

Practitioner Perspective

Is the treatment of behavioural addictions fundamentally the same as the treatment of substance addictions?

By Marie Healy



According to the DSM-5 there is currently insufficient evidence to group all behavioural addictive disorders into the same category as substance use disorders (Potenza, 2014). However, a comparative analysis of the two highlights significant similarities that could impact treatment options

Introduction

The concept of addiction has been described as being in a continued state of change and a “multicomponent complex phenomenon” (Thombs & Osborn, 2013, p. 27). Addiction is certainly not a new phenomenon with its origins dating back as far as the 19th century. The Industrial

Revolution provided a cultural context in which problematic drinking could be defined (Yates & Malloch, 2010). However, the DSM-5 has brought new ways of defining addiction, choosing to use terms such as Alcohol Use Disorder and Substance Use Disorder (APA, 2013). It has been argued that not all people dependent on

substances are in fact addicts but that addiction is more than a physiological dependence. Cravings and ego-dystonic behaviours are more important to making a diagnosis of addiction than mere dependency (Rosenberg & Curtiss Feder, 2014). Orford (1985) states that addiction has become overly identified with illicit drug use. However, print media in recent times have brought us stories of people whose lives have been adversely affected by behavioural addictions such as gambling, food and sex addictions. Articles on gaming are appearing with increasing frequency such as; Hsu, 2018, Marsh, 2018, Dodgen-Magee, 2019. An article in the *New York Times* outlines concerns that many young Chinese children need glasses due to excessive time spent on the Internet. New controls on online games were among Chinese authorities recommendations for reducing this problem of near sightedness. The same article sadly mentions a 17-year-old who died after playing a smart phone game continuously for 40 hours (Zhong, 2018).

In this article I intend to look at the similarities and differences in substance addictions and behavioural addictions. I intend to address two specific behavioural addictions, gambling and sex and how the areas of psychoeducation and working with cognitive distortions can be different from

working with substance addictions. I will explore to what extent treating behavioural addictions is different to treating substance addictions.

Defining Behavioural Addictions

There are many people who actually dispute the concept of behavioural addiction. Dr Allen Frances, a well-known psychiatrist who chaired the American psychiatric task force which developed the *DSM-4*, is one such objector. Instead, he describes it as “normal” for people to repeatedly pursue entertaining activities which are not sensible. He expresses concern that behavioural addictions would reduce what is defined as normal and having one or more mental disorders would in fact become the new normal (Frances, 2010). There may also be a concern that in legitimizing behavioural addictions as a psychiatric disorder may excuse criminal behaviour (Rosenberg & Curtiss Feder, 2014).

Many psychologists take the opposite view and propose that their prevalence is in fact underestimated (Sussman, Lisha & Griffiths 2011). Stanton Peele first wrote about love addiction in 1975. Writing in 2007 he says,

“People can become addicted to powerful experiences such as sex, love, gambling, shopping, food and indeed any experience that can absorb their feelings and consciousness.” (Peele, 2007, p. 12).

Experts do not agree on what particular disorders qualify as behavioural addictions. Black (2013) lists behaviours such as problematic gambling, compulsive sexual behaviour, compulsive buying, compulsive Internet or Internet addiction, compulsive

Diagnostic criteria for behavioural addictions in general have been adapted from the principles of substance addictions

video game playing, binge eating disorder, kleptomania and pyromania. Grant, Potenza, Weinstein and Gorelick (2010) explain that behavioural addictions are characterised by behaviours that produce short term rewards, leading to persistent behaviours despite knowledge of adverse consequences. Griffiths (2005) further elaborates on behavioural addictions, “the difference between an excessive healthy enthusiasm and an addiction is that a healthy enthusiasm adds to life, whereas addiction takes away from it” (Griffiths, 2005, p. 195).

As a counsellor working in an addiction service I have regularly encountered people who, once the therapeutic relationship was established, and the substance use under control or reduced, have expressed concerns about engagement in certain behaviours such as involvement with sex workers, spending excessive amounts of time viewing pornography or excessive amounts of time gaming. I have witnessed shame and distress in these people. With respect to Dr Allen Frances, it could be asked if such descriptions correlate more with Griffiths’ description above, rather than Dr Allen Frances’ description.

