How the Concepts of "Sex Addiction" and "Porn Addiction" are Failing Our Clients

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It is tough to dispute the adage "sex sells." Sex is used to sell almost everything imaginable. But the titillation of half naked, beautiful people is only one aspect of sex that draws people's attention. The use of shame and moral judgment about sex and sexuality has also become a highly profitable industry.

One of the more obvious examples is reparative (or conversion) therapy. It leverages shame and moral judgment about sexual diversity to sell scientifically unsupported and discredited therapy techniques to vulnerable individuals. Fortunately, rational minds have begun to prevail. There are multiple efforts being made on many fronts to eliminate and even make the practice illegal.

Since the 1980s, the concepts of "sex addiction" and "porn addiction" have utilized sex-negativity to promote and sell unfounded and unproven services. Proponents of "sex/porn addiction" claim that individuals become addicted to sexual pleasure or to watching pornography in the same way someone may become addicted to substances. Instead of approaching sexual variety as a healthy part of the human experience, they leverage society's inherent sexual shame and convince individuals that any unconventional sexual behavior is pathological.

The basis of such sex-negativity has historical roots dating back to Benjamin Rush, physician and signer of the Declaration of Independence, who declared that masturbation and sex were the cause of scourges and illnesses (including blindness). A hundred years later, Kellogg and Graham, inventors of the cereal corn flakes and the graham cracker, respectively, believed that spicy foods inflamed the senses and encouraged sex and masturbation. Corn flakes and graham crackers were developed to reduce masturbatory urges.

The concept of "sex/porn addiction" has so pervaded our culture that people, organizations and government entities treat the terms as foregone conclusions that must be supported by factual, scientific evidence. Unfortunately this isn't the case. For example, the state of Utah recently passed a resolution declaring pornography a "public health crisis, hazard and epidemic." During a radio interview the resolution's author, Senator Todd Weiler, was asked about research that contradicted his statements. He said, "I'm not interested in delving into the hard science." (Fabrizio, 2016). Hardly a day passes that there isn't an article published on this topics with much inflammatory and often inaccurate information being shared in seemingly credible ways.

It may be too much to expect laypersons or politicians to delve into the science and evidence behind mental health diagnoses and treatments. However, this *IS* the ethical and clinical responsibility of practitioners and professional associations. And yet, through misinformation touted by certain professionals in the field, many well-intentioned therapists are providing treatment not only unsupported by current research, but that has proven ineffective and even harmful.

Some people do experience sexual behavior that can become problematic, even dysfunctional or unmanageable. The objection is with the use of the term "sex/porn addiction" to describe a virtually unlimited array of sexual expression that falls outside of the typically Judeo-Christian view of heterosexual marriage. The terms contribute to a sex-negative, pleasure-phobic tone in American society and pathologizes any behavior that is not deemed "normal."

This is a point made clear by sex addiction advocates' own rhetoric. Three of the guiding principles of Sexaholics Anonymous include the notion that (1) sex is most healthy in the context of a monogamous, heterosexual relationship, (2) sexual expression has "obvious" limits, and (3) it is unhealthy to engage in any sexual activity for the sole purpose of feeling better, either emotionally or to escape one's problems. These principles do not represent science or most people's experiences. Instead, they hold to restrictive and repressive definitions created by sex addiction proponents acting as keepers of the scepter of morality and normalcy without the authority to back them up.

So, what does science actually say about addiction, sex and pornography? Here's a current snapshot:

What We Know About Addiction

The utility of the term "addiction" has long been disputed. In 1964, the World Health Organization (WHO) declared the term to be clinically invalid, recommending "dependence" in its stead. Dependence can exist in varying degrees of severity as opposed to an all-or-nothing disease model (as it is still commonly perceived). The terminology "chemical dependency" and "substance abuse" became the standard, and was considered more appropriate and clinically useful.

