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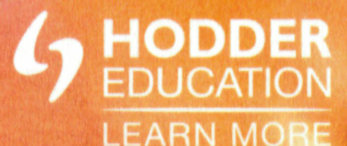

Classifying behavioural addictions

The DSM and over-pathologising everyday life

Mark Griffiths considers the problems associated with classifying behavioural addictions as mental disorders

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Signposts

DSM, behavioural addictions

Conceptualising addiction has been a matter of great debate for decades. For many people, the concept of addiction involves the taking of drugs. Therefore, it is perhaps unsurprising that most official definitions concentrate on drug ingestion. Despite such definitions, there is now a growing movement that views a number of behaviours as potentially addictive, including those that do not involve the ingestion of a drug. These include behaviours as diverse as gambling, eating, sex, exercise, videogame playing, love, shopping, internet use, social networking and work.

Such diversity has led to all-encompassing definitions of what constitutes addictive behaviour. One such definition (Marlatt et al. 1988) is:

> '... a repetitive habit pattern that increases the risk of disease and/or associated personal and social problems. Addictive behaviours are often experienced subjectively as 'loss of control' — the behaviour contrives to occur despite volitional attempts to abstain or moderate use. These habit patterns are typically characterised by immediate gratification (short-term reward), often coupled with delayed deleterious effects (long-term costs). Attempts to change an addictive behaviour (via treatment or self-initiation) are typically marked with high relapse rates.'

The components model

The way of determining whether behavioural addictions are truly addictive is to compare them against clinical criteria for other established drug-ingested addictions. Throughout my career, I have argued that all addictions — irrespective of whether they are chemical or behavioural — comprise six components: salience, mood modification, tolerance, withdrawal, conflict and relapse (Griffiths 1996; 2005a).

Salience

This occurs when the activity becomes the single most important activity in the person's life and dominates their thinking (preoccupations and cognitive distortions), feelings (cravings) and behaviour (deterioration of socialised behaviour). For instance, even if the person is not actually engaged in the activity they will be constantly thinking about the next time that they will be (i.e. a total preoccupation with the activity).

Mood modification

This refers to the subjective experiences that people report as a consequence of engaging in the activity and can be seen as a coping strategy (i.e. they experience an arousing 'buzz' or a 'high' or paradoxically a tranquilising feeling of 'escape' or 'numbing').

Tolerance

This is the process whereby increasing amounts of the activity are required to achieve the former mood modifying effects. This

basically means that for someone engaged in the activity, they gradually build up the amount of the time they spend engaging in the activity every day.

Withdrawal symptoms

These are the unpleasant-feeling states and/or physical effects (e.g. the shakes, moodiness, irritability, etc.) that occur when the person is unable to engage in the activity.

Conflict

This refers to the conflicts between the person and those around them (interpersonal conflict), conflicts with other activities (e.g. work, social life, hobbies and interests) or from within the individual (e.g. intra-psychic conflict and/or subjective feelings of loss of control) that are concerned with spending too much time engaging in the activity.

Relapse

This is the tendency for repeated reversions to earlier patterns of excessive engagement in the activity to recur, and for even the most extreme patterns typical of the height of excessive engagement in the activity to be quickly restored after periods of control.

DSM

In May 2013, the latest (fifth) edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5) was published by the American Psychiatric Association. The DSM is sometimes referred to as the diagnostic 'bible' for anyone who works in the area of mental health. For those of us working in the behavioural addictions field, the DSM-5 was widely welcomed because, for the very first time, 'Gambling Disorder' (formerly known as 'pathological gambling') was classed as an addiction (rather than a disorder of impulse control as it had been since its introduction into the DSM in 1980). Although most of us in the behavioural addiction field had been conceptualising extreme problematic gambling as an addiction for many years, this was arguably the first time that an established medical body had described it as such.

Note: The ICD (International Classification of Diseases) is the system most usually used by practitioners in the UK to diagnose mental illness. However, the DSM is the classification system used in most academic research and that is why it is referred to here.

