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Addictive behaviours: gambling, social media and pornography

1. Addictive behaviours: gambling, social media and pornography

The word 'addiction' may conjure images of IV drug users, smokers and cocaine addicts. But many highly addictive and damaging substances and behaviours are both legal and normalised in society. With ever-increasing levels of stress, and an increasing abundance of products and services using behavioural psychology to enhance sales, we are likely to see a growing impact on our patient's (and our own) health.

This article was updated in July 2025.

1.1. Classification

The most recent revision of ICD-11 ([WHO 2019](#)) introduced a new category: *Disorders due to addictive behaviours*. This marked a significant shift, broadening the concept of addiction beyond substance use to include other behaviours causing clinically significant impairment. Some experts have welcomed this as increased recognition of the harm that addictive behaviours can cause, while others have raised concerns that it risks pathologising everyday behaviours ([J Behav Addict. 2022; 1:180](#)).

In this article, we explore how to recognise and support people affected by addictive behaviours – including those not currently listed in ICD-11 or DSM classifications.

There are 3 broad categories of addiction.

Addiction	Substance addiction	• Alcohol. • Tobacco. • Drugs (illicit or prescribed).
	Disorder due to addictive behaviours	• Gambling. • Gaming.
		• Other disorders due to addictive behaviour: • ICD-11 does not list specific behaviours in this category, but defines them as persistent, repetitive actions with impaired control that continue despite negative consequences and interfere with daily functioning. • Behaviours often discussed in the literature – though not formally recognised due to limited evidence – include social media use, pornography consumption and shopping. • Other patterns such as excessive work or exercise may also meet criteria for addictive behaviours. • These behaviours reinforce reward, motivation and memory pathways in ways similar to substance use disorders.
Impulse control disorders		• Pyromania (impulsive urge to start fires). • Kleptomania (impulsive urge to steal). • Compulsive sexual behaviour disorder.
ICD-11, WHO 2019; J Behav Addict. 2022; 1:180; Behav. Sci. 2015;5:388		

What about food addiction?

This is a complex issue. Food addiction is a controversial diagnosis and is not included in DSM-5 or ICD-11. There are currently no well-defined or widely-accepted diagnostic criteria. Having an addiction to food may involve behavioural characteristics of an eating disorder, with a lack of control over eating, as well as features of a substance use disorder, and may be associated with impulsive personality traits. There may even be elements of obsessive compulsive disorder, with intrusive thoughts related to food cues ([Frontiers in Psychiatry 2021;12:824936](#)).

Not all foods trigger addictive behaviours. Certain types of food, such as ultra-processed foods high in carbohydrates and fats, may be more strongly associated with the behavioural indicators of addiction, including excessive intake, loss of control over consumption, intense cravings and continued use despite negative consequences. There is an increasing move to view these types of foods as addictive substances ([BMJ 2023;383:e075354](#)). See our article *Ultra-processed food* for more about this.

1.2. What is the difference between an addictive behaviour and an impulse control disorder?

Although both can involve repeated actions that can disrupt daily life, ICD-11 ([WHO, 2019](#)) highlights some key differences between addictive behaviours and impulse control disorders.

Disorder due to addictive behaviours	• Involve repeating a behaviour because it feels rewarding or reinforcing. • The behaviour is driven by craving or compulsion, and stopping it may lead to withdrawal symptoms. • There is an ongoing loss of control over: • How often or intensely the behaviour happens. • How long it lasts. • When or where it takes place. • The ability to stop. • It often takes priority over other activities, and continues despite harm to health, relationships, work or education.
Impulse control disorders	• Involve acting on sudden urges that bring short-term relief, excitement or escape. • These urges are often preceded by rising tension or a build-up of pressure. • The person feels unable to resist the impulse, even though they know it could cause harm. • The behaviour is usually followed by guilt, shame or regret.

Impulse control disorders vs. ADHD

Individuals with ADHD also commonly have features of impulsive behaviour. However, in ADHD, these are usually seen across multiple contexts and situations, whereas impulse control disorders are usually limited to one specific area – such as pyromania or kleptomania. Individuals with ADHD also do not typically experience tension or affective arousal

prior to the behaviour, or a sense of relief or gratification once it has been completed.

