positive cultural climate and a more sex-positive therapy climate deserves serious consideration. If we understand that a person's decision to

pathologize either her own behavior or that of another is often based upon their subjective understanding of what constitutes healthy sexuality, which can be swayed by cultural misperceptions stemming from moralistic evaluations, or deterministic appraisals of biology, it is important that we begin providing people with more holistic and more broadly understood information about sex and sexuality.

Anthropology, which deals largely with understanding how people order their lives, provides a perfect platform from which to begin investigating the ways that various ideologies, medical conceptualizations and personal subjectivities interact to produce nuanced understandings of sexuality. If we accept the premise that Western medicine has played a large role in shaping the ways that people discursively construct their identity, this has broad implications for understanding how people relate these concepts to facets of their lives outside of medical realms. Indeed, though sexuality may be popularly billed as a private space, what this research shows is that the boundaries of this terrain are often and invariably encroached upon by public and popular understandings, and which harks back to the second wave feminist motto, “The Personal is Political.”

The human tendency to ascribe social, spiritual and cultural meanings to all phenomena, regardless of how we understand them, makes sexuality in general a site for constant reinvention. Given this, rather than leaving something so important to chance, we should begin to consider the ways in which public institutions can go about providing more accurate, positive, honest, and inclusive representations of sexuality.

Indeed, the acknowledgment by two women in this study that their parents were integral to their formulation of positive attitudes about sexuality by having provided them

with comprehensive and holistic information about sex and sexuality deserves attention. As noted by anthropologist Catherine Ashcraft (2006:329), "with little positive acknowledgment of the ways in which they might enjoy sex or their sexuality, girls are left to decipher these feelings on their own, wondering if they are the only ones who have them."

For many years, educational and public health approaches to sexuality education have been singularly focused upon teaching young people and "at-risk" populations about the negative consequences of sexual activity. In fact, prior to the 2009 reversal of the so-called abstinence only federal law by President Barack Obama, public schools in the United States were mandated to teach only about abstinence, or risk losing federal funding for their programs. While abstinence may be a legitimate and suitable sexual preference for some, it is only one among many choices a person may make in regards to their sexual behavior. In addition, as argued by feminist scholar Amy Schalet (2009:155) even "public health researchers and professional organizations [which] have rejected abstinence-only approaches as ineffective and unethical [remain] caught up in a framework that views adolescent sexuality as a health hazard." This widespread failure to address the reality that people's sexual lives are not constructed solely upon the absence or presence of sexual activity, and the grip of views which deem sex and sexuality dangerous at their core, ignores the host of cultural, social and positive aspects which are tied into the lived experience of sexuality, and is therefore a grave oversight. If, as argued by Aschraft (2006: 342), we could offer young people a more holistic understanding of sexuality by creating "pedagogical spaces in which teens can interrogate dominant

representations of sexuality and negotiate more liberating alternatives" we could begin to challenge some of the cultural scripts, which often situate active sexuality in a negative and harshly judged context.

Given that there remains much to be understood about sexual addiction, its effects on the lives of women in general and its place in the medical field, it is exceedingly important to understand and expose the systems which may unfairly and unnecessarily impinge upon any person's ability to live their life in a way that they deem fit. This study is significant in its attempt to expose the degree to which popularly in the United States there has been a move toward abstract notions of "normality" in health and disease which are continually reified in Western culture. Furthermore, given that the subjective experience and understanding of sexual addiction from women's point of view has not been studied anthropologically, this research is an important first step in addressing this oversight.

Suggestions for Future Research

There are a number of areas that were broached in this study that would be compelling topics for future research. First as I was limited by time and access, speaking with women who were currently seeking treatment specifically for sexual addiction remained outside of the scope of this study. Conducting interviews with this population would be a valuable next step for further delving into female conceptualizations of the

disorder. Bringing in the voices of such women would enrich our understanding, and provide compelling fodder for future research and analysis of this issue.

Given the importance that many women placed upon the role of their partners in identifying their behavior as something deviant, it would be constructive to conduct research with the partners of women. Understanding how and why partners feel that their mates' behavior is something outside of the conventional norm would provide an in-depth look at the function and endurance of heteronormative ideals within partnered relationships.