A common assertion put forth by proponents of sex addiction states that the chemical actions in the brain during sexual activity are the same as those involved in alcohol and drug use, and that both sexual activity and substance abuse share reward and reinforcement mechanisms that produce the "craving" and "addictive" behaviors. This assertion is flawed on several levels, not the least of which is

that it is based on drawing conclusions from brain scan imaging that is devoid of any real interpretive foundation. It is a stretch to equate the neurophysiological mechanisms which underlie chemical dependency, tolerance, and withdrawal with the diverse factors that contribute to self-regulation problems consistent with gambling, shopping, eating, sex and other so-called "process addictions."

The Diagnostic and Statistical Manual (DSM) states that the word addiction was not included as part of the official DSM-5 substance use disorder diagnostic terminology because of unclear definition and its potentially negative implication (American Psychiatric Association, 2013). It does not appear in any of the International Classification of Diseases (ICD-10) (World Health Organization, 1992). "Abuse" and "dependence" do appear in the DSM, relevant only to substance use patterns, but "addiction" does not. Similarly, there is an ICD-10 code for "substance dependence," but not addiction. Even without acknowledging the many trivial uses of the addiction concept (bumper stickers stating "addicted to sports, not drugs," "deliciously addicting" cookies, or "chocoholic" T-shirts), consistent clinical definitions do not exist.

In spite of these problems, a disease-model of addiction has emerged and taken center-stage since the development of a specialty known as "addictionology." Made up primarily of physicians, but including a variety of "addiction professionals," this field has helped forge a treatment industry based on the addiction model that is at the core of 12-step fellowships (i.e., Alcoholics Anonymous, Narcotics Anonymous, etc.). The 12-step model is a central component of many treatment programs, despite its status as a form of social support as opposed to clinical treatment. While facilitated 12-step treatment does have some clinical support with substance use disorders, the effectiveness of 12-step theory in addressing sexual behaviors has never been evaluated, and there is no evidence to support it as a clinically appropriate model in residential treatment.

What We Know About Sex Addiction

American sex researcher Alfred Kinsey famously said that a nymphomaniac is someone who has more sex than you do (Pomeroy, 1972). Subjectivity is an unavoidable hurdle within the process of assessment and diagnosis of "sex addiction." How much sex is too much? And who gets to decide? There are no reliable answers. At one point, sex addiction researchers claimed that having an orgasm an average of once a day was addictive and destructive (Kafka, 2010). However, with setting the bar at this level is that it would have diagnosed and pathologized an inordinate amount of the population (as many as forty percent of men) (Winters, Christoff, & Gorzalka, 2010).

Diagnostic subjectivity is not the only problem with using the sex addiction model. In recent years, many of its core components have been empirically tested and consistently debunked. Those labeled as "sex addicts" are considered (and self report) as having executive function deficits in areas such as impulsivity and self-control, which is taken as further evidence of their "disease." However, data that includes neuropsychological testing show that those identified as sex addicts have just as much self-control and executive functioning as their counterparts, that libido predicts sexual behaviors much better than measures of addiction, and that an internalized religious-moral conflict over sex is at the core of the sex addiction label (Winters, Christoff, & Gorzalka 2009; Winters & Christoff, & Gorzalka, 2010; Reid, Garos, Carpenter, & Coleman, 2011). Researchers at UCLA have demonstrated that there is no evidence of the brain patterns associated with chemical addictions in those who are self-described sex addicts, and found evidence that pre-existing traits such as libido and sensation-seeking explain far more of the variance in people's behaviors (Prause, Steele, Staley, Sabatinelli, & Hajcak, 2015).

Research invoked by proponents of the sex addiction model is overwhelmingly based on cross-sectional data, poor research design, extreme sample bias, and core assumptions which are rarely, if ever, considered or tested. For instance, sex addiction therapists would commonly assume that when a clinically depressed man reports he is having lots of sex or watching lots of porn, that the sex or porn are causally related to the depression. Instead, longitudinal research has revealed in multiple cases that sex and porn viewing are ways in which males commonly, and effectively, cope with negative emotions (Wright, 2012). In other words, sex addiction mistakes a symptom for the cause.

