

# Pornography-Related Sexual Concerns

## Understanding Problematic Pornography Use, Sexual Function, Emotional Health and Relationship Well-Being

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These professional details follow the author profile and qualification structure used in the attached Saira Health Care article pattern.

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### Introduction

In my clinical work in sexual disorders and infertility, I increasingly meet men—and sometimes couples—who come to me with a question such as:

“Doctor, I watch pornography regularly. Has it damaged my sexual health?”

Another patient may say:

“I can become aroused while watching pornography, but when I am with my wife, my erection is not as good.”

Someone else may tell me:

“I have tried many times to stop, but after a few days I start watching again.”

And another patient may be deeply worried even though his actual pornography use is occasional:

“Doctor, I feel very guilty. I think I am addicted.”

These patients do not necessarily have the same problem.

This distinction is extremely important.



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**Pornography-related sexual concerns** is best used as a broad clinical and educational term covering sexual, psychological, behavioural or relationship difficulties that a person believes are connected with pornography use.

It is **not itself a formal medical diagnosis**.

Pornography use can range from occasional viewing that causes no obvious functional difficulty to repetitive and poorly controlled use associated with significant distress, loss of time, relationship conflict, sexual-function problems or interference with work and daily responsibilities.

Modern medical evidence therefore requires us to ask a much more useful question than:

“Does this person watch pornography?”

The better questions are:

- Can the person control the behaviour?
- Is pornography becoming the main source of sexual stimulation?
- Is use interfering with partnered intimacy?
- Has the person repeatedly tried and failed to reduce it?
- Is it interfering with sleep, work, study or relationships?
- Is the patient distressed because of genuine loss of control, or mainly because the behaviour conflicts with personal or religious values?
- Is there erectile dysfunction, delayed ejaculation, reduced desire or performance anxiety?
- Are depression, anxiety, loneliness, stress or another mental-health condition contributing?
- Is the relationship already experiencing conflict or emotional distance?
- Are unrealistic expectations about sex, bodies or performance developing?

Only after understanding these questions can treatment become rational.

WHO's ICD-11 recognizes **Compulsive Sexual Behaviour Disorder (CSBD)** as an impulse-control disorder. It involves persistent difficulty controlling repetitive sexual impulses or behaviours over an extended period, together with significant distress or impairment. Importantly, WHO specifies that distress caused **only by moral judgment or disapproval is not sufficient** for the diagnosis.

This is one reason why I prefer the careful term **pornography-related sexual concerns** when first evaluating a patient instead of immediately telling someone:

“You have pornography addiction.”

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## What Is Pornography?

Pornography generally refers to sexually explicit material primarily intended to produce sexual arousal.

Today it may be accessed through:

- websites;
- videos;
- social-media platforms;
- messaging applications;
- photographs;
- erotic stories;
- virtual or interactive media;
- live-streaming services;
- other internet-based sexual content.

The internet has changed pornography consumption substantially because access is immediate, private and practically unlimited.

A person can therefore move from one image or video to another within seconds.

However, availability alone does not determine whether an individual develops a problem.

Different people respond differently depending on psychological health, sexual development, relationship circumstances, personal beliefs, impulse control, stress, coping style and patterns of use.

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## Pornography Use Is Not Automatically a Disease

This point should be understood clearly.

A person should not be labelled mentally ill merely because they have watched pornography.



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Similarly:

**frequency alone does not diagnose a disorder.**

One individual may view sexual material relatively frequently without experiencing loss of control or functional impairment.

Another may view it less frequently but experience intense compulsive behaviour, secrecy, relationship disruption or inability to stop despite serious consequences.

A 2026 systematic review examining pornography consumption and male sexual dysfunction found mixed results. Some studies found associations with sexual problems while others found no relationship or even beneficial outcomes in some contexts. The review concluded that simple frequency of pornography viewing appeared less important than **problematic use, insecurities and related psychological factors**.

This distinction prevents unnecessary fear.

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### **What Is Problematic Pornography Use?**

Researchers often use the term **problematic pornography use (PPU)** when pornography use becomes difficult to control and contributes to meaningful distress or impairment.

Possible features include:

- repeatedly watching for longer than intended;
- unsuccessful attempts to reduce or stop;
- spending excessive time searching for material;
- neglecting sleep;
- neglecting work or studies;
- using pornography despite serious relationship problems;
- repeatedly returning to it despite personal consequences;
- feeling unable to control urges;
- pornography becoming the main or preferred source of sexual stimulation;
- increasing secrecy;
- significant distress regarding loss of control;
- using pornography habitually to escape unpleasant emotions;



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- difficulty remaining sexually engaged with a real partner.

PPU is not currently a separate standalone diagnosis in ICD-11. Severe dysregulated pornography use may instead occur as one manifestation of **Compulsive Sexual Behaviour Disorder** when the full diagnostic requirements are met.

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### How Common Is Problematic Pornography Use?

Prevalence estimates vary considerably depending upon country, population, measurement scale and definition.

A 2025 meta-analysis incorporating 22 studies and more than 31,000 participants reported a pooled estimate of approximately **13%**, but the authors found very high statistical heterogeneity. Estimates differed substantially depending upon region, population and the screening instrument used, so 13% should not be interpreted as a universal prevalence rate.

This uncertainty illustrates an important point:

We still do not have one universally accepted definition or screening threshold for “problematic pornography use.”

Therefore, patients should be evaluated individually rather than diagnosed through one question such as:

“How many times per week do you watch?”

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### Pornography Addiction: Why the Terminology Requires Care

Patients frequently use expressions such as:

“I am addicted to porn.”

Clinically, however, terminology matters.

WHO classifies Compulsive Sexual Behaviour Disorder under **impulse-control disorders**, not under substance-use disorders.

The American Association of Sexuality Educators, Counselors and Therapists has also stated that available evidence is insufficient to treat “porn addiction” or “sex addiction” as established mental-health diagnoses in their own right and cautions against unnecessarily pathologizing consensual sexual behaviour.

At the same time, this should **not** be interpreted as saying that pornography can never become problematic.



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Some people clearly experience:

- loss of control;
- repeated unsuccessful attempts to stop;
- strong cravings;
- relationship difficulties;
- emotional distress;
- excessive time spent using pornography;
- interference with responsibilities.

The correct clinical response is therefore neither:

“Pornography can never cause a problem”

nor:

“Anyone who watches pornography is addicted.”

The correct response is careful assessment.

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## The Difference Between High Sexual Desire and Compulsive Behaviour

A patient may naturally have a strong libido.

High sexual desire alone is not a disease.

