# Compulsive Sexual Behavior: Managing Pornography Use, Hypersexuality and Loss of Control

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**Understanding the Problem Without Shame or Judgment**

In my clinical practice, I meet many patients who come to me worried about excessive pornography viewing, repeated masturbation, uncontrolled sexual thoughts, repeated online sexual activity, frequent sexual encounters, or a feeling that their sexual urges have become difficult to control. Some patients use the words **"porn addiction," "sex addiction," "hypersexuality," or "bad habit."** Others simply say, "Doctor, I have tried many times to stop, but I keep going back to it."

The first thing I tell such patients is very important: **sexual desire itself is not a disease, masturbation by itself is not a disease, and pornography use by itself does not automatically mean that someone has a psychiatric disorder.** The medical concern begins when a person repeatedly loses control over sexual urges or behaviors, continues despite significant negative consequences, and experiences real impairment in relationships, work, health, studies, finances, sleep, or emotional well-being.

Modern medicine increasingly uses the term **Compulsive Sexual Behavior Disorder (CSBD)** for the more severe and clinically significant form of this problem. The World Health Organization includes CSBD in ICD-11 under impulse-control disorders. Its central feature is a persistent inability to control intense, repetitive sexual impulses or urges resulting in repeated sexual behavior that becomes harmful or disruptive. WHO guidance also makes an important distinction: distress caused only by guilt, cultural disapproval, or moral judgment is not enough to diagnose CSBD.

This distinction is especially important in societies where sexuality may be associated with shame. A person should not be labelled "addicted" simply because he or she has sexual thoughts, masturbates, has a high libido, or has viewed pornography. Current sexual-medicine experts specifically warn against pathologizing normal sexual desire or automatically treating pornography and masturbation as unhealthy behaviors.

**What Is Compulsive Sexual Behavior Disorder?**

CSBD describes a long-standing pattern in which sexual impulses, fantasies, pornography viewing, masturbation, cybersex, sexual encounters, or related behaviors become increasingly difficult to regulate. The individual may repeatedly decide to reduce or stop the behavior, remain successful for a short period, and then return to the same pattern despite knowing that it is causing problems.

The key issue is therefore **not simply how often sexual behavior occurs; the key issue is impaired control and harmful consequences**.

According to ICD-11 concepts, the problem usually persists for an extended period, commonly around six months or more, and produces significant impairment or distress in important areas of life. Examples include repeatedly missing work or studies, neglecting family responsibilities, damaging a relationship, spending excessive money, losing sleep, taking sexual risks, or continuing despite emotional or physical consequences.

A very large International Sex Survey involving more than 82,000 participants across 42 countries found that approximately **4.8% were classified as being at high risk for CSBD**, although screening risk is not the same as receiving a clinical diagnosis. Only about 14% of those at high risk reported ever seeking treatment, illustrating how shame and lack of awareness may delay appropriate help.

**Pornography Use: When Does It Become Problematic?**

The internet has made sexually explicit material available continuously and privately. For many people, occasional pornography use does not lead to loss of control. For another group, however, pornography may become part of a repetitive habit cycle involving boredom, loneliness, anxiety, emotional stress, novelty seeking, sexual arousal and temporary relief.

A person may start spending increasingly long periods searching for material, repeatedly return to pornography despite intending not to, hide the behavior from a partner, sacrifice sleep or work, or feel that pornography has become the main way of managing uncomfortable emotions.

This is often described in research as **problematic pornography use (PPU)**.

It is important not to diagnose the condition simply by counting how many times pornography is viewed. Sexual-medicine research shows that some people use pornography frequently without impaired control or significant harm, whereas some people use it relatively infrequently but experience intense guilt because the behavior conflicts with their personal or religious beliefs. Therefore, frequency alone is not a reliable diagnostic test.

The correct clinical question is not simply, **“How often do you watch pornography?”** It is, **“Can you control the behavior, and what effect is it having on your life?”**

**Hypersexuality and High Sexual Desire Are Not the Same Thing**

Some patients naturally have stronger sexual desire than others. This is part of normal human variation. A high libido should not automatically be treated as hypersexuality.

A person with high sexual desire may think about sex frequently while still being able to control behavior, respect consent, maintain responsibilities, enjoy healthy relationships, and decide when or when not to act on those thoughts.