There are currently two behavioural addictions listed in the *DSM-5* as official disorders and (one listed in the appendix). Gambling disorder is listed under substance related and addictive disorders (formerly classified as an impulse control disorder) and

binge eating disorder is listed under feeding and eating disorder. Gaming disorder, although not listed as an official disorder in the *DSM-5*, has been included in the appendix and the American Psychiatric Association has requested additional research in this area (APA, 2013).

What is Similar?

There are many similarities between substance addictions and behavioural addictions and this aids the treatment process. They both generally develop in adolescence and young adulthood (Thombs & Osborn, 2013). They both have a pattern which may be chronic and relapsing and like substance use disorder, many people recover on their own without undergoing formal treatment (Slutske, 2006) Neuroscience also supports a unified neurobiological theory of addictions regardless of the addictive substance or activities which now includes behavioural addictions (Rosenberg & Curtiss Feder, 2014).

Ambivalence can be a key feature in any addictive behaviour including both substance addictions and behavioural addictions (Arkowitz, Miller & Rollnick, 2015). Therefore Motivational Interviewing (MI) can be used as a possible intervention. Del Guidice & Kutinsky (2007) advocate the use of MI in the treatment of sexual compulsivity and addiction when incorporated alongside other approaches, which are integrated and promote empathic and active engagement. Cognitive distortions feature strongly in any addictive process (Kouimtsidis, Reynolds, Drummond et al, 2007), therefore Cognitive Behavioural Therapy (CBT) may also be used as a possible intervention.

There are 12-step programmes for both substance addictions and behavioural addictions. Examples

are; Gamblers Anonymous (GA), Overeaters Anonymous (OA), Sex and Lovers Anonymous (SLA) and Alcoholics Anonymous (AA) Diagnostic criteria for behavioural addictions in general have been adapted from the principles of substance addictions. Carnes (1991) proposed 10 diagnostic criteria for sexual addiction adapted from the criteria for chemical addiction. Co-morbidity with mental health conditions is very common in alcohol and substance addictions (Phillips, McKeown & Sandford, 2010). This can also be the case with behavioural addictions (Rosenberg & Curtiss Feder, 2014).

What is Different?

Perhaps one of the main differences between behavioural and substance addictions is that most behavioural addictions are not listed in the *DSM-5* and as already stated, there are many who question if these behaviours are in fact addictions at all. This clearly has an impact on how people can talk about these difficulties and there are obvious difficulties in accessing treatments. This is clearly different in substance and alcohol addictions.

Definitions of abstinence are more complex in behavioural addictions (Thombs and Osborn, 2013), this is particularly relevant in the area of food and sex addiction (Carnes, 1991). Evolutionary psychology explains how the need for both is necessary for survival. Food and sex addictions are the most fundamental human addictions (Carnes, 1991).

Clearly, behavioural addictions do not carry the risk of physical withdrawal which may lead to a medical emergency. Yet, withdrawal has been noted in behavioural addictions and have been included in diagnostic criteria

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(Donovan & Marlatt, 2005). It is not at all unusual for a client in the early stage of abstinence from gambling disorder to complain of insomnia, agitation, poor concentration and low mood.

Addiction Treatment

Treatment in the addiction field has not had a straightforward path. Early services were based on the Minnesota Model which primarily treated alcoholism and the addiction counselling field has developed from the treatment of alcoholism (Butler, 2011). Addiction was recognised as a disease (Butler, 2011). The Minnesota Model appears to have treated the behavioural addiction of gambling from the early stages. A recent review of a predominantly Minnesota Model service in the Cork area reported that 22% of people attending the service in 2017 had been treated for problem gambling (Murphy, A., 2018). With the ideological demise of the disease concept other treatment options became available to people with alcohol and/or substance misuse problems. As cited in Thombs and Osborn (2013) Carroll (2012) notes what constitutes clinically meaningful outcomes remains in dispute in the substance treatment and research field. There is consistent evidence that outcomes of several different approaches vary widely (Miller, Zweben and Johnson, 2005). However, there is agreement that the quality

of the therapeutic relationship and high levels of empathy have a positive impact on outcomes (Hester & Miller, 1995). Among the evidence-based treatments recommended for the treatment of substance and alcohol use disorders are: MI, CBT, Community Reinforcement Approach and Contingency Management (Miller & Carroll, 2006). Given the various presentations of substance and alcohol use disorders, it is argued that that no single treatment model can solve all substance abuse problems and that an integrated treatment system is the most effective solution for substance abuse problems (Broekart et al., 2010). It could be contended that due to the history of alcohol and substance addiction treatment, there is no straightforward formula for the treatment of behavioural addictions. People with addictions, both substance and behavioural, can present with a wide variety of issues. It could also be asked if treatment is simply about the substance or the behaviour or is it more concerned with the person?

