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The moral maze of sex & porn addiction

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ABSTRACT

Sex addiction, a term first coined in the early 80s, has always been met with controversy. Some say the label of addiction is an excuse used by those who have lost their moral compass or refuse to accept responsibility for their sexual choices. Others claim the label is used to pass moral judgement on those whose sex lives or internet viewing habits do not fit societally prescribed norms. The acceptance by WHO of CSBD (Compulsive Sexual Behaviour Disorder) into ICD11 was heralded as a moral victory by the sex addiction naysayers who claimed WHO's position 'proved' it wasn't an addiction; conversely sex addiction professionals claimed victory saying that finally this was a step in the right direction. This paper will explore the divide and provide insight on how using a pure medical model of addiction has contributed and fueled the debate. An alternative model for conceptualization from a biopsychosocial perspective will be provided to suggest ways of moving forward that could ease the controversies as well as opening new areas for research and most importantly, greater understanding and empathy for clients.

1. Introduction

The first literature review on sex addiction was published in 1998 by Gold and Heffner (1998) and began by stating there was little empirical data to support the concept of sex addiction and concluded that 'if' sex addiction exists, further research was imperative due to the potential consequences of 'reckless' sexual behaviour. A second literature review in 2020 (Grubbs et al., 2020) explored a subsequent proliferation of literature, some of which addressed the criticisms of Gold & Heffner and concluded there is now clear evidence that compulsive sexual behaviour is a real phenomenon, but research is still woefully lacking in theoretical integration, methodological rigor, epidemiological studies and treatment outcomes. What these two papers have in common, along with almost every other paper written about sex and porn addiction, is the issue of morality.

Whether you're a scientist, researcher or clinician, the subject of sex and porn addiction is difficult to address in almost any domain, whether public or professional, without mention of the moral implications. Indeed, using the metaphor of the maze, finding a route through the topic without hitting a moral block, a dead end, is nigh impossible and it's easy to feel you're going around in circles getting increasingly confused and disorientated. There are many different paths to be navigated in the maze, including nomenclature, definition, nosology, conceptualization, diagnosis and treatment. Regrettably the maze doesn't just affect professionals, but also those who are seeking help, with the first hurdle for many being knowing what to call it.

Though many names have been suggested, including sexual compulsivity, hypersexuality, out of control sexual behaviours, dysregulated pornography use and problematic pornography use, to name a few, sex addiction and porn addiction continue to be the most common terms used (Cavaglion, 2009; Perry, 2019; Taylor, 2020; Wordesha et al., 2018). Most recently CSBD (Compulsive Sexual Behaviour Disorder) was accepted by WHO (World Health Organization) into ICD 11, despite receiving the highest number of submissions of all mental disorders, including antagonistic accusations of conflicts of interest and incompetence (Fuss et al., 2019). The definition accepted by WHO explicitly addressed one of the most common concerns, namely self-diagnoses based on moral incongruence (Grubbs et al., 2019) by emphasizing that CSBD should not be diagnosed based on psychological distress caused by moral judgements or disapproval (Kraus et al., 2018). But as will be discussed in this paper, the controversy has not abated.

Whilst there are many paths to be explored within the moral maze of sex and pornography addiction, this paper will focus on how the term 'addiction' has fueled the debate and offer a model of addiction that can guide people out of the maze. But first, we need to look at the context within which this debate sits, namely the eternal moral minefield that is human sexuality.

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2. The morality of sexuality

Ever since Adam and Eve, the physical act that creates human life has been both feared and revered. Whilst sex may be an intimate act, it is also a political one, because reproduction has significant social consequences. Subsequently, the issue of sexuality has played a profound role in all major religions and within the belief systems of most of the world's cultures throughout the ages. Sexual mores constantly change and responsibility for who and how sex is controlled oscillates between the individual, the family, the church and government.

Like sex, pornography seems to have been around almost since the dawn of man with erotic illustrations found in caves in France which are thought to be 37,000 years old. From the 15th century, when the printing press was invented, the public enjoyed 200 years of unlimited access to erotic images and words until obscenity laws were gradually introduced, ostensibly to protect the public from corruption. As societies have evolved, so too has the perception of pornography and obscenity. From ancient Greek sculpture, through renaissance nudes, to topless glamour models and hentai - the evolution, the desire and the objections continue.

The role of science within sexuality is also ethically challenging with many objecting to what is seen as the medicalisation of sexuality (Tiefer, 2004; Markovic, 2017; Kleinplatz, 2018). The presence of sexual 'dysfunctions' within the medical literature, assumes there is a right way to sexually 'function'. For example, DSM-5 includes HSDD (Hypoactive Sexual Desire Disorder) and ED (Erectile Disorder) as sexual dysfunctions which begs the question what is 'enough' sexual desire and how do you measure an adequate erection? Furthermore, if one uses the language of sexual 'health' then does the presence of a dysfunction mean one is sexually unhealthy? It's often thought that the moral dilemmas around healthy sexuality are predominantly the domain of religion, but these challenges also plague the scientific and sexology field.

