



Pornography Viewing: Keep Calm and Carry On

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Sexual medicine has expressed concern about the presumed negative effects of pornography on sexual aggression, sexual relationships, and sexual function since the inception of the scientific study of human sexuality. Ivan Bloch,¹ the German physician who coined the term *sexology*, asserted as long ago as 1902 that “[t]here is no sexual aberration, no perverse act, however frightful, that is not photographically represented today” [p. 204]. Experimental studies of pornography and aggression conducted in the 1970s and 1980s appeared to support an assumed relation between pornography and anti-woman sexual aggression, with Malamuth et al² concluding broadly, in 2000, that “... exposure to both nonviolent pornography and violent pornography affects both aggressive attitudes and behaviors” [p. 44]. Extending the harm-focused narrative, many have recently suggested that pornography damages sexual satisfaction and harms intimate relationships. For example, in 2010, Lambert et al³ reported that “[w]e have examined whether the consumption of pornography affects romantic relationships, with the expectation that higher levels of pornography consumption would correspond to weakened commitment ...” [p. 410]. In their report, evidence collected across five studies showed that higher pornography consumption was linked with lower levels of relationship commitment, more extra-dyadic flirting, and higher levels of relationship infidelity. More recently still, activists, clinicians, and researchers have asserted that pornography use is linked with sexual dysfunction and that there have been unprecedented increases in what is termed “[p]ornography-induced erectile dysfunction (PIED) and pornography-induced abnormally low libido”⁴ [p. 3] as a result of the availability of sexually explicit material on the internet. The possibility that pornography use might causally influence sexual aggression, sexual and relationship dissatisfaction, and sexual dysfunction is of considerable significance for sexual medicine, and we comment briefly on the available evidence.

With respect to an asserted causal link between pornography and anti-woman sexual aggression, research findings have been inconsistent across decades of study. Early laboratory research in which men were angered by a female confederate of the

researcher, shown violent pornography, and instructed to administer painful electrical shocks to the confederate appeared to produce artifactual evidence that pornography causes men to aggress against women⁵ because of the artificially constrained research design used. Subsequent research similarly used a female confederate who angered male participants who were shown violent pornography, but then the male participants were given a choice to make aggressive or non-aggressive responses to the confederate. Given a choice in the matter, such as exists in the real world, nearly all men declined to engage in anti-woman aggression despite having been angered by a woman and stimulated with violent pornography.⁶ Other research that failed to support a pornography-aggression link indicated that convicted sex criminals might report less exposure to sexually explicit materials than other criminals, that the legalization of all forms of sexually explicit materials in several nations has not been associated within increases in reported sex crimes, and that users of pornography might have more pro-feminist and progressive attitudes toward women than non-users of pornography.^{7,8} A reformulated approach, suggesting that men with multiple pre-existing antisocial and anti-woman tendencies who also are frequent users of pornography are most likely to engage in sexual aggression against women—a “confluence model” of pornography and aggression—has limited research support. However, the confluence model is vulnerable to “third variable” explanations in which unmeasured factors that are not accounted for in confluence model research might be responsible for the predicted effects. Demonstrating such “third variable” effects, Baer et al⁹ examined the relations among men’s pornography use, sex drive, and anti-woman sexual aggression. Findings indicated that male sex drive supplanted male pornography use in the prediction of sexual aggression, decreasing the predictive significance of pornography use to non-significance. The fact that the reported occurrence of sexual assault has decreased substantially during the era of unlimited access to all forms of internet pornography also is inconsistent with an asserted robust causal relation between pornography and sexual aggression.⁷

With respect to the assertion that pornography contributes to decreases in sexual and relationship satisfaction, findings are quite mixed. In efforts to identify pornography-induced harm to relationships, researchers have commonly limited research to facets of relationship functioning where harm is most likely to occur.¹⁰ Some of this research has confirmed the occurrence of pornography-induced negative effects on relationships, some of this research has indicated mixed negative and positive effects of pornography on sexual and relationship satisfaction, and some findings for negative effects of pornography on

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relationship-related outcomes have been subject to multiple failures to replicate.^{10,11} A recent study¹⁰ using the simple open-ended approach of asking individuals whether their own pornography use, their partner's pornography use, or their mutual pornography use with their partners had had an effect on their relationship found that the predominant reported effect was "no effect" by a very considerable margin. When effects of pornography use on participants' relationships were reported, reports of positive effects (eg, adds variety to our sex life, decreases pressure on my partner, and increases intimacy) predominated and reports of negative effects on the couple relationship (eg, leads to unrealistic expectations) were in the decided minority. This pattern of results has been replicated in subsequent unpublished research by the same scholars. The fact that the rate of divorce per thousand marriages has decreased substantially and consistently during the era of widespread availability of pornography on the internet also is inconsistent with the presumption of broad negative effects of pornography on couples' sexual and romantic relationships.¹²

With respect to the assertion that pornography has produced a spike in sexual dysfunctions including erectile dysfunction, hyposexual desire disorder,⁴ hypersexuality, and sex addiction,¹³ findings are inconsistent. Media claims of a widespread problem with pornography-induced sexual problems exceed research evidence available to support these claims,¹³ and at least two studies have failed to find a link between frequency of pornography use and erectile dysfunction or other sexual problems in men.^{14,15} In fact, Prause and Pfaus¹⁴ found that "[m]ore hours viewing Visual Sexual Stimuli (VSS) was related to stronger experienced sexual response to viewing VSS in the laboratory, was unrelated to erectile functioning with a partner, and was related to stronger desire for sex with a partner" [p. 90]. Similarly, Landripet and Štulhofer¹⁵ reported, in studies of two large samples of European young men, that they "... found little evidence of the association between pornography use and male sexual health disturbances. Contrary to raising public concerns, pornography does not seem to be a significant risk factor for younger men's desire, erectile, or orgasmic difficulties" [p. 1136].

Where does all of this leave sexual medicine clinicians and researchers?

First, as consumers of and contributors to sexual medicine research, we need to step back from the media hype, recognize that the evidence concerning pornography harms is often inconsistent or flawed, and read research reports carefully and critically. As a field, we need to think about conducting more definitive studies, where previous research approaches have been flawed, and conducting more research, where the accumulation of research findings has been limited.

Second, from a clinical perspective, we need keep eternally open minds. We are always treating individuals and partners and never treating peer-reviewed research samples. Our patients might have backgrounds and beliefs that incline them to

self-diagnose sex addiction, they might find that blaming pornography is a reassuring explanation for an embarrassing sexual dysfunction, they might seek to address a problem with pornography as a way to avoid addressing deeper relational and sexual conflicts, they might have intolerant partners as opposed to excessive pornography use, or they might have experienced genuine pornography-induced harms. Patients might find that pornography provides access to sexual cues that match their specific sexual interests that are not available to them elsewhere, they might find that pornography stimulates sexual function when such function is difficult to sustain in other settings, and they might have genuinely conditioned sexual responses, including antisocial or aggressive sexual responses, to pornographic content. Patients might develop expectations from watching pornography that are unrealistic, contributing to sexual dissatisfaction for themselves or their partners, or they might develop expectations that are aspirational and stimulate efforts to enrich their sexual relationships. As always, clinical challenges rest on comprehending and addressing individual and relationship dynamics. This can include a careful consideration of issues involving pornography but should avoid under- or over-crediting pornography as a clinically relevant issue.

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