1.3. How do we know if someone is addicted?

Determining when a behaviour crosses the line from being socially accepted to clinically significant can be difficult. However, both ICD-11 and DSM provide criteria that help identify when a behaviour may be classified as an addiction ([WHO, 2019](#)); [DSM-V TR 2022](#)). Key features include:

- A pattern of excessive, repetitive and persistent behaviour.
- Diminished control or a compulsive urge to engage in the behaviour.
- Continued engagement despite clear harm to self or others.
- Negative consequences across multiple life domains, including health, relationships, work or education.
- A shift from pleasure to compulsion, with the behaviour becoming less enjoyable over time.
- Recurring emotional cycles such as guilt, shame, anxiety or craving linked to the behaviour.

What can this look like?

18-year-old Felicity books to see you as she has been struggling with low mood for several months. She feels under a lot of pressure with her upcoming A-levels and can't get any revision done. She spends most of her time in her room on various social media platforms. Even when she closes all the apps on her laptop, she ends up regularly picking up her phone during revision time. She often declines social invites from friends and to eat dinner with her family because she

would rather spend the time online. When out socially, she tends to sneak to the toilets to check her notifications.

1.4. Are some of us more susceptible than others?

Addiction is influenced by complex biopsychosocial interactions, explaining why some people are more susceptible than others (Physiol Rev 2019;99:2115). Individual vulnerabilities include:

- Genetic/epigenetic variation.
 - Studies looking at genetic risk in siblings have given a rough estimate of 50% for the contribution of genetics to overall addiction risk.
- Neurodevelopmental stages.
 - Foetal, childhood and adolescent development are times of greater risk for development of addiction vulnerability if exposed to drugs or adverse stimuli at these times.
- Childhood experiences.
 - Seeing addictive behaviours in parents or carers.
 - Seeing positive attitudes towards substance use.
 - Harsh or absent parenting.
- Sociocultural effects.
 - Normalised cultural use of addictive substances.
 - Availability.
 - Legal status.

- Lack of social connection/social isolation.
- Comorbid conditions.
 - Pathological gambling and impulse control disorders are more common in people with Parkinson's disease than in the general population. The mechanism is not well understood, but the dopamine reward and inhibition systems may be involved. Drugs such as dopamine agonists may also play a role (Front Psychiatry 2021; 12:635494).
 - Mental health conditions are common in people with substance misuse disorders (and vice versa). An association between substance misuse and depression, anxiety disorders, PTSD, ADHD, bipolar disorder and psychosis has been shown ([NIDA 2022 – Common comorbidities with substance use disorder research report: part 1 – the connection between substance use disorders and mental illness](#)).

1.5. Neuroscience

Neurochemical changes

Addiction is increasingly recognised as a neurobiological disorder involving lasting changes in brain structure and function that affect systems related to reward, motivation, stress regulation and executive control ([Lancet Psychiatry, 2016; 3:760](#)). Addiction can be viewed as a three-stage cycle:

- **Binge/intoxication:** cues associated with the substance become strongly linked to pleasure and habit, reinforcing repeated use through increased dopamine and glutamate activity in the basal ganglia.
- **Withdrawal/negative affect:** with ongoing substance use, the brain's

ability to respond to natural rewards is reduced, while stress systems in the amygdala become overactive. This contributes to negative emotional states such as anxiety, irritability and dysphoria when the drug is absent.

- **Preoccupation/anticipation (craving):** dysfunction in the prefrontal cortex, which supports self-regulation, attention and decision-making, leads to a persistent focus on seeking the substance. This stage is marked by heightened sensitivity to drug-related cues, a reduced ability to experience pleasure from everyday activities and increased stress responsiveness. Together, these factors intensify craving and increase the risk of relapse.

This cycle reflects a shift from impulsive behaviour (driven by the desire for immediate reward) to compulsive behaviour (driven by the need to relieve distress), although the two can often co-exist. Repeated substance use dulls the brain's response to pleasure, particularly through changes in the mesolimbic dopamine system, leading to tolerance and a need for increasing doses. At the same time, impaired decision-making and self-regulation make it harder to stop.

Operant conditioning

Operant conditioning may also play an important role in behavioural addictions. When behaviours are rewarded unpredictably with variable reinforcement, they become more persistent. This is demonstrated in gambling, where near misses (losses that feel close to a win) activate brain reward centres, reinforcing continued play. These responses are similar to those seen in substance addiction and help explain compulsive use.

Cues associated with these rewards (such as lights, sounds or notifications) can themselves become reinforcing, prompting behaviour even when no

reward follows. Over time, this can shift behaviour from being goal-directed to habitual, continuing even when it brings less satisfaction or causes harm ([J Neuroscience 2010; 30:6180](#)).

