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The pseudoscience behind public health crisis legislation

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Beginning in 2016 in Utah, multiple jurisdictions around the world have either passed or considered passing legislation that identifies online pornography access as a public health crisis. These debates and related legislation have often involved statements that pornography acts as a neurologically altering stimulus, changing behaviours and sexual experiences, and creating patterns of self-destructive behaviours identical to those associated with substance addictions. In relying upon the language, ideological constructs, and concepts of addiction, anti-pornography activists may be hoping to bolster the legitimacy of their arguments. Certainly, the concept of sexual or pornography addiction has been uncritically adopted by pop psychology, mainstream media, and a general public. Unfortunately, the application of an addiction model to sexual behaviour, including pornography consumption, has severe limitations. Here, I will set forth some of the research findings, theoretical weaknesses, and methodological problems which are commonplace in the 'pornography is addictive' justification for anti-pornography legislation:

- (1) **Mistakes effect for cause:** a key issue in claims of porn addiction is that these arguments assume, a priori, that porn use is the cause of later issues in a person's neurological, psychological, or relational functioning (Wéry et al. 2016). However, multiple studies (for example, Wright 2012; Hald et al. 2013) have found that negative affective states such as depression or anxiety typically precede increases in use of pornography, particularly by males, who are more likely to view sex and masturbation as acceptable ways to cope with emotional stressors (Hendrick, Hendrick, and Reich 2006). Similar arguments are commonly made to blame porn for an altered sexuality; rather than investigating whether pornography is being used as a private, safe outlet for preceding or repressed sexual interests.
- (2) **Overlooks critical third variables:** claims of measurable health outcomes caused by porn ignore other variables that have considerable scientific evidence supporting them. For example, the claim that porn addiction results in erectile dysfunction ignores the research that shows it is actually quite common, occurring in up to 30% of men under age 40, and has many underlying causes (Capogrosso et al. 2013). Erectile dysfunction in young men is better explained as a result of anxiety, inexperience, or simply a normal aspect of the range of sexual functioning (Mialon et al. 2012).
- (3) **Diagnoses a moral/social conflict:** recent research has noted that many self-diagnosed porn addicts view less porn than average – they just feel worse about it. This

guilt and shame emerges from an internal conflict between their religious and moral sexual values and their pleasure in watching pornography. A majority of self-identified sex and porn addicts in treatment centres are religious, usually heterosexual, and mostly married white men (Bradley et al. 2016). Similarly, sex addiction therapists tend to come from sexually moralistic and religiously conservative backgrounds (MacInnis and Hodson 2016). Several studies now demonstrate that religious people who watch more porn tend to become less religious over time, and experience more crises of faith (Grubbs et al. 2015a).

- (4) **Promotes an iatrogenic, damaging concept:** researcher Joshua Grubbs found that over time (approximately a year, in one longitudinal study) the perception of oneself as addicted to pornography predicted later distress, depression, and dysfunction, where actual use of pornography did not (Grubbs et al. 2015c). These findings have now been replicated in subsequent research (Bradley et al. 2016; Wilt et al. 2016). Adopting the metaphors of addiction promotes perceptions of pornography use as medically harmful, which, in and of itself, may increase later difficulties. Thus, the concept of addiction, intended to be a healing intervention, may create, in this instance, greater internalized shame and distress.
- (5) **Promotes an unsupported, exploitative treatment approach:** modern behavioural health treatments are expected to be evidence based, and to have data supporting their effectiveness. Unfortunately, with nearly four decades under its belt, the field of sex addiction treatment has yet to produce a study using a randomized control design to measure the effectiveness of their treatment model, and the field is criticized for a severe lack of outcomes research (Grubbs et al. 2015b). Because the concepts of porn or sex addiction are not diagnosable, they cannot be billed to an individual's health insurance. As a result, these programmes largely operate on a cash-based business model, serving those individuals who can pay out of pocket for these services. Because porn and sex addiction are not diagnosable, they qualify as experimental diagnoses or treatment. Ethically, treatment providers should be informing their patients of this, and obtaining consent to move forwards with an unsupported, controversial diagnosis and treatment (Moser 2013).
- (6) **Stigmatizes marginalized sexual communities:** rates of porn use are consistently higher in men who identify as gay or bisexual. Early studies in support of the concept of porn addiction found significant overrepresentation of gay and bi men (Cooper, Delmonico & Burg 2000). Nationally representative samples reveal higher rates of porn use in adolescents and adults who identify as non-heterosexual (Valkenburg 2011). Studies of clinical samples have found similarly high rates of gay and bi males (Green et al. 2012). Research testing-proposed Diagnostic and Statistical Manual 5 hypersexual disorder criteria found that gay and bi males were more than three times as likely to be in sex addiction treatment settings, compared with rates of gay or bi men in comparable substance abuse or mental health facilities (Reid et al. 2012). The concept of sex addiction itself has a long history of moral and clinical opposition to homosexuality (Reay, Attwood, and Gooder 2015).
- (7) **Defining problem porn use as a brain disease increases mental health stigma:** in 2011, the American Society for Addictive Medicine defined addiction as a 'primary, chronic disease of brain reward, motivation, memory and related circuitry' (American Society for Addictive Medicine 2011a). They included sex as a part of this definition of