The important issue is **control and consequences**.

A person with a strong sexual drive may still:

- control sexual behaviour;
- respect responsibilities;
- maintain healthy relationships;
- choose when to engage sexually;
- stop when necessary.

A person with compulsive behaviour may feel:

“I don't really want to do this anymore, but I keep returning to it.”

The behaviour begins controlling the person rather than the person controlling the behaviour.



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## The Role of Moral and Religious Conflict

This is especially important in societies where pornography strongly conflicts with religious, cultural or personal values.

Some patients experience genuine behavioural dysregulation.

Others experience intense guilt primarily because even occasional pornography use conflicts with deeply held beliefs.

These situations are not identical.

Researchers describe this second pathway as **moral incongruence**—a conflict between a person's behaviour and personal moral values.

Research across multiple countries has increasingly confirmed that behavioural dysregulation and moral conflict can both contribute to a person's feeling that their pornography use is problematic. A large international study involving nearly 67,000 participants from 42 countries identified distinct pornography-use profiles involving problematic behavioural regulation, moral disapproval or combinations of the two.

Another large international analysis published in 2026 found that moral incongruence influenced how pornography-use frequency related to self-perceived problematic use across countries, genders and religious groups.

This is why WHO specifically warns clinicians that distress arising entirely from moral judgment is not sufficient by itself for diagnosing CSBD.

A patient's values should still be respected.

If someone genuinely wants to stop pornography because it conflicts with personal beliefs, counselling can support that goal.

But we should not frighten the patient by automatically telling them they have a brain disease or irreversible addiction.

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## Why Can Pornography Become Difficult to Control?

There is unlikely to be one explanation that applies to everybody.

Problematic use may involve combinations of:

- habit formation;
- easy internet availability;
- sexual arousal;



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- emotional regulation;
- loneliness;
- boredom;
- anxiety;
- depression;
- stress;
- relationship dissatisfaction;
- novelty seeking;
- impulsivity;
- avoidance of difficult emotions;
- sexual curiosity;
- shame;
- secrecy;
- repetitive masturbation patterns.

A 2026 systematic review and meta-analysis of psychological correlates found problematic pornography use to be associated with factors including craving, difficulties with emotional regulation, depression, loneliness, sexual shame and moral disapproval. These are associations, however, and do not prove that pornography directly causes each psychological condition.

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### **Pornography as Emotional Coping**

Some patients do not primarily seek pornography because they are unusually sexually excited.

They seek it when they are:

- stressed;
- lonely;
- angry;
- bored;
- rejected;



- emotionally exhausted;
- unable to sleep;
- anxious.

The sequence may become:

**Stress → pornography → temporary relief → guilt or exhaustion → stress → pornography again.**

When I see this pattern, I do not ask only:

“How can we stop pornography?”

I also ask:

“What emotional need has pornography been temporarily managing?”

If loneliness remains untreated, removing pornography alone may leave loneliness unchanged.

If depression remains untreated, compulsive behaviour may return in another form.

If severe relationship conflict is driving avoidance, that conflict needs attention.

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### **Avoid the Oversimplified “Dopamine Damage” Explanation**

Patients frequently arrive after watching online videos claiming:

“Pornography has destroyed my dopamine.”

This wording is scientifically oversimplified.

Dopamine is a normal neurotransmitter involved in motivation, learning, reward and many other brain functions.

Sexual stimuli can activate reward pathways, as do many pleasurable or motivating experiences.

However, we should not tell patients that their brain has been permanently “fried,” “damaged” or “depleted of dopamine” simply because they have viewed pornography.

Current understanding of CSBD and problematic pornography use remains complex and includes psychological, behavioural, social, sexual and neurobiological factors. A major 2026 interdisciplinary review emphasizes that significant scientific controversies and methodological limitations remain.

Fear-based explanations may actually increase anxiety.



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## **Pornography and Sexual Expectations**

Pornographic entertainment is not a medical education programme.

Performers, editing, camera angles, selected body types and scripted sexual behaviour can create impressions that do not accurately represent ordinary partnered sexuality.

Some viewers may gradually develop unrealistic expectations regarding:

- penis size;
- breast size;
- genital appearance;
- duration of intercourse;
- frequency of sex;
- erection firmness;
- number of orgasms;
- sexual positions;
- immediate arousal;
- partner behaviour;
- spontaneous desire;
- ejaculation timing.

Healthy sexual relationships are much more variable.

Real intimacy includes:

- communication;
- consent;
- pauses;
- affection;
- humour;
- tiredness;
- emotional connection;
- different levels of desire;



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- changes in erections;
- differences in orgasm;
- negotiation between partners.

When pornography becomes a person's primary source of sex education, expectations may need correction.

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### **Pornography and Body Image**

Pornographic media commonly presents selected bodies rather than the full natural diversity of human bodies.

A man may begin thinking:

“My penis is too small.”

A woman may think:

“My breasts or genital appearance are abnormal.”

A systematic review examining pornography exposure and sexual body image found evidence of associations between greater exposure and more negative body or sexual-body perceptions in both heterosexual men and women, although study limitations mean causation cannot automatically be assumed.

In practice, body insecurity itself can then affect sexual performance.

The person may continuously monitor:

“How do I look?”

Instead of experiencing:

“What am I feeling?”

This is called self-monitoring or spectating and can interfere with natural arousal.

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### **Pornography and Erectile Dysfunction**

This is probably the most common question I hear from men.

“Doctor, has pornography caused my erectile dysfunction?”

The scientifically responsible answer is:

**Sometimes pornography-related patterns may contribute to erection difficulty, but pornography viewing cannot automatically be assumed to be the cause of ED.**



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Erection depends upon many factors:

- blood circulation;
- nerves;
- hormones;
- diabetes;
- cardiovascular health;
- medications;
- sleep;
- smoking;
- alcohol;
- neurological conditions;
- anxiety;
- partner attraction;
- relationship circumstances;
- sexual stimulation.

Evidence concerning pornography and ED has been inconsistent.

A 2026 systematic review concluded that simply viewing pornography did not appear to be a major independent predictor of sexual dysfunction, whereas problematic pornography use, body dissatisfaction and insecurity may have more meaningful relationships with sexual difficulties.

Earlier longitudinal research similarly found associations between self-reported problematic pornography use and concurrent ED, but did not establish that pornography caused future deterioration in erectile function.

Therefore:

**Never diagnose “porn-induced erectile dysfunction” without evaluating ordinary medical causes of ED.**

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### **Why Can Some Men Have Good Erections With Pornography but Difficulty With a Partner?**

This situation deserves proper assessment.