While gambling is well studied, behaviours such as social media use or shopping are less well understood in terms of specific reinforcers. The role of intermittent feedback, arousal or social approval in maintaining these behaviours needs further research ([Clinical Psychology Review 2017; 52:69](#)).

1.6. Gambling disorder

In 2025, NICE issued its first clinical guidance on gambling-related harms ([NICE 2025, NG248](#)).

What is gambling?

Gambling in Great Britain is regulated under the Gambling Act 2005, which defines it as betting, playing games of chance for a prize or taking part in lotteries. The UK has one of the largest gambling markets in the world, generating £14.2 billion in profit in 2020. Online gambling is the fastest growing sector, accounting for over a third of the market, with more than 33 million active accounts ([BMJ 2019;365:l1807](#)).

How common is gambling?

Gambling is widespread in the UK ([OHID, 2023](#)):

- In 2018, 54% of UK adults reported gambling in the past year, dropping

to 40% if the National Lottery is excluded.

- Men are more likely to gamble than women, especially online (15% vs. 4%).
- 0.7% of the adult population (around 340 000 people) meet the criteria for problem gambling. A further 1.1% are at moderate risk of harm.
- Harmful gambling is more strongly associated with men, younger people, alcohol use, those living in deprived areas and those with mental health problems such as depression.
- Concerningly, 11% of children aged 11–16y reported gambling in the past week, with participation more common in boys and older adolescents. Gambling was more prevalent than smoking or drug use in this age range, and was associated with other risky behaviours including alcohol and substance use.

What is the impact of gambling?

Gambling causes wide-ranging harms that affect individuals, families and society. The estimated annual economic burden of gambling-related harm in England is between £1.05 and £1.77 billion. Key areas of harm include ([OHID, 2023](#)):

- Financial harms: increased risk of debt, bankruptcy, housing instability and homelessness.
- Relationship harms: gambling can lead to family conflict, relationship breakdown and domestic abuse.
- Mental and physical health: increased rates of anxiety, depression, poor self-care and suicide. People also report feelings of guilt, shame, low self-esteem and loneliness.
- Employment and education: gambling can lead to job loss, reduced

work performance and disrupted education.

- Criminal and antisocial behaviour: financial desperation may lead to theft, fraud or drug-related crime.
- Harms to others: around 7% of the UK population is negatively affected by someone else's gambling. The most severe impacts are experienced by close family members:
 - There may be financial strain, emotional distress, anxiety and sleep problems.
 - Children may struggle with academic performance due to stress and unstable home environments.
 - Friends and relatives may be deceived or financially exploited.

Lessons from the tobacco industry about how to tackle gambling harms

A BMJ Analysis discusses reported parallels between the tactics used by the tobacco and gambling industries to influence public health ([BMJ 2025;388:e082866](#)). The authors describe how the gambling industry, like the tobacco industry in the past, has been accused of downplaying harm, funding selective research and positioning itself as a responsible partner. They raise concerns about gambling industry involvement in policy and regulation, including the tendency to frame gambling-related harm as a matter of individual responsibility rather than highlighting risks relating to the industry itself. The article suggests that UK regulation may have enabled this influence to continue, drawing comparisons with past delays to tobacco reform.

The authors call for a fundamental shift away from industry-led approaches and towards a public health model that is independent, prevention-focused and free from conflicts of interest. This includes removing industry

influence from policymaking and research, enforcing stricter controls on advertising and marketing, and moving away from misleading terms such as 'responsible gambling'. For health professionals, this means recognising gambling as a commercial determinant of health – and supporting policies that prioritise public protection over industry partnership.

When and how should we ask about gambling in primary care?

NICE recommends that we routinely ask patients about gambling – particularly patients with risk factors – to support earlier identification and intervention. We should do this whenever we would be asking about smoking, alcohol consumption or substance use, for example during health checks or when people register with a GP.

NICE suggests using simple, direct questions such as:

- Do you gamble?
- Are you worried about your own or another person's gambling?

Be aware that people may feel uncomfortable discussing gambling. It's important to create a non-judgemental space and to pay particular attention to those at increased risk of gambling-related harm.

