The SAGE Encyclopedia of Abnormal and Clinical Psychology

Behavioral Addictions

Contributors: Lisa M. Najavits
Edited by: Amy Wenzel
Book Title: The SAGE Encyclopedia of Abnormal and Clinical Psychology
Chapter Title: "Behavioral Addictions"
Pub. Date: 2017
Access Date: June 27, 2017
Publishing Company: SAGE Publications, Inc.
City: Thousand Oaks,
Print ISBN: 9781483365831
Online ISBN: 9781483365817
DOI: http://dx.doi.org/10.4135/9781483365817.n167
Print pages: 440-443

Behavioral addictions (BAs), which are also referred to as "process addictions," are persistent reward-seeking activities that do not involve use of a substance, yet lead to significant negative consequences. Substance use disorder (SUD) is the most widely recognized addiction, and thus BAs, which are only more recently being studied, are typically compared with SUD in terms of criteria and clinical features. BAs comprise a wide array of behaviors that can become problematic, including gambling, shopping, eating, sex, use of electronics (e.g., web surfing, texting, gaming, television), work, exercise, and hobbies. There are also reports of less common BAs such as tanning, plastic surgery, tattooing, and going to psychics. This entry first addresses the challenges with defining BAs and then discusses the clinical importance, assessment, and treatment of BAs.

Definition Challenges

Typical criteria for BAs, like those for SUD, include aspects such as craving, tolerance, withdrawal, relapse, guilt, clinically significant impairment and distress, and major consequences in social, medical, legal, work, and/or psychiatric domains. However, a major challenge in the field of BAs is that there is no uniform definition of them as yet, leading to widely divergent criteria sets.

The American Society of Addiction Medicine defines addiction as a chronic disease related to brain reward, memory, and motivation. Problems in these areas and related circuitry are associated with manifestations in biological, social, psychological, and spiritual domains. The individual pursues substance-related and other behaviors to seek rewards and/or relief. Ulrike Albrecht and colleagues describe BAs in terms of biochemical processes, noting that although no external psychotropic substances are consumed, the body's biochemical processes result in psychotropic effects. Jon Grant and colleagues focus on loss of control, observing that BAs produce short-term rewards that can induce persistent repetitive behavior despite knowing that negative consequences may result.

Most BAs are not yet in the *Diagnostic and Statistical Manualof Mental Disorders* (*DSM*), as most have not been studied sufficiently to warrant inclusion. The only BA recognized in the current fifth edition of the *DSM* (*DSM-5*) is gambling disorder (GD), known as "pathological gambling" in the previous edition of the *DSM* (*DSM-IV*). GD is more clearly identified as a BA in the *DSM-5* than in the *DSM-IV*, as it was moved from the category of Impulse Control Disorders Not Elsewhere Classified in the *DSM-IV* to the category of Substance-Related and Addictive Disorders in the *DSM-5*. This shift speaks to the growing recognition of BAs beyond just SUD. Also, the *DSM-5* appendix, which identifies potential disorders for further study, includes Internet gaming disorder (IGD) for the first time. The IGD draft criteria have clear origins in SUD criteria and provide a good illustration of a potential BA. The criteria include preoccupation with Internet games; psychological withdrawal symptoms when Internet gaming is removed, such as anxiety, irritability, or sadness; tolerance (needing to spend more and more time in Internet gaming); lack of success in controlling participation in Internet gaming; loss of interest in other entertainment or hobbies outside of Internet gaming; continuing to do Internet gaming excessively despite psychosocial problems; deception of others (e.g., family or therapists) about the extent of Internet gaming; using Internet gaming to relieve a negative mood; and jeopardy or loss of a major relationship, work, or school opportunity because of Internet gaming.