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Possible explanations include:

- performance anxiety;
- fear of pregnancy;
- fear of being judged;
- relationship conflict;
- lack of emotional comfort;
- very specific masturbation habits;
- preference for familiar visual stimulation;
- anxiety about erection firmness;
- previous sexual failure;
- excessive self-monitoring;
- differences between fantasy and real-life sexual stimulation.

A man may begin thinking:

“I have to prove that I am sexually normal.”

He checks his erection.

The erection decreases slightly.

He becomes alarmed.

He thinks:

“Porn has destroyed me.”

Anxiety increases.

The erection decreases further.

Now he feels the theory has been confirmed.

But the immediate mechanism may partly be **performance anxiety**.

This does not mean pornography is always irrelevant.

It means the entire pattern must be understood before deciding what is responsible.

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## **Pornography and Delayed Ejaculation**

Some men report:



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“I can ejaculate during masturbation but take a very long time with my wife.”

Again, several factors may contribute:

- medication effects, especially certain antidepressants;
- reduced penile sensitivity;
- diabetes or neurological problems;
- anxiety;
- relationship difficulties;
- particular masturbation techniques;
- very frequent masturbation;
- differences between preferred fantasy and partnered stimulation.

Pornography is often blamed automatically.

Current evidence does not establish that pornography universally causes delayed ejaculation. Older reviews found insufficient evidence for a simple causal relationship between pornography use and delayed ejaculation or ED.

Therefore, assessment must be individualized.

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### **Pornography and Premature Ejaculation**

Premature ejaculation usually has multiple possible contributors.

These include:

- lifelong ejaculatory patterns;
- anxiety;
- relationship factors;
- erectile concerns;
- genital sensitivity;
- psychological anticipation;
- acquired medical or sexual factors.

Pornography use should not automatically be blamed.



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However, if sexual activity becomes associated with urgency, secrecy or highly rapid masturbation, behavioural patterns may become clinically relevant for an individual patient.

The appropriate approach is to evaluate the premature ejaculation itself.

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### **Pornography and Low Sexual Desire for a Partner**

Some patients report:

“I still become aroused online, but I don't feel much interest in sex with my partner.”

Several possibilities should be considered.

The issue may involve:

- relationship conflict;
- resentment;
- stress;
- fatigue;
- depression;
- medication;
- hormonal problems;
- sexual boredom;
- performance anxiety;
- discrepancy in sexual desire;
- repetitive solitary sexual habits;
- preference for fantasy-based stimulation.

Pornography may sometimes become part of this pattern, but it is not the only explanation.

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### **Pornography, Masturbation and Sexual Conditioning**

Pornography and masturbation commonly occur together.

Masturbation itself is not automatically a medical disorder.



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However, when sexual stimulation becomes extremely repetitive and dependent on one particular combination of:

- visual material;
- masturbation speed;
- grip pressure;
- body position;
- fantasy;
- constant novelty,

some patients report that partnered sexual stimulation feels substantially different.

In treatment, we may therefore evaluate the **entire masturbation pattern**, not simply ask whether pornography is present.

The goal is not to create fear about masturbation.

The goal is to identify whether a rigid pattern has developed that is interfering with desired partnered sexuality.

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### **Pornography and Sexual Satisfaction**

Research concerning pornography and sexual satisfaction is complex.

A 2025 meta-analysis of 41 studies involving more than 70,000 participants found a small overall negative association between pornography use and sexual satisfaction. However, the magnitude was small and results differed according to gender and study design.

Another meta-analytic investigation also reported differences between men and women and concluded that simple overall statements about pornography and satisfaction can hide substantial variation.

This is an excellent example of why we should not use exaggerated statements such as:

“Pornography always destroys sexual satisfaction.”

The reality is more individual.

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### **Pornography and Relationship Health**

Pornography may affect couples differently.



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For some couples it may be irrelevant.

For others it creates:

- secrecy;
- mistrust;
- jealousy;
- feelings of inadequacy;
- reduced partnered intimacy;
- disagreement over boundaries;
- sexual pressure;
- resentment.

Some research has also reported neutral or positive experiences in particular relationship contexts, especially when partners mutually agree about use. A systematic review of women in relationships, for example, identified both positive and negative reported experiences.

A qualitative study similarly identified beneficial, harmful and neutral relationship experiences rather than one universal outcome.

This means the clinical question is not merely:

“Is pornography good or bad?”

The better questions are:

- Is it secret?
- Does one partner feel betrayed?
- Was there a mutually understood boundary?
- Has partnered sexual interest changed?
- Is pornography replacing emotional or sexual connection?
- Are unrealistic demands being placed upon a partner?
- Is either partner being pressured into unwanted sexual behaviour?

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### **Secrecy May Be More Damaging Than the Screen Itself**

Sometimes a couple's major injury is not simply that pornography was viewed.



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It is that the partner discovers:

- deleted browser history;
- hidden subscriptions;
- private accounts;
- repeated lying;
- financial spending;
- broken promises.

The partner then thinks:

“If this was hidden from me, what else is being hidden?”

Treatment may therefore involve rebuilding trust.

Simply telling the patient:

“Stop watching pornography”

may not repair the relationship.

Repair may require:

- honest communication;
- realistic boundaries;
- accountability;
- listening to the partner;
- consistency over time;
- couple therapy when necessary.

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### **Different Pornography Preferences Between Partners**

Relationships can also become stressed when partners have very different values regarding pornography.

One partner may consider occasional pornography acceptable.

The other may regard any use as betrayal.

Neither disagreement can be solved simply by saying:

“My view is scientifically correct.”



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Relationships require negotiation of boundaries.

Research involving couples has found that differences between partners in pornography use can be associated with poorer satisfaction and communication in some samples, although relationship findings remain context-dependent.

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## **Pornography and Mental Health**

Pornography-related difficulties frequently coexist with emotional problems.

Patients may report:

- anxiety;
- depression;
- loneliness;
- shame;
- low self-esteem;
- social isolation;
- stress;
- compulsive thinking.

A 2026 systematic review and meta-analysis examining pornography-consumption patterns found positive correlations with both anxiety and depression, with exploratory analyses suggesting that problematic—not ordinary—consumption was especially relevant. The authors appropriately cautioned that observational studies cannot establish whether pornography causes these mental-health problems or whether people experiencing these problems are more likely to use pornography.

This distinction is essential.

Depression may contribute to compulsive pornography use.

Compulsive use may worsen isolation.

Both processes can potentially occur together.