People at increased risk of gambling-related harm (NICE 2025, NG248):

- Mental health problems or substance misuse.
- Drug treatments that affect impulse control (e.g. dopamine agonists for Parkinson's, aripiprazole for psychosis).
- Current or a high risk of homelessness.
- Financial difficulties.
- Safeguarding concerns, including domestic abuse.
- A family history of harmful gambling, alcohol or drug use.
- Neurological conditions or acquired brain injuries that cause disinhibition or impulsivity.
- High-risk occupations such as armed forces, veterans, gambling or finance industry workers and professional athletes.
- Young people who have recently left home for the first time.

How can we recognise problem gambling?

DSM-5 and ICD-11 ([WHO 2019](#); [DSM-V TR 2022](#)) give some helpful pointers for when gambling is becoming a significant problem:

- Gambling that continues for 12m or more despite ongoing harm, with poor control over when, how often or how much the person gambles (ICD-11).
- Frequent thoughts about gambling or planning the next opportunity to gamble.
- Gambling more to try and win back previous losses (chasing losses).
- Needing to bet larger amounts over time to get the same level of excitement (tolerance).

- Using gambling to cope with feelings of stress, low mood or anxiety.
- Repeated failed attempts to cut down, often with restlessness or irritability when trying to stop (withdrawal).
- Hiding or downplaying gambling behaviour from others.
- Gambling that puts jobs, education or close relationships at risk.
- Financial problems, including debt, borrowing or even theft, linked to gambling.
- Co-existing symptoms of depression, anxiety, insomnia, substance misuse or suicidal thoughts linked to gambling.

Primary care assessment

When assessing the impact and severity of gambling in primary care, NICE recommends exploring the following areas:

Areas to cover	• Gambling history: when it began, how it has evolved and any increase in frequency or intensity. • Types and settings: including online or in person, and specific activities (e.g. betting, gaming, lottery). • Current frequency: days per week or hours per day. • Physical and mental health: past or current problems, including substance use. • Impact on daily life: including sleep, mood, relationships, work, education or involvement in crime. • Psychological role: motivations, emotional triggers, cravings and the function gambling serves. • Readiness for change: reasons for seeking help, motivation, expectations and goals for treatment.
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	• Safeguarding: any concerns about exploitation, violence or vulnerability. • Immediate needs: such as urgent help with housing, debts, food or safety. You can also signpost patients to the gambling self-assessment tool on the NHS website, which uses the Problem Gambling Severity Index (PGSI).
Risk assessment	NICE highlights gambling as a significant risk factor for suicidal thoughts and behaviours, especially immediately following gambling episodes. A risk assessment is therefore essential and should include: • Suicidal thoughts or behaviour. • Protective factors and social support. • A safety plan if the risk is acute. • Clear signposting to emergency services or crisis support if needed. See our article <i>Suicide</i> for more about effective suicide risk assessment.

Primary care support for people with gambling-related harms

According to NICE, support for people affected by gambling will depend on the level of harm and the person's needs. This may include:

- **Providing information:** about the nature of gambling-related harms and where to get help.
- **Signposting:** encourage the person to access support for gambling or associated problems, including finances, debt, housing, employment, legal issues or domestic abuse.

- **Medication review:** to assess whether medications (e.g. dopamine agonists) may be contributing to gambling behaviours. Adjustments should be made, in consultation with a specialist if needed.
- **Brief motivational interviewing:** to explore ambivalence and to build motivation for change.
- **Referral:** to specialist gambling treatment services, when appropriate.

Tips for reducing gambling

NICE recommends we discuss practical strategies that people can use to reduce or stop gambling. These include some 'dos' and 'don'ts':

Do	Don't
• Sign up for GamStop – this prevents access to UK-licensed gambling websites and apps for 6m, 1y or 5y. • Install Gamban or similar software to block gambling on your devices. • Ask your bank to block gambling transactions. • Use self-exclusion schemes for casinos, betting shops and arcades. • Block marketing emails, texts and notifications from gambling organisations. • Limit access to money – ask a trusted person to help manage your finances temporarily. • Pay essential bills first – set up standing orders on payday. • Get debt advice from National Debtline or StepChange. • Spend time with non-gambling friends and family. • Talk to someone you trust about what you're going through.	• Don't view gambling as a way to make money – this fuels chasing losses and risk taking. • Don't carry credit cards or large sums of money when gambling urges are strong. • Don't isolate yourself – secrecy makes it harder to get support.
NICE 2025, NG248, NHS - gambling addiction	

Management of gambling-related harms

NICE ([NICE 2025, NG248](#)) recommends a comprehensive, person-centred approach to the management of gambling-related harms. Care should be holistic, tailored to individual needs and delivered by multidisciplinary teams that may include health and social care services, the voluntary sector and, where relevant, the criminal justice system.