There are also significant global differences in the moral judgements made about healthy sexuality, largely dependent on a country's dominant culture; this is especially noticeable around attitudes towards gender, sexual and relationship diversity. Though no global research has been undertaken on perceptions of sex and pornography addiction there is awareness that research undertaken within the North American cultural context cannot automatically be applied to other countries or cultures (Grubbs, Le, & et al., 2020). The hottest porn addiction debates seem to be within the US, which may be due to a greater volume of research (Grubbs, Hoagland, & et al., 2020), or greater religiosity (Lewczuk et l., 2020) or the prevailing dominant discourse of a disease model of addiction (Hall et al., 2015; Heather, 2017); or perhaps it's simply because the concept of sex addiction began in the US.

3. The history of sex addiction

The term sex addiction became popularized through the work of Patrick Carnes in the US over 30 years ago (Carnes, 1983) and the moral outrage that ensued has remained largely unchanged to this day. Carnes was a prison psychologist who based his theory of sex addiction on his clinical observations. He described sex addiction as being almost identical to drug and alcohol addiction with identifiable features of excessive, dangerous and out of control behaviour that progressively led to significant harmful consequences. The primary treatment interventions proposed were ones based on the Minnesota model which included establishing sobriety, exploring character defects and accepting powerlessness over the disease; interventions that, at the time, were widely considered effective in treating chemical addictions.

One of the earliest opposers of the sex addiction label was sexologist John Money who described it as a "newly coined term for a disorder as fictitious as thirst addiction, hunger addiction or reading addiction" (Money & Lamacz, 1989) adding that it was based on an antisexualism theory. Other critics arose from the American sexologist community including Eli Coleman who proposed that the behaviours Carnes observed were better viewed as a compulsive attempt to soothe other underlying issues (Coleman, 1991) and Marty Klein who accused Carnes approach as pathologizing healthy sexuality (Klein, 2002) and later suggested problems with porn are due to gender differences, not addiction (Klein, 2016). Meanwhile the concept of sex addiction was attracting growing media attention with a number of male celebrities checking into luxury rehabs to treat their infidelity. This led other critics such as Ley (2014) a clinical psychologist specialising in sexuality, to claim that the label sex addiction was invented to excuse men from taking responsibility for their sexual choices and create a treatment industry driven by economic greed. The body of dissention grew claiming the sex addiction label, and the emerging label of porn addiction, were based on questionable research and subjective moral judgements (Steele et al., 2013; Grubbs, 2015; Reay et al., 2015; Williams et al., 2020; Taylor, 2019).

In 2016, after growing pressure from sexologists in the US, AASECT (American Association of Sexuality Educators, Counsellors and Therapists) released a position statement on sex and porn addiction stating they did not find sufficient empirical evidence to endorse the sex addiction model, adding that the methods used for both treatment and training were not informed by accurate human sexuality knowledge. However, equivalent bodies in other countries have not followed suit such as EFS (European Federation of Sexology) or SAS Society of Australian Sexologists. Indeed, the UK equivalent, COSRT (College of Sexual and Relationship Therapists), of which I am an accredited member, went on to approve sex addiction training and a growing number of psychosexual therapists within the UK work in the field.

On the other side of the debate were those who alleged compulsive sexual behaviours did warrant the addiction label, pointing to their own body of research which highlighted similarities with chemical addictions (Love et al., 2015; Carnes & Love, 2017; Cuesto et al., 2020; Wilson, 2020). Much of this research was strongly challenged, as indeed was the 'scientific' language that was used (Clarkson & Kopaczewski, 2013; Williams, 2016; Burke & MillerMacPhee, 2020; Prause & Williams, 2020). Whilst a growing number of addiction professionals added sex and porn to their list of addictive behaviours, ASAM (American Society of Addiction Medicine) updated its definition of addiction in 2011 to include behavioral addictions such as food, gambling and sex; stating that like chemical addictions, sex addiction was a chronic disease of the brain. In addition to the professional supporters of the addiction label were those who seized the term to bolster anti-porn agendas and use it as a portent of doom against sexual liberalism.