Various *DSM-5* disorders could be potentially identified as BAs as they focus on a single problematic behavior that is excessive and results in negative consequences. These include

binge eating disorder, trichotillomania (hair pulling), excoriation disorder (skin picking), pyromania (firesetting), kleptomania (stealing), and some sexually related disorders such as fetishistic disorder and voyeuristic disorder. However, such disorders occur across many different categories in the *DSM-5* including Disruptive, Impulse Control, and Conduct Disorders (e.g., pyromania and kleptomania); Feeding and Eating Disorders (e.g., binge eating disorder); Obsessive-Compulsive and Related Disorders (e.g., trichotillomania, excoriation disorder); and Paraphilic Disorders (e.g., fetishistic disorder, voyeuristic disorder). Another example of the challenges in *DSM* identification of BAs is sexual addiction. It was listed in the *DSM-III*; removed in the *DSM-IV* as a disorder, although left as an option under the more general Sexual Disorders Not Otherwise Specified; and evaluated for inclusion in the *DSM-5* but ultimately excluded.

In sum, the field of BAs is very young with limited research data to support most BAs and a lack of consensus on definitions. Yet BAs are widely discussed in the media and in common parlance, especially sex, electronics, pornography, gambling, food, and relationship addictions. An essential question with regard to defining BAs is the extent to which a behavior needs to occur before it is classified as an addiction. What is the line between normal working versus work addiction, for example? What is normal sexuality versus sex addiction? Also, so many behaviors have been informally identified as addictive ("chocoholics," "rageaholics") that sometimes the entire category of BAs is disavowed. Most experts, however, view BAs as being serious disorders that involve persistence of the behavior despite significant, recurring negative consequences, which may be legal, medical, social, psychological, vocational, and/or physical in nature. This means that it is not only just the quantity of a behavior but also that it must have a major negative impact on a person's functioning.

Because of the very early stage of research on most BAs, there is also very limited knowledge of their rates in the population. The most studied BA is GD as it is listed in the *DSM*. GD is estimated at 0.5% to 1.5% prevalence. As definitions and measurements for BAs improve in the future, reliable estimation of other BAs will follow.

Clinical Importance

Despite controversies over the definition of BAs, their clinical impact can be substantial. BAs that result in loss of money (e.g., gambling, spending) can bankrupt individuals and their families and may lead to homelessness. Crime conducted to support the BA, such as stealing, also has direct legal and societal impact. People with body-related BAs (e.g., tanning, plastic surgery, exercise) can cause major and sometimes permanent damage to their health. IGD can lead to poor work or school functioning because of the time devoted to gaming. Pornography or sex addiction can lead to relationship loss such as divorce. Work addiction can lead to social isolation and poor physical health.

Despite such important consequences, BAs are generally underrecognized in clinical settings. This is due to various factors: the definitional challenges described earlier; the fact that most BAs are not in the *DSM* and thus do not link to insurance codes; the low base rates for some BAs, such as GD; a lack of formal training regarding BAs; the absence of gold standard measures for most BAs; and limited development of BA-specific treatments and research on them.

Furthermore, some BAs are highly socially acceptable. For example, work, shopping, and recreational activities such as hobbies, electronics use, and gaming are generally socially valued behaviors that people engage in from childhood on. If such behaviors become

addictive, this may be difficult to perceive due to the perceived normalcy of the activities. Also, there are usually no laws that prohibit the behavior, and the legal consequences only come, if at all, from antecedent impact of the BA, such as writing bad checks to cover shopping debts. Furthermore, some behaviors that become addictive are necessary for human functioning, and abstinence is not possible (e.g., eating, sex, exercise). Thus, identifying the line between an addiction and a normal amount of the behavior is challenging. Daily exercise might appear commendable, but if it is several hours a day at high intensity with dangerous medical consequences, it would be perceived as an unhealthy addiction. Context also plays a role. Exercise that an Olympic athlete engages in could look like an addiction if it were not planned, carefully monitored, and goal oriented, all of which can protect against serious negative consequences.

For the clinician and others, the negative effects of BAs are often not as clear as in SUD. People cannot overdose on a behavior the same way they can overdose on a substance. They cannot change the route of administration to make the effects more potent. Withdrawal typically presents in a more subtle form than in substance addiction, with irritation, restlessness, or depression rather than obvious physical phenomena such as vomiting and diarrhea. One cannot measure blood levels of the behavior in the body in the way one can measure a substance. Tolerance is harder to measure as quantifying the behavior is often less clear than quantifying ingestion of a substance.