Treatment should be planned collaboratively, using shared decision-making that reflects the person's own goals and values. While abstinence is often the primary aim, other important goals may include improved mental health, relationships and financial stability.

Principles of care

Effective care should include:

- An empathic, non-stigmatising approach that builds a strong therapeutic relationship.
- Flexible delivery – including both in-person and remote formats – to support engagement.
- Continuity of care, with consistent communication and ongoing support.
- Involvement of family or significant others, where appropriate and agreed.
- Access to evidence-based, gambling-specific interventions delivered by trained practitioners within a defined competency framework.
- Peer support to provide shared experience, emotional connection and encouragement in recovery.

Gambling-specific interventions

NICE recommends that the following treatments and support be considered as options for gambling-related harm:

Psychological therapies	These include: • Motivational interviewing: to support confidence and readiness for change. • CBT: delivered in groups or individually by clinicians trained in gambling-specific CBT.
Medication	• Consider naltrexone (off-label) to reduce gambling severity if psychological therapy has not been effective or there have been repeated relapses. This should only be prescribed by an experienced specialist and is not routinely initiated in primary care.
Family support	Families affected by someone's gambling should also be offered support to: • Manage their own distress and prioritise their wellbeing. • Learn to communicate with the person in a supportive, non-judgemental way. • Access help and advice specific to their situation.
Managing relapse	NICE highlights that relapse after progress in gambling behaviour can be highly distressing and may increase the risk of suicide or self-harm. People at higher risk of relapse may benefit from additional therapy sessions, peer support or support groups, or help with social issues such as debt, housing or relationship difficulties. It's important to emphasise that: • Relapse is not a failure – it can be a part of recovery and a chance to learn.

- | | |
|--|---|
| | <ul style="list-style-type: none">• Planning for relapse improves confidence and reduces shame. Skills to manage high-risk situations can be learned.• Understanding personal triggers helps reduce the risk of relapse. These may be internal or external, including stress, social pressure or gambling ads. |
|--|---|

Referral

- For problem gambling, consider referral to an NHS gambling triage service, where available.
- The patient can often self-refer to NHS gambling services or can contact the [National Gambling Helpline](#) for support and referral options.

Management of comorbid conditions

Comorbid problems such as mental health conditions, alcohol or substance dependence, and acquired cognitive impairments are common among people experiencing gambling-related harms; they require coordinated, integrated care. According to NICE, effective management should:

- Recognise that comorbidities may result from gambling, predate it or need stabilising before gambling treatment can begin.
- Prioritise the treatment of severe conditions such as substance dependence or PTSD when these are likely to interfere with engagement in gambling-related interventions.
- Provide timely access to appropriate support through established referral pathways or in-house expertise.
- Coordinate care to minimise the risks of multiple or fragmented

appointments across different services.

- Address comorbidities alongside gambling where possible, to support recovery and reduce disengagement.

1.7. Social media addiction

Social media is now deeply woven into daily life, particularly for adolescents, who frequently rely on it for connection, self-expression and access to information. Although it is widely used across all age groups, research has largely focused on adolescents due to their high levels of engagement and the developmental importance of this stage of life.

Problematic social media use or addiction?

Social media addiction refers to excessive and compulsive use that significantly disrupts daily functioning ([Front Psychol 2022; 13:837766](#)). However, this is not formally recognised in diagnostic manuals such as ICD or DSM.

An alternative concept is *problematic social media use*, which is defined by the WHO as a pattern of behaviour with addiction-like symptoms. These include:

- Difficulty controlling usage.
- Withdrawal symptoms when not online.
- Neglect of responsibilities and offline activities.
- Negative life consequences linked to excessive use ([WHO, 2024](#)).

How common is problematic social media use?

The Health Behaviour in School-aged Children Study ([WHO, 2024](#)) surveyed almost 280 000 young people aged 11–15y globally. It reported a significant increase in problematic social media use among teenagers.

Findings included:

- 11% showed signs of problematic social media use (increased from 7% in 2018).
- Girls were more likely to report problematic use (13% vs. 9%) and continuous online contact.
- 34% of teens played digital games daily, with 22% playing for 4+ hours.
- Boys were more likely to engage in prolonged gaming, including at-risk patterns of behaviour.