In between the polarities of opinion were more moderate voices who, rather than refuting the addiction label completely, took a cautionary stance; warning against using the addiction label without further clinical evidence and research (Voon et al., 2014; Larkin et al., 2006; Griffiths, 2016; Kraus et al., 2016)). When WHO (World Health Organization accepted CSBD (Compulsive Sexual Behaviour Disorder) into ICD11 in May 2019, a now irrefutable problem that was rapidly growing was formally acknowledged. But with CSBD under the heading of 'impulse control disorders', rather than 'addictive disorders' the controversies of nomenclature, conceptualization and treatment did not abate. Supporters of sex addiction proclaimed WHO's clinical recognition as a victory for their cause, citing the history of compulsive gambling as proof that it's only a matter of time before the research catches up and CSBD will be put in its rightful category of addictive disorders. Meanwhile the US sexologists claimed the victory saying WHO's decision was further proof that an addiction model could not be applied to problematic behaviours with sex or porn.

4. The addiction model

What all of these arguments have in common is that they assume a disease model of addiction and whilst the merits of this definition of addiction are contested in terms of accuracy, so are their ethical and moral merits. The 'disease' of addiction is often coupled with denial of

self-responsibility and absence of choice and subsequently they often lead to being trapped within the addiction maze by stigma and shame (Hall et al., 2015; Lewis, 2015; Heather, 2017; Taylor, 2019). In the realm of human sexuality where morality and ethics have always loomed large, further opportunity for stigma and shame is understandably unwelcomed.

The ethical and moral challenges of a disease model are especially problematic when applied to human sexuality for two distinct, but closely related reasons. Firstly, an oversimplification of sexuality focusing on physical behaviours and functioning and secondly an assumption that abstinence is the route to recovery. The World Health Organization's definition of sexual health includes emotional, mental and social well-being in relation to sexuality, not just physical, and goes on to say that sexual health is more than an absence of disease. The goal of recovery from sexual addiction or porn addiction, is to achieve positive, fulfilling sexuality and hence a disease model of the problem does not suffice. Furthermore, establishing 'sobriety', to use the common language of addiction, does not mean abstinence but rather defining which aspects of sexuality are deemed unwanted and damaging. The limitations and risks of relapse associated with focusing addiction recovery purely on abstinence, as is often the case in disease models, is challenged in chemical addiction (Laudet, 2011; Kelly et al., 2018) but with sex and porn addiction, defining what should be abstained from has further moral implications, as it will vary from individual to individual.

In the moral maze of sex and porn addiction defining healthy, non-compulsive sexuality is where many get lost, because there is no single path to follow. Assuming sexual behaviours are within the law, it is up to the individual to decide what is permissible. But if sexual behaviours are causing considerable harmful consequences in someone's life, yet they feel compelled to continue and unable to stop, then they may question if they have developed an addiction to the behaviours. Whether the label of 'addiction' is an accurate diagnosis is debatable, and not the focus of this paper, but whatever the nomenclature, including CSBD, if a disease or medical lens is used, then the risk of oversimplified conceptualization, and therefore treatment, remains; risks that can be significantly reduced by using a biopsychosocial model.

Over recent years, biopsychosocial models have gained popularity among addiction professionals (Griffiths, 2005; Lewis, 2015; Heather, 2017; Chandler & Andrews, 2019; Heather et al., 2018) and it was first applied to sex addiction in 2010 (Samenow, 2010) and expanded upon from a psychosexual perspective in 2011 (Hall, 2011) to provide more space for the nuances of human sexuality. Whilst a biopsychosocial lens provides clear advantages over a disease model by allowing space for psychological factors to be explored along with a client's socio-cultural constructs and context, it still omits crucial elements when applied to sexuality.

5. The BERSC model

The BERSC Model (Hall, 2011; Hall 2013) evolved from a biopsychosocial model to specifically address relational and cultural factors that also influence sex and porn addiction. As you can see in Fig. 1. BERSC is an acronym that stands for Biological, Emotional, Relational, Social and Cultural. Biological equates to the bio of biopsychosocial, emotional and relational expand on the psycho of biopsychosocial and social and cultural expand on the social of biopsychosocial. The BERSC model uses bi-directional arrows to address issues around correlation and causation within each of the five factors. Whilst sex addiction can be evident in each of these factors in terms of the development, maintenance and consequence of the condition, the reverse is also true.

The *biological* component of the model acknowledges the neuroscientific research that indicates brain changes in people struggling with sex and porn addiction, but like other biopsychosocial models, it does not assume that brain change necessarily equals disease. The bi-directional arrow indicates that people with certain biological dispositions may be more at risk of developing addiction in the first place, or indeed of demonstrating some of the symptoms, for example people with bi-polar disorders or those receiving certain medications for Parkinsons.