By contrast, compulsive behavior is characterized by **repeated loss of control**. Sexual activity may start taking priority over work, sleep, relationships, personal care or previously important activities. Attempts to cut back repeatedly fail, and the behavior continues despite clear negative consequences.

The distinction protects patients from unnecessary guilt and unnecessary medicalization.

**Common Warning Signs**

A patient may need professional assessment when several patterns occur together over time, including repeated unsuccessful attempts to reduce pornography or sexual behavior; spending so much time on sexual content that sleep, study, work or relationships suffer; repeatedly returning to the behavior during stress, loneliness, anger, boredom or sadness; hiding or lying about the behavior; continuing despite relationship, financial or health consequences; taking increasingly risky sexual decisions; or feeling unable to control sexual impulses even when the activity is no longer particularly satisfying.

The strongest warning sign is **loss of control combined with impairment**, rather than sexual activity itself.

**Why Does Compulsive Sexual Behavior Develop?**

There is no single cause. It is inaccurate to tell patients that the problem is simply caused by “too much dopamine,” weakness of willpower or a particular hormone.

Human sexual behavior is influenced by a combination of brain reward systems, impulse regulation, emotional states, learned habits, relationships, environment, personality, mental health and access to sexual stimuli. Research supports a **biopsychosocial model**, meaning that biological, psychological and social influences may interact.

For one person, repeated pornography viewing may become a learned method of escaping loneliness. For another, sexual behavior may be associated with anxiety, trauma or poor emotional regulation. Some people struggle particularly when alone with unrestricted internet access. Others develop the pattern in association with alcohol or drug use.

Repeated behavior can also create a strong habit loop: a trigger appears, sexual material is sought, short-term relief or reward follows, and the brain learns to repeat the same

response when the trigger returns. Treatment therefore needs to address both the behavior and the emotional circumstances surrounding it.

**Mental Health Conditions That Must Be Considered**

One of the most important parts of assessment is determining whether apparent hypersexuality is actually part of another medical or psychiatric condition.

Compulsive sexual behavior frequently coexists with depression, anxiety, ADHD, substance-use problems and other psychiatric difficulties. Sexual impulsivity may also increase during manic or hypomanic episodes in bipolar disorder. Neurological conditions and certain medicines, especially dopamine-agonist medicines used in conditions such as Parkinson's disease, can occasionally produce impulse-control problems including compulsive sexual behavior.

This is why proper evaluation matters. Simply advising a patient to “control yourself” may completely miss the real underlying problem.

If a patient tells me that sexual behavior suddenly increased together with unusually high energy, very little need for sleep, excessive spending, racing thoughts or unusually risky behavior, I consider the possibility of mania or hypomania and recommend appropriate psychiatric assessment.

**Effects on Emotional Health**

Many patients develop a repeating cycle of urge, behavior, temporary relief, regret, guilt and another attempt to stop.

Over time this cycle can affect self-esteem. A patient may begin thinking, “I am weak,” “I will never change,” or “There is something wrong with me.”

Such self-condemnation often makes matters worse rather than better. Shame increases stress, and stress can itself become a trigger for the same behavior.

Treatment therefore needs to replace shame with responsibility. The patient needs to understand: **I am responsible for changing my behavior, but I do not need to hate myself in order to change it.**

That distinction is extremely important.

**Effects on Marriage and Relationships**

Compulsive pornography or sexual behavior may affect a relationship through secrecy, loss of trust, emotional distance, unrealistic expectations, reduced attention to a partner, financial problems or sexual dissatisfaction.

Partners may understandably feel hurt, rejected or deceived. At the same time, accusing, humiliating or publicly shaming the person rarely produces healthy long-term change.

Where appropriate, couples counseling can help both partners discuss boundaries, expectations, trust, intimacy and recovery in a structured manner. Sexual health treatment should ultimately aim not merely to eliminate a behavior but to help the individual develop a **healthy, safe, consensual and satisfying sexual life**. This positive sexual-health approach is specifically emphasized by contemporary sexual-medicine experts.

**Can Pornography Permanently Damage Sexual Function?**

Patients frequently ask me whether pornography or masturbation has permanently damaged their nerves, testosterone, semen, penis or ability to have intercourse.

These fears should be assessed medically rather than reinforced.

There is no accepted medical diagnosis in which ordinary masturbation automatically causes permanent physical weakness, infertility or permanent loss of masculinity. Likewise, experts have cautioned against presenting so-called “pornography-induced erectile dysfunction” as an established diagnosis without properly evaluating other causes of erection difficulty.