However there are specific differences in the treatment of behavioural addictions in the areas of psychoeducation and working with cognitive distortions. For the purpose of this article I shall focus primarily on two behavioural addictions gambling disorder and sex addictions, to illustrate these differences.

Gambling Disorder

The assessment of any addictive disorder can be complex and gambling disorder is no different. (Marlatt & Donovan, 2005). Any assessment should include a risk assessment for suicidal ideation and psychiatric co-morbidity should be screened for as well. Psychiatric co-morbidity is the norm rather than the exception in gambling disorder (Rosenberg & Curtiss

Feder, 2014). It is essential to rule out manic or hypomanic episodes.

Research has shown that most people think irrationally when gambling and there is some evidence that problem gamblers hold more irrational beliefs than non-problem gamblers (May, Whelan, Meyer & Stenberg 2005). There are a number of irrational beliefs documented in which people with gambling disorder may frequently engage. Primarily among these are the illusion of control and the gambler's fallacy (the belief that a string of losses must predict an imminent win) (Petry, 2005). I have witnessed in addiction counselling sessions a person bargaining about abstinence, believing that the next bet would solve all his/her financial difficulties. Many individuals report intrusive thoughts and urges related to gambling which can interfere with their ability to concentrate at home or at work (Grant & Kim, 2001). Grant & Odlaug (2014) say that the primary differences between non-problem and problem gamblers seem to be in how much the problem gambler holds on to his gambling related beliefs.

Cognitive strategies used in the treatment of problem gambling usually include cognitive restructuring, psychoeducation, understanding of gambling urges and irrational cognition awareness training (Grant & Odlaug, 2014). Cowlshew et al (2012) examined 14 studies, as part of a Cochrane review. Their review concluded that there is efficacy for CBT in reducing gambling behaviour following therapy, but the duration of this gain is not known.

While acknowledging the important part which cognitive distortions play in gambling disorder, many researchers propose a broader perspective to be taken in this complex disorder.

There are many features of the internet which assist and even enhance the addictive tendencies in relation to sexual behaviour such as, accessibility, affordability, convenience, and disinhibition

May et al (2005) questioned the validity of the cognitive model as the only explanation for the cause and continuation of gambling disorder. Blazczynski & Nowers (2001) proposed a pathway model of problem and pathological gambling. They argue that problem gamblers are not a homogenous group and describe three subgroups; behaviourally conditioned, emotionally vulnerable and antisocial and impulsive. They propose that treatment approaches should be tailored in accordance with specific needs.

Sexual Addiction

Rosenberg, O'Connor and Carnes (2014) deliberate that excessive sexual appetites were identified as far back as 1812. They cite that in 1886 a German psychiatrist, Dr Richard von Krafft-Ebbing argued that pathological sexual behaviour was in fact a true psychiatric illness. However, as already discussed it has not been included in the DSM-5. The difficulty in separating normal and abnormal sexual behaviours, the difficulty in determining when loss of control occurs and the difficulty in assessing the role of culture have been cited as reasons for problems with defining the dependence model of sexual

addiction (Carnes, 1991). Levine and Troiden (1998) argue that the label of sexual addiction is stigmatizing and renders a moral judgement on behaviour which diverges from the prevailing cultural standards.

“Sex addicts use their sexuality as a medication for sleep, anxiety, pain and family and life problems.” (Carnes, 1991, p23)

I believe that this statement does not deviate at all from what could be said about a person addicted to benzodiazepines, heroin or alcohol. While there are a lot of similarities between working with substance addiction and sexual addiction, there are some notable differences.