Another issue is that the "sex addiction" label is disproportionately applied to males. Estimates suggest that 82%-88% of those seeking treatment are men (Guigliamo, 2006, as cited in Carnes, 1992; Wines, 1997). In the hypersexual disorder field trials, the most recent sexual behavior disorder criteria that was proposed, researched and rejected for the DSM, 95% of the hypersexual test group was male compared to only 60% of the comparison group (Reid et al., 2012). The list of sexual behaviors that are allegedly addictive is dominated by stereotypically masculine sexuality. Things like masturbation, pornography, cyber-sex, going to strip clubs, engaging prostitutes, and even infidelity are all behaviors that over a century's worth of sexuality research have demonstrated as common, if not virtually universal, in men. Even when women are diagnosed as sex addicts, it is usually because they are either seen as "acting like men" or are being stereotyped as "loving too much."

Sex addiction is also used as a way to pathologize homosexual behavior. With the growing resistance to reparative therapy, sex addiction therapists (again without evidence) suggest that "sex addictions" cause "unwanted same-sex attraction." A recent piece in the Huffington Post, *Sex Addict or Gay Man?* states "sexual addiction expert Robert Weiss recognizes that it can be difficult for some people to differentiate between sex addicts and regular gay guys in a sexually liberated—some would say oversexed—gay culture" (Barucco, 2016). This suggests that the behaviors sex addiction therapists pathologize are so commonplace that they are indistinguishable from "regular" behavior.

While sex addiction proponents are worrying about people having too much or the wrong kind of sex, there is a large body of research that says sex is linked to positive outcomes. Unfortunately, this data gets ignored in the "sex addiction" dialogue when the focus

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highlights danger and disease. For example, sexual activity and enjoyment have been linked to greater longevity (Davey Smith, Frankel, Yarnell, 1997; Palmore, 1982; Persson, 1981), better coronary health, reduced instances of fatal coronary events, reduced damage as a result of heart attack, and reduced rates of endocrine diseases and type-2 diabetes (Brody, 2004; Mamtani & Kulkarni, 2005; Rexrode, 1998; Smith et al., 2005). Studies have also linked increased frequency of sex to reduced rates of breast cancer and prostate cancer (Giles et al., 2003; Lê, Bacheloti, & Hill, 1989; Leitzmann, 2004; Petridou, Giokas, Kuper, Mucci, & Trichopoulos, 2000; Rossing, Stanford, Weiss, & Daling, 1996) and improved immune systems (Charnetski & Brennan, 2001). The list goes on—improved sleep (Ellison, 2000; Odent, 1999), youthful appearance (Weeks & Jamie, 1998), reproductive health (Brody & Krüger, 2006; Exton et al., 2000; Krüger, 2003; Meaddough, Olive, Gallup, Perlin, & Kliman, 2002), improved fertility (Bancroft, 1987; Blaicher et al., 1999; Cutler, 1991; Kunz, Beil, Deininger, Wildt, & Leyendecker, 1996; Levin, 2002; Levitas et al., 2005; Singh, Meyer, Zambarano, Hurlbert., 1998; Wilcox, Weinberg, & Baird., 1995; Wildt, 1998), and better pain management, including chronic pain, menstrual cramps, migraines, muscle pain and lower back pain (Alaca, Goktepe, Yildiz, Yilmaz, & Gunduz, 2005; Biering-Sorensen et al., 2005; Ellison, 2000; Evans & Crouch, 2001; Halstead and Seager, 1991; Komisaruk & Whipple, 1995; Shapiro, 1983; Whipple & Komisaruk, 1985; Whipple & Komisaruk, 1988).