Risk factors for social media addiction include ([Front Psychol 2022; 13:837766](#)):

- Female gender.
- High impulsivity.
- Attention bias towards negative information.
- Low self-esteem and social anxiety: may drive individuals to seek refuge and validation through online platforms, reinforcing compulsive use.

The harms of social media use

Problematic social media use is associated with multiple negative outcomes, including:

- Depressive symptoms.
- Anxiety and psychological distress.
- Cyberbullying and negative social comparison.
- Body image concerns and disordered eating.
- Substance use.
- Disrupted sleep.
- Deliberate self-harm and suicidality.
- Increased sedentary behaviour.
- Greater likelihood of risky behaviours (alcohol, smoking/vaping, drug use, unhealthy diet, risky sexual behaviour, gambling, aggression).

[WHO, 2024, Current Opinion in Psychology 2022; 44:58, BMJ 2023;383:e073552](#)

A longitudinal cohort study of young people aged 10–14y found that the type of screen engagement may be more important than total time when predicting mental health outcomes ([JAMA 2025;334:219](#)). Adolescents with high or increasing addictive use of social media, mobile phones or video games – characterised by compulsive engagement, difficulty disengaging and distress when not using – had significantly greater risks of suicidal thoughts, suicidal behaviours and emotional or behavioural difficulties. These patterns were more strongly linked to negative outcomes than overall screen time. The authors suggest that these findings highlight the need to monitor problematic patterns of use over time, and to shift the focus from total screen time to include other indicators of digital media-related risk.

Potential benefits

Not all social media use is harmful. When used in moderation and with intention, it can offer a range of benefits. This underlines the importance of balanced approaches that aim to maximise positive outcomes while reducing potential harms. Positive effects are more likely when use is active, purposeful and socially connected, and may include:

- Improved mood, happiness and life satisfaction.
- Social support, including maintaining long-distance relationships and finding like-minded peers.
- Reduced loneliness and encouragement of prosocial behaviour.
- Easier access to health information and professional advice.
- Opportunities for identity development, validation and authentic self-expression.

Current research is limited, but suggests that both positive and negative effects of social media tend to be small in size, vary between individuals and depend on the context and nature of engagement.

How to ask about problematic social media use

Problematic social media use involves more than just excessive time online. It involves compulsive use, emotional dependence and disruption of mood, sleep, relationships and daily life. In primary care, the Bergen Social Media Addiction Scale provides a helpful framework for exploring patterns of use. It is based on core features of behavioural addiction, and can help guide conversations and support recognition of problematic use ([Clin Psych 2024; 28:185](#)):

Questions to help explore social media use in primary care (SCREEN)

- **Social preoccupation:** Do you often find yourself thinking about social media or planning how to use it?
- **Compulsion:** Do you feel a strong urge to use social media more and more over time?
- **Refuge/escape:** Do you turn to social media to manage or escape from negative feelings?
- **Efforts to cut down:** Have you tried to cut down without success?
- **Emotional distress:** Do you feel restless or low when unable to access social media?
- **Negative impact:** Has it ever interfered with your work, studies or relationships?

[Clin Psych 2024; 28:185](#)

What can we do in primary care?

There are no formal UK guidelines for managing problematic social media use in primary care. However, some helpful strategies include ([J Med Internet Res 2023;25:e4492](#)):

- **Building rapport:** use open, non-judgemental questions (e.g. “Can you tell me about your social media habits?”).
- **Motivational interviewing:** explore ambivalence, impact and readiness for change.
- **Advising on practical strategies** to manage social media use (see below).
- **Assessing for co-occurring problems** such as depression, anxiety, substance use or physical health concerns.

- **Follow-up:** monitor sleep, mood and impact on functioning over time.
- **Referring if needed:** consider referral or signposting to psychological therapy or mental health services, particularly if there is significant functional impairment, co-occurring mental health conditions or concerns about risk.
 - CBT can support change by: increasing self-control and helping manage urges; reducing distress and improving mood or depressive symptoms.
 - CBT for Internet Addiction (CBT-IA) combines behaviour change, cognitive restructuring and harm reduction, and may be associated with reduced symptoms of online addiction ([J Behav Addict 2013; 2:209](#)).