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## **Pornography, Loneliness and Social Withdrawal**

Some people begin using pornography partly because real relationships feel difficult.

Pornography offers:



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- privacy;
- immediate access;
- no fear of rejection;
- no need for conversation;
- no requirement to disclose emotions.

For someone experiencing social anxiety, this can become psychologically attractive.

But if pornography increasingly replaces social contact, the person may become more isolated.

Treatment should therefore include questions such as:

“Do you have meaningful social relationships?”

“Are you avoiding dating?”

“Are you afraid of sexual rejection?”

“Has online stimulation become easier than emotional vulnerability?”

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### **Pornography and Performance Anxiety**

One of the biggest clinical problems is the patient's interpretation of pornography.

The patient thinks:

“The men in these videos perform for a long time.”

“I should remain fully erect continuously.”

“My penis should look like that.”

“My partner should respond immediately.”

“I should be able to perform multiple sexual acts.”

These expectations can transform sex into an examination.

The patient becomes spectator rather than participant.

Instead of experiencing sexual pleasure, he monitors:

- erection;
- ejaculation;
- penis size;



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- duration;
- partner response.

Performance pressure then becomes the real sexual problem.

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## **Pornography and Infertility**

Pornography does **not** automatically cause infertility.

Infertility requires assessment of reproductive factors such as:

### **In men:**

- semen concentration;
- sperm motility;
- sperm morphology;
- testicular function;
- hormonal factors;
- varicocele;
- obstruction;
- infection;
- genetic causes;
- lifestyle and medical factors.

### **In women:**

- ovulation;
- ovarian reserve;
- tubal factors;
- uterine factors;
- endometriosis;
- hormonal conditions;
- age-related fertility factors;
- other reproductive conditions.



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However, problematic pornography use can sometimes **indirectly** complicate fertility treatment.

For example:

A couple is instructed to have intercourse during the fertile period.

The man has become extremely anxious regarding erection.

He masturbates frequently before intercourse.

The couple is already stressed.

Intercourse becomes difficult precisely when conception is expected.

The reproductive problem and sexual problem now interact.

Therefore, infertility care should sometimes include sexual-history assessment.

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### **Does Pornography Reduce Sperm Count?**

There is no sound basis for telling every man that pornography exposure by itself destroys sperm.

Pornography should not be confused with biological infertility.

If semen quality is a concern, the appropriate method is:

**semen analysis and clinical evaluation.**

Factors such as varicocele, hormonal disorders, smoking, obesity, heat exposure, certain medications, infection and other reproductive conditions may be more clinically important.

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### **Does Pornography Lower Testosterone?**

Claims such as:

“Watching pornography permanently destroys testosterone”

are not established medical facts.

Sexual arousal and sexual behaviour can interact temporarily with hormonal physiology, but a patient's testosterone status should not be diagnosed through pornography history.

When clinically indicated, hormonal evaluation may include laboratory testing.

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## Does Pornography Permanently Damage the Penis?

No.

Pornography itself does not physically shrink or permanently damage the penis.

However, sexual symptoms may coexist with problematic use, anxiety or particular masturbation practices.

If a patient has:

- persistent erectile dysfunction;
- pain;
- curvature;
- penile injury;
- numbness;
- other genital symptoms,

proper urological or sexual-medicine assessment is appropriate.

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## Pornography-Related Concerns in Newly Married Men

I frequently consider this subject particularly important after marriage.

Some men have had years of private sexual habits before marriage but limited experience of real partnered intimacy.

Suddenly the sexual situation becomes very different.

A real partner has:

- emotions;
- expectations;
- preferences;
- fears;
- boundaries;
- variable arousal.

The husband may become extremely nervous.

He expects himself to perform immediately.

If the first attempt is unsuccessful, he thinks:



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“I have damaged myself through pornography.”

His anxiety increases.

The next attempt becomes harder.

A cycle of honeymoon impotence or performance anxiety can develop.

The appropriate treatment may therefore involve:

- education;
- reassurance;
- reduced performance pressure;
- gradual intimacy;
- assessment for ED;
- modification of problematic sexual habits where relevant.

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### **Pornography and Unrealistic Ideas About Female Sexuality**

Pornography should not be used as a textbook of female sexual response.

Real female arousal varies greatly.

Women may require:

- emotional comfort;
- adequate stimulation;
- sufficient time;
- affectionate contact;
- communication;
- lubrication;
- freedom from pressure;
- a feeling of safety.

Not every woman responds in the same manner.

Not every sexual encounter ends in orgasm.

A wife's real sexual response should never be judged by comparison with a performer.



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## Consent Remains Essential

Pornography may depict sexual behaviours that some viewers later want to reproduce.

But no sexual act is automatically appropriate simply because it appears in pornography.

Healthy sexuality requires:

- informed consent;
- comfort;
- mutual agreement;
- the ability to stop;
- absence of coercion.

A partner should never be pressured with statements such as:

“Everybody does this.”

“I saw this online, so you must agree.”

Pornography does not override consent.

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## Warning Signs That Pornography Use May Require Professional Assessment

Consider seeking professional advice when several of the following are present:

- repeated inability to control use;
- repeated unsuccessful attempts to reduce;
- hours of time being lost;
- sleep regularly being sacrificed;
- work or studies being neglected;
- use continuing despite serious relationship consequences;
- sexual activity increasingly depending upon pornography;
- partnered sexual interest declining substantially;
- persistent erectile or orgasm difficulties;
- extreme shame or anxiety;
- pornography being used repeatedly to escape depression or loneliness;



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- secrecy and lying becoming routine;
- financial spending becoming problematic;
- content escalating in ways the person finds distressing;
- pornography use occurring despite little enjoyment;
- the individual feels controlled by the behaviour.

One symptom alone does not establish a diagnosis.

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## **How I Evaluate Pornography-Related Sexual Concerns**

When someone tells me:

“Doctor, pornography has destroyed my sexual life,”

I do not immediately accept or reject that conclusion.

I first investigate.

### **1. Pornography History**

I ask:

- How frequently is pornography used?
- How long does each session last?
- Has the pattern changed?
- Has the patient repeatedly tried to stop?
- What triggers viewing?
- What happens when the patient tries to reduce it?

### **2. Masturbation Pattern**

We may discuss:

- frequency;
- duration;
- technique;
- pressure;
- preferred position;
- dependence on visual stimulation;



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- whether ejaculation occurs normally during partnered sex.

### **3. Sexual Function**

I ask about:

- erection;
- morning erections;
- desire;
- ejaculation;
- orgasm;
- partnered arousal;
- sexual pain;
- intercourse.