Another possibility is to complete research which stratifies the sample. Uncovering the ways that socioeconomic status, age, ethnic heritage, sexual orientation, geographic origins within the United States, and religious affiliations etc... affect a person's belief that they are sexually addicted or hypersexual, would provide much greater depth and understanding of the ways that "identity" affects beliefs about the body.

As discussed in the literature review, academic and therapeutic communities are extremely interested in the ways in which pharmaceutical companies have been able to inject themselves into Western views about health. Because of the relative dearth of research which investigates the relationship between sexual addiction and pharmaceutical intervention, this intersection promises to be an apt site for future anthropological and public health research.

I end with a quote from Kaylie, because I find it important to conclude using the voice of the women who lent their time and energy to this research. Kaylie's statement is at once both troubling as well as thought provoking. Her words echo the sentiments of

many women in this study and calls for caution and pause anytime we find ourselves judging someone's sexual behavior. "I hate to sound like, you know, the big feminist, but it all fits into this system of keeping women down and making it so that women can't ever win. (Interview, Kaylie, November 4, 2009)

APPENDIX A: IRB APPROVAL LETTER



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Megan Douglass**

Date: **October 28, 2009**

Dear Researcher:

On 10/28/2009, the IRB approved the following modifications/human participant research until 10/27/2010 inclusive:

Type of Review: Submission Response for UCF Initial Review Submission Form
Project Title: Understanding the Female Conceptualization of Sexual
Addiction and the Role of Addiction Treatment
Investigator: Megan Douglass
IRB Number: SBE-09-06508
Funding Agency:
Grant Title:
Research ID: N/A

The Continuing Review Progress Report must be submitted 2 – 4 weeks prior to the expiration date for studies that were previously expedited, and 8 weeks prior to the expiration date for research that was previously reviewed at a convened meeting. Do not make changes to the study (i.e., protocol, methodology, consent form, personnel, site, etc.) before obtaining IRB approval. A Modification Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at <https://iris.research.ucf.edu>.

If continuing review approval is not granted before the expiration date of 10/27/2010, approval of this research expires on that date.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Participants or their representatives must receive a copy of the consent form(s).

In the conduct of this research, you are responsible to follow the requirements of the [Investigator Manual](#).

On behalf of Joseph Bielitzki, DVM, UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 10/28/2009 02:57:22 PM EST

IRB Coordinator

APPENDIX B: INTERVIEW GUIDES

Questions for Semi-Structured Interview with Female Sexual Addicts:

1. How did you decide you were addicted to sex?
2. Did you accept the diagnosis immediately or were you skeptical?
3. Is your addiction something that you tell family members about?
4. Why do you think that you are addicted to sex?
5. Have you sought treatment for sex addiction?
6. What is the definition of sex addiction in your own words?
7. Have you ever sought a medical intervention: pharmaceuticals, holistic treatments, Chinese medication, etc... to cure your addiction?
8. Are there any treatments that you have taken which work better than others?
9. For those participants who have sought treatment-When you entered treatment did you feel you had a problem?
10. What do you think is to blame for sex addiction in this country?
11. What does the public need to know about sex addiction?

Questions for Semi-Structured Interview with Therapists:

1. Is it more common for women than for men to seek treatment for sexual addiction or not?
2. Are there any common threads in the stories of your patients who identify their hypersexual behavior as problematic?
3. What is the most common course of treatment for female sexual addicts?
 - 3a. Is there a consensus in the field about this course of treatment being the best?
4. How do you come to the conclusion that a patient may be sexually addicted?
 - 4a. What do you use as your diagnostic criteria?
5. Are there any medications you would typically recommend for a female sexual addict? (this question for psychiatric therapists only)
6. Does the lack of a diagnosis for sexual addiction in the DSM-IV affect your decision-making during treatment?
7. Should there be a diagnosis in the DSM-IV for sexual addiction?
8. What are your perceptions about the role of 12-step/self help groups dedicated to sexual addiction?
9. Do you think that culture plays a role in supporting or undermining the diagnosis of sexual addiction or not?
11. What does the public need to know about female sexual addiction?
12. What are the underlying causes of sexual addiction in this country?

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