Strategies for self-management of problem social media use include:

Set limits and take breaks	• Use apps or settings to reduce daily screen time. • Try a 'digital detox' such as a weekend break or time-limited daily pause. • Detoxes paired with reflection or therapy (e.g. journalling, group discussion) may be more effective than breaks alone.
Self-monitoring and awareness	• Keep a usage diary. • Track emotional triggers (e.g. <i>Why am I scrolling right now?</i>). • Develop a balanced media-use plan. • Peer support or sharing goals with others can reinforce progress.

Values-based goal setting	• Reflect on how social media time compares with time on meaningful offline activities. • Set specific goals (e.g. <i>No scrolling after 9pm</i> or <i>Only 30 mins per session</i>). • Schedule joyful or fulfilling offline alternatives during high-risk times.
Environmental control and boundaries	• Use tools such as screen-time limits, grayscale mode or app blockers. • Turn off non-essential notifications. • Keep phones out of bedrooms to protect sleep. • Designate screen-free times or spaces (e.g. mealtimes or commutes). • Review social media usage patterns each week and adapt goals based on what you notice.
Encourage offline connections	• Encourage real-life social interaction to reduce excessive reliance on online validation. • Replace online time with face-to-face communication when possible.
Mindfulness and urge management	• Use 'urge surfing': notice the impulse to check your phone without acting on it. • Reflect on underlying emotions before opening an app. • Try logging thoughts or feelings before and after use. • Use brief mindfulness practices during moments of craving.
J Med Internet Res 2023;25:e4492	

What else may be needed?

The World Health Organization ([WHO, 2024](#)) emphasises the need for a coordinated approach to safeguard wellbeing in the digital age. Key priorities include:

- Starting digital education early and embedding digital literacy in schools.
- Training educators and healthcare professionals to identify and support at-risk young people.
- Promoting open, stigma-free conversations about digital habits in families and communities.
- Holding tech and gaming industries accountable for manipulative design and age-inappropriate content.

Future efforts must recognise that individual strategies alone are not enough. Reducing harm will require shared responsibility across health, education, policy and platform design.

1.8. Pornography addiction

What is problematic pornography use?

Online pornography is now highly accessible, driven by widespread internet use and tools such as VPNs, which allow individuals to bypass content restrictions and access pornography anonymously.

Problematic pornography use refers to compulsive use despite a desire to stop and ongoing negative consequences. It is increasingly understood as a

form of behavioural addiction, with frequent and escalating use leading to harm in personal and social life. This can affect relationships, work and daily responsibilities, and may result in isolation, functional impairment and, in some cases, legal, financial or employment difficulties.

As with social media addiction, problematic pornography use or addiction is not formally recognised in diagnostic manuals such as ICD or DSM.

([Ent Computing 2025; 100956](#))

What is the prevalence?

Estimating the scale of problematic online pornography use is challenging due to its private nature and underreporting. However, emerging evidence points to high levels of exposure and associated harms:

- The United States hosts approximately 60% of all pornographic websites, with the industry valued at nearly \$1 billion in 2023.
- Around 28% of adult male pornography users may experience problematic use.
- In the UK, 49% of adults accessed adult websites within a single month.
- In the US, over two-thirds of adolescents aged 14–18y have been exposed to online pornography.
- Early exposure is common, with nearly half of young people reporting first exposure before the age of 13y.
- Veterans and vulnerable groups, including individuals with ADHD or insecure attachment styles, have higher rates of problematic use and associated psychological distress.

([Sexual Health & Compulsivity 2024; 31: 207](#))

What's the impact?

Problematic online pornography use can have wide-ranging effects across emotional, relational and psychological domains. It often begins as a way of coping with distress, but, over time, it can become a source of further harm.

Long-term exposure to explicit content may lead to desensitisation, where real-life sexual experiences feel less satisfying compared with the exaggerated expectations shaped by online material. This can undermine intimacy and reduce relationship satisfaction.

Evidence suggests negative impacts across multiple areas, including:

- Cognitive function: difficulties with impulse control, working memory and decision-making.
- Mental health: higher levels of depression, anxiety, guilt, low self-esteem and negative body image.
- Relationships: reduced relationship satisfaction, increased conflict and difficulty forming or maintaining intimacy.
- Sexual health: in some men, use may be associated with erectile dysfunction or reduced sexual satisfaction, although this is not universal.
- Behavioural control: increased compulsivity and impulsivity, poorer emotional regulation and difficulty delaying gratification.
- Social connection: withdrawal from social activities, leading to isolation and loneliness.
- Work and finances: reduced work performance, financial strain and, in some cases, legal difficulties.