Work addiction provides an example that illustrates further obstacles to clinical attention. The clinician would need to distinguish work that is truly volitional rather than due to economic necessity. A single parent may work several jobs, with negative impact on self-care and health, yet he or she may have no other option for sustaining his or her family. Work can also be so firmly embedded in cultural values (e.g., corporate culture, the American dream, getting ahead) that others notice only the positive aspects—money and career advancement—rather than what may be a BA. In general, cultural attitudes often play a role in whether a BA is recognized. Peer groups who share a behavior, such as adolescents playing Internet games together or military members who exercise together, may have difficulty recognizing a BA due to group norms. Stereotypes also play a role. Compulsive spending may be seen as the frivolous activity of a “shopaholic” wealthy woman buying too much clothing. The behavior may be attributed to poor judgment rather than a mental health disorder. This stereotype also belies the fact that compulsive spending is as common in males as in females.

BAs are associated with myriad functional problems, and clinicians may focus on such immediate problems rather than also addressing the underlying BA. Functional problems include suicidal and self-harm impulses, physical neglect, criminality, homelessness, poverty, job loss, and poor parenting.

BAs are also highly comorbid with other mental health disorders, including mood and anxiety disorders, personality disorders, and posttraumatic stress disorder (PTSD). These more well-known disorders may be diagnosed instead of a BA rather than concurrent with it. The association between co-occurring disorders can, moreover, be complex, and clinicians may need to explore the historical interplay between the disorders to best understand the BA in the context of the client’s life. In some cases, the BA leads to a co-occurring disorder, such as a person with GD becoming depressed due to gambling losses. In other cases, the co-occurring disorder leads to a BA, such as a person with PTSD who works compulsively to escape the emotional pain of trauma. In other cases, both the BA and the co-occurring disorder may be caused by some other factor, such as genetic or social influences. BAs also co-occur with each other and can be challenging to distinguish. A person addicted to

pornography may be using the Internet excessively, but pornography is the core BA rather than the Internet itself.

Such gray areas result in the potential to either underrecognize a BA when it is present or to overpathologize normal behavior as addictive. Accurate clinical identification of BAs is key because people with BAs often have the same lack of awareness as occurs in SUD, with prominent denial, minimization, lying, and secrecy about the behavior. It is thus crucial to help clients identify and receive treatment for BAs when they do exist.

Assessment

There are numerous assessments for BAs. These include screens, structured interviews, and self-report symptom scales. Given the early stage of research on most BAs, it is premature to identify gold standard scales at this point. Scales even for the same BA differ in their criteria sets, and psychometric testing is typically limited. The wide array of scales also prevents a comprehensive listing here. Examples of scales include the South Oaks Gambling Screen, the Diagnostic Interview of Gambling Severity, the Problem Gambling Severity Index, Internet Addiction Test, the Problematic Pornography Use Scale, Compulsive Buying Scale, the Bergen Work Addiction Scale, the Hypersexual Behavior Inventory, the Exercise Addiction Inventory, Problem Video Game Playing Questionnaire, and the Problematic Use of Mobile Phones Scale.

Treatment

The most prominent and long-standing treatments for BAs are twelve-step models, mirroring the pattern that arose for substance addictions. Treatment emerged as a grassroots, mutual self-help model, with formal professional treatments following later. The original twelve-step model, Alcoholics Anonymous, was founded in 1935, but professional SUD behavioral therapy treatments did not emerge until later in the 20th century. Twelve-step groups for BAs include Sex Addicts Anonymous, Debtors Anonymous, Overeaters Anonymous, Workaholics Anonymous, and Gamblers Anonymous.

Some professionally led models have also emerged, most notably for GD, which is more advanced in having treatments designed for it due to its ongoing recognition in the *DSM* since the *DSM-III*. GD models with an evidence base include various cognitive behavioral models as well as Gamblers Anonymous. Therapies have also been evaluated for other BAs, including Internet addiction and sex addiction. There have also been medication trials for some BAs, including antidepressants and opiate antagonists.

However, the evidence base for treatment of most BAs is at a very early stage. BAs present notable treatment challenges, and it will be years before there is sufficient outcome research to establish empirically based guidelines for BA treatment.