The benefits go beyond physical health. Research is connecting sexual expression to improved quality of life, higher self esteem, and reduced levels of stress, depression, and suicide (Bagley & Tremblay, 1997; Brody, 2006; Catania & White, 1982; Ellison, 2000; Gallup,Burch, & Platek, 2002; Hurlbert & Whitaker, 1991; Laumann, Gagnon, Michael, & Michaels, 1994; Marwick, 1999; Nicolosi, Moreira, Villa, & Glasser, 2004; Walters & Williamson, 1998; Warner & Bancroft, 1988; Weeks, 2002).

What We Know About Porn Addiction

Pornography has become the most recent target of sex addiction therapists and the sex-negative forces in our culture. It has been identified as one of the key indicators of sex addiction as demonstrated by the Sex Addiction Screening Test, developed by Patrick Carnes (Sexual addiction screening test (SAST; Carnes, Green, & Carnes, 2010). It asks questions such as "Have you purchased services online for erotic purposes (sites for dating, pornography, fantasy and friend finder)?" and, "Have you subscribed to or regularly purchased or rented sexually explicit materials (magazines, videos, books or online pornography)?" These questions imply that any use of pornography or erotic material is an indicator of sex addiction and ignores the fact that many people use pornography in healthy personal and relationship-enhancing ways.

The ills attributed to viewing pornography are extensive. Among other things it is claimed to be the cause of erectile dysfunction, unsafe sexual practices (such as not using condoms), misogyny, and sexual violence all while destroying relationships. A look at the research suggests that once again these claims are not based on scientific data. A recent research study looked at the brainwave patterns of men and women as they viewed sexual images. Those patterns were compared to the brainwave patterns of drug addicts. A conclusion that pornography is addictive should arguably be evidenced by consistent brainwave patterns between the two test groups. Instead, the results showed the opposite. Where the brainwave patterns of drug addicts spiked when they were shown images of their drug of choice, the brainwave patterns of study participants troughed when they were shown sexual images. (Prause, Steele, Staley, Sabatinelli, & Hajcak, 2016).

While it might be logical to assume that identifying as a "porn addict" would be directly related to the amount of porn watched, research shows that seeing oneself as a porn addict is predicted not by how much porn one views, but by the degree of religiosity and moral attitudes towards sex one holds (Grubbs, Exline, Pargament, Hook, & Carlisle. 2014; Hook et al., 2015). Follow up research demonstrates that it is the perception of being a porn addict that is linked to psychological distress as opposed to the pornography itself (Grubbs, Stauner, Exline, Pargament, & Lindberg, 2015). Recent research also shows that identifying as a porn addict increases distress over time regardless of the amount of porn watched. Again, it isn't the act of watching porn itself that causes distress, but rather, the conflict between childhood religious and sexual values and current sexual behavior (Griffin et al., 2016).

Religiosity may not only impact the client but may also impact how a therapist assesses situations involving sex and porn. Research shows that therapists who identify with a higher level of religiosity were more likely to rate sexual behavior as pathological than therapists who identified as less religious (Hecker, Trepper, Wetchler, & Fontaine, 1995). In another study, therapists with a higher level of religiosity rated the use of porn as more severe and the client as more highly addicted than therapists with lower levels of religiosity

(Hertlein & Piercy, 2008). To add to the issue, results of a study by MacInnis and Hodson (2016) "indicate that religiousness influences perceptions of viewing sexual content online, even to the point of inaccuracy or denial. For example, those higher in religiousness were less accepting of factual results that violate their personal beliefs" (page 207).

There are large numbers of websites dedicated to promoting the idea that pornography is a direct cause of erectile dysfunction. While pornography-addiction advocates state this as fact, two recent studies found a negligible correlation between pornography and erectile dysfunction and no evidence of causation (Landripet & Štulhofer, 2015; Prause & Pfaus, 2015).