A patient experiencing erectile dysfunction, premature ejaculation, delayed ejaculation, reduced libido or fertility concerns deserves a proper evaluation. Hormonal problems, diabetes, vascular disease, medication effects, anxiety, relationship difficulties, sleep disorders and other conditions may be relevant.

Treat the patient—not an internet myth.

**How I Assess These Patients in Clinical Practice**

When a patient comes to me at Saira Health Care with concerns about pornography, masturbation or uncontrolled sexual behavior, I prefer a private, respectful and non-judgmental conversation.

I want to understand when the behavior began, what usually triggers it, how frequently it occurs, whether the patient can postpone or stop it, previous attempts to control it, pornography patterns, masturbation patterns, relationship circumstances, sleep, stress, occupation, substance use, medicines and any sexual dysfunction.

I also look for depression, anxiety, obsessive symptoms, ADHD features, bipolar symptoms and other conditions that may need treatment.

Validated tools such as the **CSBD-19 and CSBD-7** can support screening, but questionnaires do not replace a clinical interview. The large International Sex Survey helped validate these instruments across many populations and languages.

**Evidence-Based Treatment: What Modern Research Supports**

Psychotherapy currently has the strongest support and is generally considered the foundation of treatment.

A 2024 systematic review of problematic pornography interventions found that psychological interventions—particularly cognitive behavioral approaches—were the most commonly studied treatments, but also emphasized that the overall evidence remained limited and many studies had a significant risk of bias.

A newer 2025 meta-analysis including 20 studies and more than 2,000 participants found that psychotherapy, particularly **Cognitive Behavioral Therapy (CBT)** and **Acceptance and Commitment Therapy (ACT)**, was associated with improvement in problematic pornography use, sexual compulsivity and pornography frequency or duration compared with control conditions. However, the authors also stressed methodological limitations and the need for better randomized trials.

CBT may help patients recognize triggers, challenge unhelpful thoughts, improve emotional regulation, develop alternative behaviors, learn urge-management strategies and plan for relapse prevention.

ACT teaches patients that an urge does not have to become an action. Instead of entering a struggle with every sexual thought, patients learn to tolerate uncomfortable feelings while choosing behavior consistent with their long-term values.

Mindfulness-based strategies, motivational work and relationship therapy may also be incorporated depending on the patient's needs.

The aim is not necessarily lifelong suppression of sexuality. The aim is **restoring choice and control**.

**Practical Behavioral Management**

One of the most useful exercises is identifying the patient's individual trigger-behavior-consequence cycle.

For example, a patient may discover that the pattern usually starts late at night after scrolling alone on a smartphone. Another notices that arguments with a partner trigger pornography. Someone else may relapse when anxious, bored or using alcohol.

Once the pattern becomes visible, the treatment plan can change the environment before the urge reaches its strongest level. This may involve keeping the phone away from the bed, reducing private high-risk internet access, using content filters where appropriate, changing nighttime routines, avoiding long unstructured periods, exercising regularly, improving sleep and planning alternative responses to known triggers.

The objective is not merely to “resist harder.” It is to **make healthier behavior easier and compulsive behavior more difficult to access automatically**.

**Why Complete Abstinence Is Not the Only Measure of Recovery**

Patients sometimes believe that one lapse means treatment has failed.

That is not how behavioral treatment should be understood.

Recent psychotherapy studies have reported meaningful reductions in problematic pornography use and related symptoms without necessarily producing complete abstinence in every participant.

Recovery may therefore include reduced frequency, less time consumed by the behavior, fewer episodes of lost control, improved ability to tolerate urges, improved relationships, better sleep and work performance, and a return to healthy consensual sexuality.

Progress should be measured broadly.

**Medicines: Sometimes Useful, Never for Self-Medication**

There is currently no medicine specifically approved as a universal treatment for CSBD.

International biological-psychiatry guidance considers psychotherapy and psychoeducation first-line approaches. In selected moderate or severe cases, particularly when associated psychiatric symptoms are present, psychiatrists may consider medications such as **selective serotonin reuptake inhibitors (SSRIs)** or **naltrexone**, but these uses are generally off-label and evidence remains limited.

These medicines can cause side effects and are not appropriate for everyone. Patients should therefore never obtain antidepressants, naltrexone, hormonal medicines or sedatives independently for this condition.