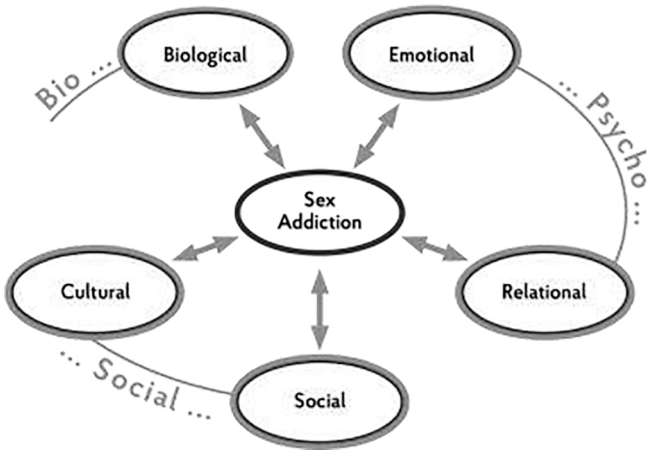

Fig. 1.

The inclusion of *emotional* factors acknowledges that compulsive sexual behaviours are often a consequence of underlying psychological factors that need to be identified, understood and addressed. Indeed, failure to address these underlying issues is unlikely to resolve the addiction, though it may change the way it is expressed. In reverse, the model indicates how addiction can directly impact someone's emotional state, for example by increasing feelings of low self-esteem, anxiety and depression.

The inclusion of a distinct relational factor acknowledges that both the cause of problematic sexual behaviours, and the perception of them, can be significantly influenced by someone's relationship status and satisfaction. Like emotional factors, these relational issues should be addressed and understood in both assessment and treatment. Conversely sex and porn addiction commonly have a negative impact on relationships, whether that's forming relationships in the first place or maintaining them (Hall, 2019). Attachment issues may often predispose someone to addictive behaviours, but it should be recognised that they are also a common consequence.

Whilst society and culture are intrinsically linked, separating them within this model provides space to consider the individual beliefs and mores of distinct groups within society. There is little doubt that society's attitudes to sexuality have changed considerably over recent years as has its access to sexual materials and services through the Internet, but within the broader picture of society we also need to consider the cultural influence of, for example, sexual orientation, gender identification, religion, race and work environment. The definition of healthy sexuality may vary hugely between an Ahmadi Muslim and a gay atheist or a Methodist lay reader and an oil rig worker. The bi-directional arrows of the BERSC model indicates how demand for sexual resources reconstructs social norms and how the ongoing dialogue around porn addiction changes cultural perceptions and reactions. For many of those opposed to the label of sex addiction, acknowledgement of cultural difference and the subsequent moral perceptions of healthy sexuality vs compulsive sexuality is a crucial missing piece.

6. BERSC and treatment

The moral maze of sex and porn addiction is particularly dense when it comes to treatment with many different potential paths to follow. When the problem is addressed through the BERSC lens, it becomes easier to navigate the multi-faceted approaches required. Biological behavioural change will be one path, but equally important is exploration of emotional and relational factors. Furthermore, this must all be viewed and explored within the client's socio-cultural perspective. As discussed previously, recovery from addiction is about much more than

abstinence and treatment strategies that focus purely on behavioural change reduce the problem to a singular biological perspective. Indeed, those that primarily focus attention on dysregulated sexual libido (Briken, 2020: Walton et al., 2017) are confusing appetite with compulsion and craving. Reducing hunger has never been sufficient to cure obesity; furthermore, reducing the amount of, or direction of, sexual desire is by most societies deemed morally wrong, or at least, questionable. Treating sex and porn addiction is not conversion or reparative therapy!

7. Conclusion

Many of the moral objections to sex addiction and porn addiction that keep us trapped in the maze can be assuaged if viewed through the lens of the BERSC model of addiction (Hall, 2014). The model provides an emotional path that acknowledges addiction is often a response to deeper psychological needs, rather than being about biological sex. And a path that explores relationship satisfaction and how that contributes to sex or porn becoming the drug of choice. BERSC also provides clear routes to understanding and exploring sexuality from a culturally sensitive perspective, both in terms of why someone might consider their behaviours problematic and also what healthy sexuality means to them. This expanded conceptualization can provide a guide that ensures an integrative and holistic assessment, formulation and treatment approach that focusses on why, rather than what and hence allows those that suffer a route out of the maze.

Moving away from a disease model of addiction also allows researchers to explore other avenues within the maze, for example focusing on other recognised components of addiction such as salience, mood modification, tolerance, withdrawal, conflict and relapse (Griffiths, 2005), rather than the current emphasis on brain studies. Updating the lens applied to sex addiction would inevitably change the picture and by addressing the moral objections, energy can be focused on other essential areas of research such as assessment and treatment efficacy.

It's argued that the label of sex addiction or porn addiction is, in itself, stigmatizing and people who self-identify with the label experience psychological distress, not because of their behaviours, but because of the label (Grubbs et al., 2015). That would not be the case if a biopsychosocial model was used and professional communities developed an integrative, inclusive and compassionate response. In the moral maze of sex and porn addiction, the person who most often gets lost is the client and whether an academic, therapist or other health professional, our greatest moral duty is to them.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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