([Sexual Health & Compulsivity 2024; 31: 207](#))

Assessment

When assessing possible problematic pornography use, the key concern is not how much someone uses, but why they use it and how it affects their life. Exploring the role pornography plays in emotional coping, self-esteem and relationships can help determine whether use has become harmful or difficult to control.

Indicators of problematic use may include:

- Persistent feelings of guilt or shame related to use.
- Escalation in frequency, use of more extreme content, or a sense that use is out of control.
- Difficulties in relationships or sexual functioning, such as reduced intimacy or sexual satisfaction.
- Financial strain related to spending money on pornography or associated services.

The Problematic Pornography Consumption Scale (PPCS) is a validated tool based on behavioural addiction theory. It highlights key areas of concern and can help guide structured, sensitive questioning in primary care ([The Journal of Sex Research 2017; 55:395](#)).

Questions to help explore pornography use in primary care

- Do you find yourself thinking about pornography frequently, even when doing other things?
- Do you use pornography to feel better when you're stressed, bored or upset?
- Have you needed to watch more, or more extreme content, over time to get the same effect?
- Do you feel anxious, restless or irritable when you can't access pornography?
- Have you tried to cut down or stop using pornography, but found yourself returning to it?
- Has your pornography use caused problems in your relationships, work, studies or daily life?

([The Journal of Sex Research 2017; 55:395](#))

Management of problematic pornography use

While high-quality evidence is lacking, several approaches have shown potential for managing problematic pornography use, including ([Arch Sex Behav 2024; 53:645](#)):

- **Online or self-help CBT:** may be a helpful first step, although engagement can vary.
- **Psychological therapy:** this is likely to be the safest and most effective first-line option in primary care. CBT-based approaches, including third-wave therapies, have the strongest evidence. These focus on managing urges, identifying triggers and developing healthier coping strategies.
- **Drug treatments:**
 - SSRIs may have a role in some cases. One small RCT found a

reduction in sexual and porn craving with paroxetine ([The Journal of Sexual Medicine 2023; qdad060.016](#)).

- Naltrexone may also reduce cravings, although it is unlikely to be initiated in primary care.
- **Transcranial magnetic stimulation:** an emerging intervention with early evidence for reducing cravings and improving impulse control. However, it is not currently recommended for use in primary care.

Tips for self-help for problematic pornography use

- The support website [Addiction Help](#) offers tips for cutting down or stopping pornography use:
- Track your use: notice when, why and how often you watch porn, and how it affects your mood and relationships.
- Know your motivation: identify your reasons for quitting and the benefits you hope to gain.
- Get support: talk to someone you trust, or join a support group or online community.
- Manage triggers: recognise what leads to urges, and find healthier ways to cope, such as exercise or hobbies.
- Limit online exposure: unfollow explicit accounts and use screen time boundaries.
- Use tech tools: install blockers or accountability software to reduce temptation.
- Challenge beliefs: reflect on unrealistic ideas about sex or relationships that are shaped by porn use.
- Focus on real intimacy: rebuild connection and, if needed, seek help for sexual difficulties.



Addictive behaviours: gambling, social media and pornography

- ICD defines addiction in two forms: substance addiction; and behavioural addictions such as gambling, gaming and potentially harmful behaviours like social media or pornography use.
- Addictive behaviours can cause psychological, social and functional harm, often involving loss of control and continued use despite negative consequences.
- NICE suggests routinely asking about gambling as we do for smoking or alcohol; this will support earlier identification and intervention in those at higher risk.
- Primary care support for gambling-related harm should be tailored to the individual. It may include information, medication review, signposting or referral to specialist services.
- Other behavioural addictions are not yet well-defined in clinical guidance, but require holistic assessment, and may benefit from psychological therapy, self-help strategies and appropriate signposting.



Useful resources:

Websites (all resources are hyperlinked for ease of use in Red Whale Knowledge)

Gambling:

- [NHS - help for problems with gambling](#)
- [National Gambling Helpline](#)
- [RCPsych – gambling disorder](#)

Social media:

- [UK Rehab – social media addiction](#) (includes a free 24/7 helpline)

Pornography:

- [Relate - understanding sex addiction](#)

- [Sex Addicts Anonymous](#)
- [Association for the Treatment of Sexual Addiction and Compulsivity](#)
- [Addiction Help – porn addiction](#)

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