When a separate condition such as bipolar disorder, depression, anxiety, substance-use disorder or another psychiatric illness is driving the behavior, treating that underlying illness may be essential.

**The Role of Unani Medicine**

As a Unani physician, I consider the patient as a whole rather than seeing only one symptom.

Traditional Unani medicine places considerable importance on **Mizaj (individual constitution), Asbab-e-Sitta Zarooriya (essential factors governing health), sleep and wakefulness, food and drink, physical activity and rest, psychological states, elimination and retention, and environmental influences**.

These principles can be valuable within an integrative management program because many patients with compulsive behavior also have disturbed sleep, prolonged screen exposure, inactivity, anxiety, irregular meals, emotional stress or poor daily structure.

In my practice, the Unani contribution is therefore primarily directed toward **restoring healthy routine, improving general well-being and supporting emotional and physical balance**, while evidence-based psychological treatment addresses the compulsive behavior directly.

**Ilaj-bil-Ghiza — Dietotherapy**

A regular, balanced diet helps establish daily structure and overall physical health. Excessive stimulants, alcohol or substances that reduce judgment should be addressed when relevant.

Diet should be individualized rather than based on claims that one particular food can "cure" pornography use or hypersexuality.

**Ilaj-bil-Tadbeer — Regimental and Lifestyle Measures**

Regular physical activity, controlled screen use, adequate sleep, structured daily routines, relaxation practices and appropriate recreation can be incorporated into a Unani lifestyle plan.

Riyazat, or appropriate exercise, is particularly valuable because exercise can improve sleep, mood, stress management and daily discipline.

**Psychological Balance**

Classical holistic medicine has always recognized the relationship between emotional state and physical health. Modern behavioral medicine strongly reinforces this connection.

For many patients, anxiety, loneliness, frustration and stress act as triggers. Learning healthier methods of emotional regulation is therefore an essential part of treatment.

**Ilaj-bil-Dawa — Unani Medicines**

Certain Unani preparations may be considered for associated complaints such as disturbed sleep, anxiety, digestive problems or general health concerns when clinically appropriate.

However, I want patients to understand an important scientific point: **high-quality clinical evidence specifically proving Unani herbal medicines as a stand-alone treatment for CSBD or problematic pornography use is currently insufficient.**

Therefore, Unani medicine should be used responsibly as **supportive integrative care**, not as a replacement for CBT, psychiatric treatment or other evidence-based interventions when these are indicated.

Herbal medicines can also interact with prescription drugs or be inappropriate in liver, kidney, cardiovascular or other medical conditions. They should therefore be prescribed only after proper assessment.

**The Saira Health Care Integrative Approach**

At Saira Health Care, our approach to patients presenting with compulsive pornography or hypersexual behavior is designed around confidentiality, dignity and individualized assessment.

I prefer to divide treatment into four broad objectives: understanding the patient's behavior without stigma, identifying triggers and associated medical or psychological conditions, restoring behavioral control, and rebuilding healthy sexual and relationship functioning.

Where psychotherapy or psychiatric care is required, the patient should receive or be referred for appropriate evidence-based treatment. Unani principles can then complement this program through sleep correction, diet, exercise, structured routine, stress management and carefully selected supportive therapy.

A patient experiencing erectile dysfunction, infertility, premature ejaculation, low libido or other sexual problems should also receive separate evaluation rather than automatically assuming that every symptom is caused by pornography.

This integrated perspective is particularly relevant to the work of **Saira Health Care in sexual disorders and infertility**, because sexual health cannot be separated completely from emotional health, relationship health, metabolic health and reproductive health.

**Dr. Nizamuddin Qasmi's Clinical Philosophy**

My approach is neither to frighten patients nor to normalize genuinely harmful behavior.

If the behavior is normal and the distress comes primarily from misinformation, I try to correct the misconception.

If the behavior has become compulsive, I take it seriously.

If depression, bipolar disorder, anxiety, ADHD, substance use or another condition is contributing, that condition must be addressed.

If a couple's relationship has been damaged, both behavioral recovery and relationship healing may be necessary.

And if a patient needs psychotherapy or psychiatric treatment, responsible Unani practice means collaborating with or referring to the appropriate professional rather than promising that an herbal formulation alone will solve the problem.

That, in my view, is the proper meaning of integrative medicine.

**A Simple Recovery Principle: Control the Trigger Before Fighting the Urge**

Patients often focus only on the moment of temptation. But by that point, several earlier steps may already have occurred.