Another frequently cited indicator of "sex addiction" is unsafe sexual practices. Pornography- addiction proponents suggest that porn use is a driver of unsafe sexual practices, such as not using condoms. Multiple studies have found that pornography is not connected to a lower rate of condom use nor promotes unsafe sexual behavior (Jonas, Hawk, Vastenburg, & Groot. 2014; Martyniuk, Briken, Sehner, Richter-Appelt, & Dekker, 2015). Further, one study showed that viewing male porn where condoms were used is correlated with actual condom use with a partner (Schrimshaw, Schrimshaw, Antebi-Gruszka, & Downing, 2016).

There is a strong belief among many people that pornography contributes to misogyny and violence towards women. Research found that both male and female adult film watchers held more egalitarian (i.e., equal) views of gender compared to non-watchers. They also held more positive attitudes toward women holding positions of power and toward women in the workplace (Kohut, Baer, & Watts, 2015). A literature review found that rather than pornography being connected to increased sexual violence, higher porn use was linked to lower rates of rape and sexual assault (Ferguson & Hartley, 2009). This was a finding consistent across cultures.

Like many things, spending time viewing porn can have a negative effect on relationships, depending on the sexual expectations of any given couple and especially when it becomes a preferred substitute to interacting with one's partner. However, porn use in these instances is more symptomatic of underlying relational issues and not indicative of inherent problems with the viewing of sexually-explicit material itself. Research also suggests that watching sexually-explicit materials can promote higher relationship satisfaction (Frederick, , Lever, Gillespie, & Garcia, 2016).

The Way Forward

Despite the huge marketing success by the sex and porn addiction industry, the social acceptance of the concepts of "sex/porn addiction" has not swayed the American Psychiatric Association, nor other mainstream professional and academic institutions and associations to accept these as legitimate clinical diagnoses. For decades, sex and porn addiction proponents have been challenged in the academic press to produce scientific studies and research to back up their hypotheses and for decades they continue to fall short. The studies they cite have been roundly criticized as subject to severe sample bias, based largely on anecdotal reports, and have no "gold-standard" studies employing randomized designs and control groups. Ironically, many in the "sex addiction" industry see this lack of scientific and empirical support as something of a "badge of honor," wearing it as an indication that they are "outsiders" in the therapeutic community—a status that confers the role of a revolutionary fighting the establishment on behalf of the silent sufferers.

The focus on addiction is a disservice to patients. It promotes treatment based on an addiction theory that has no empirical legitimacy—treatment for which there is no evidence of effectiveness in the area of sexual problems. Proponents of "sex/porn addiction" often encourage using a 12-step community, which may be harmful for many who are referred. There is no evidence of effectiveness of 12-step programs as applied to sex addiction (Dodes & Dodes, 2014; Hook et al., 2015). Furthermore, they often perpetuate the sexual shame and stigma founded in the moral judgment and religiosity of our sex-negative culture. It is important to note that 12-step programs are peer support groups and not equivalent to clinical treatment.

Treatment should be focused on helping individuals resolve those inner conflicts that are interfering with sexual functioning or relationships. For some, sexual self-soothing can be normalized and integrated into a well-balanced life. For others, the resulting distress from mood disorders, anxiety, and impulse control problems should be addressed. These are the approaches therapists use on a regular basis when helping individuals resolve issues indicative of childhood/religious mores and family/relational pressures which may not coincide with current behaviors and personal decisions.

The answer is not to identify these individuals as pathological or mentally ill. Rather, we can help them sort through their values, use self-compassion, and resolve complexities associated with cognitive dissonance. We can utilize the many evidence-based approaches to treating depression, anxiety, fear, poor coping mechanisms, obsessive-compulsive patterns, and other related issues that result from these conflicts. When we allow the moral judgments against sex and pornography to distract us from these well known, empirically-informed approaches, we do our clients a great disservice. They deserve treatment that is based in science, not opinion or arbitrary rhetoric, and that has demonstrated sustainable efficacy. Approaches that focus on passing moral judgment are doing harm in a profession where we have pledged to do the exact opposite.

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