addiction, and explained that their intent was to shift policy around addictions away from just substances and to ‘focus on the underlying disease process in the brain that has biological, psychological, social and spiritual manifestations’ (American Society for Addictive Medicine 2011b, 3). This policy stance is consistent with the belief that presenting addiction, or mental illness in general, as a biological, brain-related problem decreases stigma and increases the chances that people will seek help for problems. Unfortunately, this belief is unsupported by science, as addiction cannot be reliably diagnosed or distinguished through neurological markers. Furthermore, the neuro-centric approach is ‘reductively inattentive to individual variables and social context’ (Courtwright 2010, 144). Describing porn addiction as a brain disease may actually increase stigma towards people, by portraying them as having an irrevocable biologically based problem (Hammer et al. 2013), and may even serve to justify current and future discriminatory behaviours which impede social justice and rely on gender or racial stereotypes (Hart 2017).

- (8) **Uses argument by analogy:** proponents of porn addiction concepts rarely rely on actual research or theory regarding pornography’s impact or effect. Instead, they suggest that pornography consumption has similar effects on the brain as drugs or alcohol. Often, they point to cross-sectional studies which found neurological differences between those who use high levels of pornography and those who do not (for example, Kühn and Gallinat 2014; Banca et al. 2016). However, these studies consistently ignore critical predisposing variables of sensation-seeking, attentional bias to novelty cues, and libido. It is likely that these neurological differences are real, at least in part. However, these neurological differences could precede the pornography use, and may therefore be intrinsic (not to mention harmless) to the individual.
- (9) **Rests on a priori assumption that pornography is unique from other media:** porn addiction arguments often implicitly or explicitly treat pornography as a ‘Supernormal-Stimulus’, with a universal, overriding negative effect (Gottman and Gottman 2016). However, substantial research exists demonstrating the potentially positive effects of pornography use (for example, Hesse and Pedersen 2017). In other words, pornography may or may not have an impact, positive or negative, on an individual, in the same way that some people love *Sound of Music* and others do not. Research by Hald and Malamuth (2015) on sexual violence and pornography exposure indicate that a person’s response to pornography is highly contextual to their personality and experiences.

Conclusion

There are people who are experiencing challenges integrating pornography into their life. Unfortunately, the label of porn addiction is commonly thrown at these individuals in a manner which feeds moral panic, diverts attention and resources from effective, evidence-based strategies to support these individuals, pathologizes otherwise-benign behaviours, serves a profit-driven, exploitative industry, and confuses cause and effect. The label of porn addict increases the sense of hopelessness that individuals struggling with their porn use experience. It takes our focus away from the person, places it on pornography, and ignores the user’s social, religious, and personal contexts. Alternative strategies

for supporting these individuals include: providing greater sexual education; helping them to understand the origin of their struggles; assisting them to evaluate and reconcile their moral beliefs with their sexual behaviours; assisting them in learning how to communicate and negotiate around sexual needs and desires; addressing empathy within relationships; enhancing impulse control and mindfulness; and educating them about ways to achieve sexual health. To assist most effectively, we must evaluate and consider those contextual variables, and allow them to guide our individual, therapeutic, and public responses.

Disclosure statement

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