See alsoAddictive Disorders: Overview; *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*); Gambling Disorder; Internet Gaming Disorder; Substance-Related and Addictive Disorders

- addiction
- behavioral addictions

- sex addiction
- disorders
- co-occurring disorders
- gambling
- kleptomania

Lisa M. Najavits
http://dx.doi.org/10.4135/9781483365817.n167
10.4135/9781483365817.n167

Further Readings

Albrecht, U., Kirschner, N. E., & Grusser, S. M. (2007). Diagnostic instruments for behavioural addiction: An overview. GMS Psycho-Social-Medicine,4, 1–11.

Black, D. W., Shaw, M., McCormick, B., Bayless, J. D., & Allen, J. (2012). Neuropsychological performance, impulsivity, ADHD symptoms, and novelty seeking in compulsive buying disorder. Psychiatry Research, 200(2), 581–587. doi:http://dx.doi.org/10.1016/j.psychres.2012.06.003

Freimuth, M., Moniz, S., & Kim, S. R. (2011). Clarifying exercise addiction: Differential diagnosis, co-occurring disorders, and phases of addiction. International Journal of Environmental Research and Public Health, 8(10), 4069–4081. doi:http://dx.doi.org/10.3390/ijerph8104069

Grant, J. E., Potenza, M. N., Weinstein, A., & Gorelick, D. A. (2010). Introduction to behavioral addictions. American Journal of Drug and Alcohol Abuse, 36(5), 233–241. doi:http://dx.doi.org/10.3109/00952990.2010.491884

Griffiths, M. D. (2012). Internet sex addiction: A review of empirical research. Addiction Research & Theory, 20(2), 111–124. doi:http://dx.doi.org/10.3109/16066359.2011.588351

Najavits, L., Lung, J., Froias, A., Paull, N., & Bailey, G. (2014). A study of multiple behavioral addictions in a substance abuse sample. Substance Use and Misuse, 49(4), 479–484. doi:http://dx.doi.org/10.3109/10826084.2013.858168

Petry, N. M. (2009). Disordered gambling and its treatment. Cognitive and Behavioral Practice, 16(4), 457–467. doi:http://dx.doi.org/10.1016/j.cbpra.2009.02.005

Reid, R. C., & Kafka, M. P. (2014). Controversies about hypersexual disorder and the DSM-5. Current Sexual Health Reports, 6(4), 259–264. doi:http://dx.doi.org/10.1007/s11930-014-0031-9

Sussman, S., Leventhal, A., Bluthenthal, R. N., Freimuth, M., Forster, M., & Ames, S. L. (2011). A framework for the specificity of addictions. International Journal of Environmental Research and Public Health, 8(8), 3399–3415. doi:http://dx.doi.org/10.3390/ijerph8083399

Young, K. S., Yue, X. D., & Ying, L. (2011). Prevalence estimates and etiologic models of Internet addiction. In K. S. Young & C. N. de Abreu (Eds.), Internet addiction: A handbook and guide to evaluation and treatment (pp. 1–17). Hoboken, NJ: Wiley.

Dorahy, M. J. & Huntjens, R., 2017, the SAGE encyclopedia of abnormal and clinical psychology. Wenzel, A. (ed.). Thousand Oaks: SAGE Publications Inc. Research output: Chapter in Book/Report/Conference proceeding â€º Entry for encyclopedia/dictionary â€º Academic â€º peer-review. Discrimination: Revisiting Tajfelâ€™s minimal group studies. Spears, R. & Otten, S., 2017, Social psychology: Revisiting the classic studies.Â SAGE Publications Inc., p. 329-343 15 p. (The Sage Handbook of Online Research Methods). and Clinical Psychology. Bipolar Disorders: Biological Factors. Contributors: David Colin Cicero & Mallory Klaunig. Edited by: Amy Wenzel. Book Title: The SAGE Encyclopedia of Abnormal and Clinical Psychology. Chapter Title: "Bipolar Disorders: Biological Factors". Pub.Â Despite 25 years of structural imaging in bipolar disorder, brain regions affected in the disorder are ill defined. To use meta-analytical techniques to investigate structural brain changes in bipolar disorder and to assess the effect of medication use and demographic and clinical variables. The MEDLINE, EMBASE, and PsycINFO databases were searched from 1980-2007 for studies using magnetic resonance imaging or x-ray computed tomography to compare brain structure in patients with bipolar disorder and controls.