Carnes (1991) proposes that the core beliefs for sexual addicts arise out of a history of abuse, trauma and neglect. Birchard (2015) says that almost every sex addict he has worked with has a history of traumatic attachment. There are others who advocate a broader approach. Hall (2013) suggests the Opportunity, Attachment and Trauma Model (OAT). She lists opportunity as a key player in the list of variables which may lead to sexual addiction, paying particular attention to the role of the Internet and the increase in opportunity which it has brought. Samenow (2010) proposes a biopsychosocial model of hypersexual disorder/sexual addiction which allows for a more comprehensive understanding of the individual rather than focusing on a particular theory. He guards against one school of thought such as “most sexual addicts have been traumatised and have shame”.

Sexual addiction frequently co-occurs with other addictions, Birchard (2015) uses the term Addiction Interaction Disorder.

Psychiatric co-morbidity should also be screened for, as this is also common (Birchard, 2015) I have already referred to the importance of the therapeutic relationship as a predictor of satisfactory outcomes in therapy. Birchard (2015) places a very strong emphasis on the therapeutic alliance. He states that the capacity of the therapist to talk about sex and to understand sex is crucial in this. He guards against automatic reactions, evident in body language and facial expression, in response to some of the material discussed which may compound the shame of the person seeking help.

(Hart et al, 2012) argue that the treatment for sexual addiction is firstly about education. Hall (2013) proposes that among the treatment objectives include understanding the cycle of addiction, shame reduction, commitment to recovery, resolution of the underlying issues, prevention of relapse and the development of a healthy lifestyle. Undoubtedly, it could be argued that these treatment objectives are very similar to that of treating a substance addiction. However, I see the biggest difference in the area of education on the cycle of addiction and shame reduction.

Birchard (2015) says the concept of supernormal stimuli has been extremely helpful in helping people understand the place of pornography in sexual addiction. Birchard (2015) explains that the excitement about the artificially enhanced is greater than the excitement of the reality. He suggests that this may be the reason why so many people presenting for treatment have difficulty in sustaining an intimate relationship.

The Internet has clearly made the availability of supernormal stimuli much more accessible.

We always need to ask, is it people or substances/behaviours we are treating? The focus of our attention should always be the best treatment to meet the needs of the service user

There are many features of the Internet which assist and even enhance the addictive tendencies in relation to sexual behaviour such as, accessibility, affordability, convenience, and disinhibition. The Internet can also make possible activities, which would not be possible offline, such as cybersex (Griffiths, 2016). Equally, sexual addiction is not the only area where the Internet has played a significant role. It can be clearly seen in the area of gambling disorder and indeed substance use disorder. It is also not at all unusual for service users to access drugs online, particularly benzodiazepines.

Conclusion

This article has looked at both the similarities and differences between substance and behavioural addictions. There are some important similarities in the treatment approaches. As discussed both types of addictions may present with impaired insight, ambivalence and distorted thinking. Therefore, MI and CBT can be considered to be appropriate treatment approaches. The role of the therapeutic relationship will always have an important impact on outcomes (O'Driscoll and Foy, 2017). Some specific areas which are different in their treatment are addressed with reference to gambling disorder

and sexual addiction. Specifically, the issue of psychoeducation was discussed with reference to sexual addiction and working with cognitive distortions in relation to gambling disorder. Even within the substance addiction field, psychoeducation can vary depending on which substance is being abused. Psychoeducation for somebody abusing opiates will be very different from psychoeducation for somebody abusing alcohol. The fact that very few behavioural addictions are recognised in the *DSM-5* is very significant with regard to how people will access help for their difficulties. Abstinence is also less clearly defined in behavioural addictions. In addition some behavioural addictions may actually be overvalued by society, for example the over pursuit of exercise is not generally met with criticism, moral judgement or negative social consequences (Ascher & Levounis, 2015). Excessive working may also be seen in the same light.

As a practitioner I expect that we shall be hearing a lot more about behavioural addictions in the addiction treatment field. Counsellors working in addiction services will need to embrace these changes, a task which should not be difficult given the variety of issues with which clients with addictions present. Undoubtedly, the number of similarities far outweighs the differences in treating both types of addiction. In the addiction treatment field, you can never say that treatments are exactly the same because of the varying needs of service users. We always need to ask, is it people or substances/behaviours we are treating? The focus of our attention should always be the best treatment to meet the needs of the service user. ○

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