### **4. Relationship Factors**

Is there:

- conflict?
- rejection?
- mistrust?
- secrecy?
- infidelity?
- mismatched desire?
- poor communication?

### **5. Mental Health**

We consider:

- anxiety;
- depression;
- obsessive thinking;
- loneliness;
- trauma;
- ADHD symptoms;



- mood disorders;
- significant stress.

## 6. Physical Health

Depending upon symptoms, assessment may involve:

- diabetes;
- blood pressure;
- cardiovascular risk;
- thyroid problems;
- testosterone or other hormones when indicated;
- medication effects;
- neurological disease;
- urological conditions.

## 7. Fertility

When conception is also a concern, evaluation may include:

- semen analysis;
- reproductive history;
- female fertility assessment;
- intercourse frequency;
- sexual performance during the fertile window.

This prevents us from blaming pornography for every sexual symptom.

---

## Screening Questionnaires

Researchers and clinicians have developed instruments such as:

- Problematic Pornography Consumption Scale;
- Brief Pornography Screen;
- Compulsive Sexual Behavior Disorder-related measures.

These questionnaires may be useful as part of an assessment.

However:



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**a questionnaire should not replace clinical judgment.**

A high score may suggest the need for further evaluation rather than serving as a diagnosis by itself.

---

### **Medical Conditions Must Not Be Missed**

Suppose a 52-year-old man develops erectile dysfunction.

He also watches pornography.

It would be dangerous to immediately say:

“Stop pornography and your erection will return.”

His ED might be related to:

- diabetes;
- hypertension;
- cardiovascular disease;
- low testosterone;
- medication;
- smoking.

Similarly, a younger man may have primarily psychological ED.

Assessment determines the difference.

---

### **Treatment: Can Problematic Pornography Use Improve?**

Yes.

People can improve control over problematic sexual behaviour and rebuild healthier sexual patterns.

Treatment depends upon what is driving the problem.

Possible interventions include:

- psychoeducation;
- cognitive behavioural therapy;
- acceptance and commitment therapy;
- mindfulness-based techniques;



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- behavioural modification;
- trigger management;
- emotional-regulation training;
- couple counselling;
- psychosexual therapy;
- treatment of depression or anxiety;
- treatment of associated sexual dysfunction;
- sleep and lifestyle improvement.

A 2025 meta-analysis involving 20 psychotherapy studies and more than 2,000 participants reported significantly greater improvements in problematic pornography use, pornography frequency/duration and sexual compulsivity among patients receiving psychotherapy compared with controls. Most interventions involved CBT or acceptance-and-commitment approaches.

However, earlier systematic reviews also emphasized limitations in study quality, small samples and risk of bias.

Therefore, treatment is promising but should not be advertised as a guaranteed instant cure.

---

## 1. Identify the Trigger

One of the first therapeutic questions is:

“When does the urge usually appear?”

A patient may discover:

“I watch pornography when I am lonely.”

Another:

“When I am stressed after work.”

Another:

“Late at night when everybody is sleeping.”

Another:

“After arguing with my spouse.”

Now treatment becomes more precise.



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We treat the pattern, not merely the screen.

---

## **2. Break Automatic Behaviour**

Problematic behaviour often becomes automatic.

Trigger → phone → pornography → masturbation.

Introducing a pause can be useful.

The person learns to recognize:

“I am experiencing an urge. I do not have to act immediately.”

This is different from telling oneself:

“I must never have a sexual thought.”

Sexual thoughts are normal.

Control involves deciding how to respond.

---

## **3. Cognitive Behavioural Therapy**

CBT can help examine beliefs such as:

“I cannot tolerate this urge.”

“I have already failed once, so there is no point trying.”

“My sexuality is permanently damaged.”

“I need pornography to become aroused.”

“My partner will never satisfy me.”

Therapy helps replace rigid or catastrophic beliefs with more realistic ones.

A 2026 scoping review of CBT-based interventions found promising reductions in problematic pornography symptoms across CBT, ACT, mindfulness and combined programmes, while also emphasizing that the evidence base still requires stronger and more standardized clinical trials.

---

## **4. Do Not Turn Recovery Into Obsession**

Some patients begin counting every sexual thought.

They constantly test themselves:



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“Am I cured?”

“Do I still feel an urge?”

“Did I accidentally see something?”

This can create another anxiety cycle.

Recovery should focus on:

- control;
- healthy functioning;
- emotional well-being;
- realistic sexuality;
- relationships;

rather than constant fear.

---

## **5. Reduce Easy Access When Necessary**

Behavioural strategies may include:

- not taking the phone into bed;
- avoiding long periods of unstructured browsing;
- reducing private trigger situations;
- filtering unwanted content;
- turning off particular recommendations;
- maintaining structured routines.

Technology alone is rarely the entire treatment.

But environmental modification can make behavioural change easier.

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## **6. Improve Sleep**

Late-night pornography use can cause:

- delayed sleep;
- sleep deprivation;
- daytime fatigue;



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- reduced concentration;
- irritability.

Poor sleep can then worsen impulse control and emotional regulation.

Sleep therefore deserves attention.

---

## **7. Physical Activity and Daily Structure**

Regular exercise and structured daily activity can support:

- mood;
- sleep;
- metabolic health;
- stress management;
- self-confidence.

A person spending long periods isolated and inactive may benefit from rebuilding a fuller daily life.

---

## **8. Rebuild Partnered Intimacy**

If pornography has replaced partnered sexuality, recovery should not focus solely on avoiding pornography.

We may also need to rebuild:

- affection;
- communication;
- touch;
- emotional connection;
- sexual comfort;
- mutual desire.

Partnered intimacy should not become an examination of whether the patient is “cured.”

---

## **9. Reduce Sexual Performance Pressure**



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For a man with sexual anxiety, the therapeutic goal may initially be:

**comfort before erection.**

**connection before performance.**

**pleasure before proving masculinity.**

A temporary erection fluctuation should not automatically be interpreted as failure.

---

## **10. Address Relationship Injury**

When pornography use involved repeated deception, both partners may require support.

The viewing behaviour may improve quickly.

Trust usually improves more slowly.

Relationship repair involves behaviour over time.

---

## **11. Treat Depression, Anxiety or Other Mental-Health Conditions**

If problematic pornography use is partly serving as emotional escape, mental-health treatment may be essential.

Severe depression, suicidal thinking, severe anxiety, mania or other significant psychiatric symptoms require appropriate specialist assessment.

---

## **What About Medication?**

There is no universally established tablet that simply “cures pornography addiction.”