The more useful questions are: What happened during the previous hour? Was I lonely? Angry? Anxious? Awake after midnight? Scrolling privately? Drinking alcohol? Had I argued with my partner? Was I procrastinating?

When patients learn to identify these patterns, they move from feeling powerless to understanding that many episodes can be interrupted earlier.

Recovery is therefore not a single act of willpower. It is the gradual construction of a healthier system around the patient.

**Relapse Does Not Mean Failure**

Behavior change is rarely perfectly linear.

A patient may remain in control for several weeks and then have one episode. The correct response is to study what happened, not to conclude, “Everything is ruined.”

Ask what the trigger was, what protective routine was missing and what should be changed before the next similar situation.

This approach converts relapse from a source of shame into useful clinical information.

**When Professional Help Should Not Be Delayed**

Prompt professional assessment is especially important when sexual behavior is causing major impairment, threatening a marriage or employment, producing substantial financial losses, leading to unsafe sexual contact, occurring together with substance misuse, or becoming suddenly much more intense.

Immediate mental-health assessment is also warranted if the person has suicidal thoughts, severe depression, signs of mania or psychosis, or feels at risk of harming another person.

Any sexual behavior involving coercion, non-consenting people or illegal sexual material requires immediate safeguarding and appropriate professional intervention.

**What Family Members and Partners Should Understand**

Partners frequently ask whether they should monitor every phone call or constantly confront the patient.

Extreme surveillance may produce further secrecy without building self-control. On the other hand, pretending that a serious compulsive pattern does not exist is also unhelpful.

Healthy support usually combines clear boundaries with respectful communication.

The partner can support treatment, but cannot perform treatment for the patient. Responsibility for behavioral change must remain with the person experiencing the problem.

**What Patients Should Remember**

A sexual urge is not the same as a command.

A thought is not an action.

A lapse is not the same as permanent failure.

Having sexual desire does not make a person diseased, and needing professional help for loss of control does not make a person morally inferior.

The real goal of treatment is neither fear of sexuality nor uncontrolled sexuality. It is **healthy sexuality with choice, responsibility, consent, control and well-being**.

**Contribution of Saira Health Care to Sexual and Reproductive Health**

At Saira Health Care, our continuing work in sexual disorders and infertility is directed toward reducing misinformation, encouraging earlier consultation and offering patients an environment where sensitive problems can be discussed confidentially.

Issues such as pornography concerns, masturbation anxiety, compulsive sexual behavior, erectile difficulties, infertility and relationship distress often overlap. Patients therefore benefit when physical, psychological, sexual and reproductive health are considered together.

Our clinical philosophy is to combine the strengths of traditional Unani principles with responsible modern investigation, evidence-based counseling or psychotherapy where required, and referral to appropriate specialists whenever a patient's condition extends beyond the scope of one discipline.

**Final Message From Dr. Nizamuddin Qasmi**

If you feel that pornography or sexual behavior is controlling your life, repeatedly telling yourself to “be stronger” may not be enough.

The first step is to understand what is actually happening.

For some people, reassurance and correct sexual-health education are sufficient. For others, structured behavioral treatment is required. Some need relationship counseling. Others have anxiety, depression, bipolar disorder, ADHD or substance-use problems that must be treated alongside the sexual behavior.

There is no reason to approach these problems with humiliation or exaggerated fear.

My message to patients is simple: **seek help when you are losing control, understand your triggers, treat the whole person, and work toward a healthy sexual life rather than toward shame.**

With proper assessment, psychotherapy, lifestyle restructuring, medical care where required, supportive Unani management and consistent follow-up, meaningful improvement is possible.

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**Medical and Scientific Note**

Compulsive Sexual Behavior Disorder is recognized in ICD-11 as an impulse-control disorder, while “pornography addiction” and “hypersexual disorder” are not separate diagnoses in

DSM-5-TR. Diagnosis should therefore be made carefully and should distinguish genuine loss of control from high sexual desire, culturally influenced guilt and moral incongruence.

Current evidence supports psychotherapy—particularly CBT- and ACT-based approaches—as the main treatment direction. Pharmacological treatment may be considered by appropriately qualified clinicians in selected cases, but evidence remains limited and medicines used for CSBD are generally off-label.

This article is intended for patient education and should not replace an individual consultation, psychiatric assessment or psychotherapy when required.