Medication may sometimes be considered by appropriately qualified specialists when clinically indicated for CSBD or associated psychiatric conditions.

A systematic review of pharmacological treatments found that the existing evidence remains limited and is based on relatively small numbers of patients.

Patients should therefore avoid self-medicating with:

- psychiatric drugs;
- hormonal medicines;
- sexual-performance medicines;



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- unregulated supplements.

Treatment must match the actual diagnosis.

---

## The Role of the Unani System of Medicine

The Unani system traditionally approaches health in a broad and integrative manner.

Official Ministry of AYUSH material describes the **Asbab-e-Sitta Zarooriya**, or six essential factors, including:

- air;
- food and drink;
- physical activity and rest;
- sleep and wakefulness;
- retention and evacuation;
- mental and emotional well-being.

The Unani tradition also describes **Nafsiyati Tadbeer**, referring to psychological or mental-health-oriented measures within its wider health framework.

This broad perspective can be clinically useful in patients whose pornography-related concerns occur alongside:

- poor sleep;
- sedentary lifestyle;
- chronic stress;
- fatigue;
- anxiety;
- digestive or metabolic problems;
- sexual weakness complaints;
- reproductive-health concerns.

However, a scientific distinction is important:

**There is currently no high-quality evidence establishing a particular Unani medicine as a stand-alone cure for problematic pornography use or CSBD.**



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Therefore, in my approach, Unani medicine should be used responsibly as part of an **integrative and individualized plan** rather than as a substitute for appropriate psychological or psychiatric treatment.

---

### **Unani Understanding of Lifestyle Balance**

From a traditional Unani perspective, health is supported when essential lifestyle factors remain appropriately balanced.

This is relevant because sexual-health problems rarely occur in complete isolation.

For example:

Late-night pornography → poor sleep.

Poor sleep → fatigue and irritability.

Fatigue → reduced partner interest.

Reduced intimacy → relationship tension.

Relationship tension → emotional stress.

Stress → further pornography use.

The cycle therefore contains several components.

A holistic approach asks:

**Which parts of the cycle can we change?**

---

### **Ilaj bil Ghiza – Dietary Support**

Diet does not directly remove compulsive sexual behaviour.

However, nutritional health matters for:

- metabolic health;
- energy;
- hormonal function;
- cardiovascular health;
- general well-being.

If a man has obesity, diabetes or metabolic illness alongside sexual dysfunction, dietary management may indirectly support sexual health.



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Unani dietary principles may therefore be incorporated where appropriate to the person's constitution and medical situation.

---

### **Sleep and Wakefulness**

This is particularly important in pornography-related concerns because internet use commonly occurs late at night.

A patient may tell me:

“I start watching at 11 PM and suddenly it is 2 AM.”

Treatment should therefore include sleep behaviour.

Good sexual health requires good general health.

---

### **Exercise and Rest**

Moderate physical activity may help:

- reduce stress;
- improve cardiovascular health;
- support sleep;
- improve mood;
- maintain healthy body weight.

For men experiencing ED, cardiovascular and metabolic health can be particularly relevant.

---

### **Nafsiyati Tadbeer and Psychological Support**

The traditional Unani recognition that psychological states influence physical health is particularly relevant in sexual medicine.

Sexual arousal is affected by:

- emotion;
- anxiety;
- expectations;
- attention;



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- confidence;
- relationship context.

However, traditional psychological support must not replace evidence-based mental-health treatment when a serious psychiatric disorder is present.

I strongly favour referral or collaborative care when necessary.

---

### **What About Unani Herbal Medicines?**

Herbal medicines should not be given automatically merely because a patient reports pornography use.

A medicine cannot:

- repair relationship trust by itself;
- eliminate loneliness;
- teach impulse control;
- resolve moral conflict;
- replace psychotherapy;
- remove performance anxiety without addressing its cause.

Unani medicines may have a role when a properly diagnosed associated medical or sexual-health condition is present and treatment is clinically appropriate.

This is an important principle at Saira Health Care:

**Treat the patient—not the label.**

---

### **My Clinical Approach at Saira Health Care**

When a patient comes to Saira Health Care and says:

“Doctor, I think pornography has ruined me,”

my first responsibility is not to frighten him.

My responsibility is to understand him.

I ask:

Is pornography actually compulsive?

Is the patient primarily experiencing guilt?



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Is there erectile dysfunction?

Is there premature or delayed ejaculation?

Is masturbation extremely frequent?

Is there relationship conflict?

Is the person depressed?

Is there anxiety?

Is infertility creating performance pressure?

Is diabetes contributing?

Are medications involved?

Is there a hormonal problem?

Only after separating these possibilities can an appropriate treatment plan be made.

---

### **Step One: Confidential Sexual-History Assessment**

Sexual-health consultations require privacy.

Many patients have never discussed pornography, masturbation or sexual difficulties openly with another person.

A non-judgmental consultation allows honest information to emerge.

My goal is not humiliation.

My goal is diagnosis.

---

### **Step Two: Separate Normal Use From Problematic Use**

I assess whether there is:

- loss of control;
- impaired daily functioning;
- repeated failed reduction attempts;
- meaningful consequences.

Frequency alone is not enough.

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### **Step Three: Evaluate Sexual Dysfunction**

If the patient has ED, I assess ED.

If he has premature ejaculation, I assess premature ejaculation.

If he has delayed ejaculation, that requires a different evaluation.

The presence of pornography does not remove the need for ordinary sexual-medicine assessment.

---

### **Step Four: Evaluate Physical Health**

When clinically required, evaluation may include:

- blood pressure;
  - blood sugar;
  - thyroid testing;
  - hormonal evaluation;
  - cardiovascular risk;
  - medication review;
  - urological assessment.
- 

### **Step Five: Evaluate Psychological Factors**

I consider:

- performance anxiety;
  - depression;
  - loneliness;
  - shame;
  - obsessive thinking;
  - body-image concerns;
  - stress;
  - relationship problems.
- 



### **Step Six: Evaluate Infertility When Relevant**

When pornography concerns occur in a couple seeking pregnancy, I consider:

- semen quality;
  - timing of intercourse;
  - erection during fertile days;
  - ejaculation;
  - relationship stress;
  - reproductive health of both partners.
- 

### **Step Seven: Behavioural and Sexual Counselling**

Depending upon the case, counselling may focus on:

- reducing triggers;
  - developing behavioural control;
  - restructuring habits;
  - correcting sexual misconceptions;
  - improving partnered sexual confidence;
  - reducing performance anxiety;
  - rebuilding intimacy.
- 

### **Step Eight: Responsible Unani Integration**

Where appropriate, Unani care may support:

- healthier sleep;
- diet;
- lifestyle regulation;
- general physical health;
- associated sexual-health conditions.

It should complement—not compete with—necessary psychological and medical treatment.



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### **Step Nine: Refer When Necessary**

A responsible physician must also recognize when another specialist is needed.

Referral may be appropriate for:

- severe depression;
- suicidality;
- significant anxiety disorders;
- suspected bipolar disorder;
- trauma;
- compulsive behaviour requiring specialist psychotherapy;
- couple therapy;
- psychiatric medication assessment;
- complex urological disease.

Integrated care is often the strongest care.

---

### **Dr. Nizamuddin Qasmi's Clinical Focus**

My professional work at Saira Health Care has a focused emphasis on sexual disorders and infertility.

My qualifications and training include:

**BUMS – Hamdard University, Delhi**

**MD**

**CGO**

**Certificate in Infertility – MGBIMS, Delhi**

**Certificate in Urology – London, UK**

**Masters in Male Infertility – MasterHealthPro (HealthPro)**

**Integrated Sexual and Reproductive Health – ISRH, UNFPA**

This combination of sexual-health, infertility, reproductive-health and urological training supports an approach in which pornography-related concerns are not viewed merely as a behavioural issue.

We also consider:

- erectile health;



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- ejaculation;
- male infertility;
- hormonal health;
- reproductive function;
- psychosexual factors;
- relationship factors.

---

### Saira Health Care's Contribution to Sexual Disorders & Infertility

One of the major challenges in sexual medicine is **embarrassment**.

Men may wait years before discussing:

- pornography concerns;
- masturbation anxiety;
- ED;
- premature ejaculation;
- infertility;
- low desire.

During that time, some repeatedly purchase sexual medicines without diagnosis.

Others watch alarming online videos and become convinced that their bodies are permanently damaged.

At Saira Health Care, our clinical objective is to make sexual-health consultation:

- confidential;
- understandable;
- respectful;
- individualized;
- evidence-aware.

We emphasize:

- proper sexual history;
- medical evaluation;



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- fertility evaluation where appropriate;
- responsible Unani integration;
- patient education;
- psychological and relationship assessment;
- specialist referral when necessary.

Sexual-health care should treat the entire person, not merely the erection.

---

## Common Myths

### Myth 1: Anyone Who Watches Pornography Is Addicted

**Reality:** No. Diagnosis requires evidence of impaired control and meaningful distress or functional impairment.

### Myth 2: Pornography Always Causes Erectile Dysfunction

**Reality:** Research is mixed. Problematic use and psychological or relationship factors may be relevant in some patients, but ED has many possible medical causes.

### Myth 3: Pornography Permanently Destroys Dopamine

**Reality:** This is an oversimplification of brain reward physiology.

### Myth 4: Pornography Automatically Causes Infertility

**Reality:** Infertility requires reproductive assessment. Pornography is not itself a semen-analysis diagnosis.

### Myth 5: Masturbation Means Someone Has a Sexual Disease

**Reality:** Masturbation itself is not automatically pathological. The context, control and consequences matter.

### Myth 6: Every Patient Must Completely Abstain Forever

**Reality:** Treatment goals should be individualized according to the patient's values, behaviour, impairment and clinical needs.

### Myth 7: Medicine Alone Will Cure the Problem

**Reality:** Behavioural, emotional and relationship components frequently require counselling or psychotherapy.

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## Frequently Asked Questions



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### **Is pornography-related sexual concern a disease?**

It is better understood as an umbrella term describing sexual, psychological, behavioural or relationship problems associated with pornography use. Some severe cases may meet ICD-11 requirements for Compulsive Sexual Behaviour Disorder.

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### **Is “porn addiction” an official diagnosis?**

“Porn addiction” itself is not a standalone WHO ICD-11 diagnosis. Severe problematic pornography use may occur within Compulsive Sexual Behaviour Disorder when diagnostic requirements are met.

---

### **How do I know whether my pornography use is problematic?**

Concern increases when use becomes difficult to control and begins interfering with relationships, responsibilities, sleep, sexual functioning or emotional health.

---

### **I watch pornography but can easily stop. Am I addicted?**

Not necessarily. Frequency alone does not establish a disorder.

---

### **I feel very guilty after watching pornography. Does that prove addiction?**

No.

Guilt may occur because behaviour conflicts with personal, cultural or religious values. Moral conflict should be evaluated separately from behavioural loss of control.

---

### **Can pornography cause erectile dysfunction?**

It may be associated with sexual difficulties in some patients, particularly when pornography use is problematic, but the evidence does not support assuming that pornography viewing alone causes ED. Medical, psychological and relationship causes must also be considered.

---

### **Why do I get an erection while watching pornography but not with my wife?**



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Possible reasons include performance anxiety, relationship factors, stimulation differences, masturbation habits and psychological conditioning. Medical causes of ED should also be evaluated.

---

### **Can pornography cause delayed ejaculation?**

It may be relevant in an individual case, but current evidence does not establish pornography as a universal cause. Medication, diabetes, neurological factors, masturbation technique and psychological factors may also contribute.

---

### **Can pornography cause premature ejaculation?**

Pornography should not automatically be blamed. Premature ejaculation requires its own sexual-health evaluation.

---

### **Does pornography cause low testosterone?**

There is no basis for diagnosing chronic testosterone deficiency simply from pornography use. Hormones should be evaluated medically when symptoms justify testing.

---

### **Can pornography reduce sperm count?**

Pornography itself is not an established direct cause of low sperm count. Men concerned about fertility should undergo semen analysis and appropriate reproductive evaluation.

---

### **Can problematic pornography use affect marriage?**

Yes, particularly when use involves secrecy, disagreement about boundaries, reduced intimacy or compulsive behaviour. However, research demonstrates a range of experiences rather than one inevitable relationship outcome.

---

### **Can pornography create unrealistic expectations?**

It can in some individuals, especially when pornography becomes a major source of sex education or comparison.

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### **Can anxiety make the problem worse?**

Yes.

Anxiety can increase pornography use in some people and can independently contribute to erection, ejaculation and desire problems.

---

### **Is psychotherapy effective?**

Psychotherapy—especially CBT and related behavioural approaches—has shown encouraging evidence for problematic pornography use, although the field still requires stronger clinical trials.

---

### **Can Unani medicine help?**

The Unani system can contribute to an integrative approach through lifestyle regulation, sleep, diet, psychological support and treatment of associated health conditions when clinically appropriate.

However, no particular Unani herbal medicine has been established by high-quality evidence as a stand-alone cure for problematic pornography use or CSBD.

---

### **Should I suddenly stop all sexual activity?**

Not necessarily.

Treatment should be individualized.

The purpose of treatment is not to create fear of sexuality.

The goal is healthy control, sexual well-being and better functioning.

---

### **Is recovery possible?**

Yes.

Many patients can improve control over behaviour, reduce pornography-related distress, rebuild partnered sexuality and address associated anxiety or sexual dysfunction with appropriate assessment and treatment.

Recovery usually occurs through gradual behavioural change rather than one instant intervention.

---

## When Professional Help Is Recommended

Professional assessment is particularly important when pornography-related behaviour:

- feels uncontrollable;
- repeatedly disrupts marriage or relationships;
- interferes with work or study;
- causes persistent erectile or ejaculatory difficulties;
- replaces desired partnered sexual activity;
- occurs alongside significant depression;
- occurs alongside severe anxiety;
- causes extreme emotional distress;
- is associated with suicidal thinking;
- leads to financial or occupational consequences;
- occurs alongside other compulsive behaviours.

Urgent mental-health care is needed when severe depression, self-harm or suicidal thinking is present.

---

## A Message From Dr. Nizamuddin Qasmi

When a man sits in front of me and says:

“Doctor, I have destroyed myself because of pornography,”

my first message is:

Do not diagnose yourself from frightening information on the internet.

Let us understand what is actually happening.

Perhaps there is compulsive pornography use.

Perhaps there is performance anxiety.

Perhaps you have erectile dysfunction from diabetes.

Perhaps masturbation patterns need modification.

Perhaps your marriage is under stress.

Perhaps you are depressed.



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Perhaps guilt has convinced you that occasional pornography means addiction.

Perhaps more than one of these problems is present.

Medicine begins when we separate these possibilities.

Sexual health is not simply the ability to achieve an erection.

It involves the interaction of:

- body;
- mind;
- emotions;
- relationships;
- reproduction;
- personal values.

This is why my approach at Saira Health Care is not simply:

“Take this medicine and everything will become normal.”

I prefer to understand:

### **Why is this patient experiencing the problem?**

When the cause becomes clearer, treatment can become more precise.

---

### **Final Perspective**

Pornography-related sexual concerns are real for many people.

But responsible sexual medicine requires balance.

We should not dismiss a patient who has genuinely lost control over repetitive pornography use.

At the same time, we should not label every viewer as addicted or sexually damaged.

Current scientific evidence suggests that problematic pornography use is a complex phenomenon involving different combinations of:

- behavioural dysregulation;
- emotional coping;
- mental health;
- sexual functioning;



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- relationships;
- shame;
- personal values;
- moral incongruence.

Research on sexual dysfunction is similarly nuanced. A major 2026 systematic review found that simple pornography viewing is not consistently associated with male sexual dysfunction, while problematic patterns and psychological factors appear more relevant.

Modern psychotherapy research is encouraging. CBT, acceptance-based approaches and related psychological interventions appear capable of helping many people with problematic pornography use, although further high-quality treatment studies remain necessary.

The Unani system can contribute an additional supportive framework through its traditional emphasis on:

- sleep;
- diet;
- exercise;
- rest;
- mental well-being;
- overall lifestyle balance.

But Unani treatment should be integrated responsibly with sexual medicine, psychological care and specialist referral where necessary.

My message to patients is simple:

**Do not allow pornography to define your sexuality.**

**Do not allow guilt to become your diagnosis.**

**Do not assume every sexual problem is caused by pornography.**

And most importantly:

**Do not lose hope.**

With proper evaluation, realistic sexual education, behavioural change, treatment of associated medical problems and appropriate psychological support, many patients



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can regain greater control, confidence and satisfaction in their sexual and relationship lives.

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### Selected Scientific Evidence Used in This Article

1. **World Health Organization — ICD-11 Clinical Descriptions and Diagnostic Requirements.** Compulsive Sexual Behaviour Disorder is classified as an impulse-control disorder, emphasizing persistent failure to control repetitive sexual behaviour with significant functional impairment.
  2. **Ince C, et al., 2026.** Comprehensive interdisciplinary review of Compulsive Sexual Behaviour Disorder and Problematic Pornography Use, including assessment, epidemiology, causes, consequences and treatment.
  3. **Zacharopoulos Z, et al., 2026.** Systematic review of pornography consumption and male sexual dysfunction reporting mixed evidence and emphasizing differences between ordinary and problematic use.
  4. **Chew PKH, et al., 2025.** Meta-analysis of problematic pornography-use prevalence. The pooled estimate was approximately 13%, but very high heterogeneity limits universal interpretation.
  5. **Bóthe B, et al., 2025.** International 42-country investigation distinguishing behavioural dysregulation from moral-disapproval-related pornography concerns.
  6. **López-Pinar C, et al., 2025.** Meta-analysis of psychotherapy for problematic pornography use finding significant benefit compared with control conditions.
  7. **CBT-Based Interventions for Problematic Pornography Use, 2026.** Current review finding promising results from CBT, ACT, mindfulness and combined approaches while noting methodological limitations.
  8. **Ministry of AYUSH.** Official descriptions of Unani health principles including Asbab-e-Sitta Zarooriya and Nafsiyati Tadbeer support the traditional holistic framework discussed in this article.
- 

### About the Author

#### Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care  
Focused Practice in Sexual Disorders & Infertility

### Qualifications & Training



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  - MD
  - CGO
  - Certificate in Infertility, MGBIMS, Delhi
  - Certificate in Urology – London, UK
  - Masters in Male Infertility by MasterHealthPro (HealthPro)
  - Integrated Sexual and Reproductive Health (ISRH, UNFPA)
- 

### Medical Disclaimer

This article is intended for **patient education and general health information**.

Pornography-related sexual concerns may arise from behavioural, psychological, relationship, cultural, medical or sexual-health factors. Problematic pornography use should not be diagnosed simply on the basis of viewing frequency, masturbation or personal guilt.

Erectile dysfunction, premature ejaculation, delayed ejaculation, low sexual desire, infertility and other sexual problems can have multiple physical and psychological causes and should be evaluated individually.

Unani medicine may form part of an integrative treatment plan when clinically appropriate, but it should not replace necessary medical investigation, psychotherapy, psychiatric treatment or specialist care.

Patients experiencing severe depression, suicidal thoughts, uncontrolled compulsive behaviour or other serious psychological symptoms should seek appropriate professional mental-health care promptly.



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