Internet addiction not yet included

There had also been debates about whether or not 'Internet Addiction Disorder' (i.e. 'internet addiction') should have been included in the DSM-5. As a result of these debates, the Substance Use Disorder Work Group recommended that the DSM-5 include 'Internet Gaming Disorder' (often referred to as 'videogame addiction') in the DSM-5's Appendix as an area that required further research before possible inclusion in future editions of the DSM.

To be included in its own right in the next edition, research will have to establish the defining features of Internet Gaming Disorder, obtain cross-cultural data on reliability and validity of specific diagnostic criteria, determine prevalence rates in representative epidemiological samples in countries around the world, and examine its associated biological features. Other than gambling and gaming, no other behaviour (e.g. sex, work, exercise, etc.) has yet to be classified as a genuine addiction by established medical and/or psychiatric organisations.

Prevalence

In one of the most comprehensive reviews of chemical and behavioural addictions, I and two of my colleagues examined all the prevalence literature relating to 11 different potentially addictive behaviours (Sussman et al. 2011). We reported overall prevalence rates of addictions to cigarette smoking (15%), drinking alcohol (10%), illicit drug taking (5%), eating (2%), gambling (2%), internet use (2%), love (3%), sex (3%), exercise (3%), work (10%), and shopping (6%) based on the literature published up to that point. However, most of the prevalence data relating to behavioural addictions (with the exception of gambling) did not have prevalence data from nationally representative samples, and therefore relied on small and/or self-selected samples.

An internet café in China. Internet gaming disorder has not yet been included in the DSM but further cross-cultural data may confirm it

Gambling Disorder is now classified as an addiction in the DSM

Global view of addiction

Addiction is an incredibly complex behaviour and always results from an interaction and interplay between many factors, including the person's biological and/or genetic predisposition, their psychological constitution (personality factors, unconscious motivations, attitudes, expectations, beliefs, etc.), their social environment (i.e. situational characteristics such as accessibility and availability of the activity) and the nature of the activity itself (i.e. structural characteristics such as the size of the stake or jackpot in gambling). This 'global' view of addiction highlights the interconnected processes and integration between individual differences (i.e. personal vulnerability factors), situational characteristics, structural characteristics, and the resulting addictive behaviour.

Vulnerability for behavioural addictions

There are many individual (personal vulnerability) factors that may be involved in the acquisition, development and maintenance of behavioural addictions (e.g. personality traits, biological and genetic predispositions, unconscious motivations, learning and conditioning effects, thoughts, beliefs, and attitudes), although some factors are more personal (e.g. financial motivation and economic pressures in the case of gambling addiction).

However, there are also some key risk factors that are highly associated with developing almost any (chemical or behavioural) addiction, such as having a family history of addiction, having co-morbid psychological problems, and having a lack of family involvement and supervision. Psychosocial factors such as low self-esteem, loneliness, neuroticism, depression, high anxiety, and stress all appear to be common among those with behavioural addictions.

Implications of the new DSM classification

One of the major implications of the DSM re-categorising Gambling Disorder and Internet Gaming Disorder as addictions is that there is now no theoretical reason why other excessive behaviours that cause problems in individuals' lives cannot be classed as a potential addiction. This has led to a big debate in the addictions field about whether the components model of addiction has contributed to the unnecessary over-pathologising of everyday behaviours such as work, sex and exercise (Billieux et al. 2015) — see Box 1.

Criticisms and counter-criticisms

A recent critique on this issue by Kardefelt-Winther et al. (2017) correctly noted that the components model of addiction uses the symptoms of substance addiction. This was intended as a criticism but I would argue that common components are key to delineating addictions in the first place. All addictions have idiosyncrasies (such as chasing losses in gambling) but it is the similarities (i.e. the core components) that are key to the behaviour being labelled an addiction. If behavioural addictions do not share these core components, they should not be labelled as addictions and should be called something else.

Kardefelt-Winther et al. also suggested four exclusion criteria and argued that behaviours should not be classed as a behavioural addiction if:

1 'The behaviour is better explained by an underlying disorder (e.g. a depressive disorder or impulse-control disorder).'
2 'The functional impairment results from an activity that, although potentially harmful, is the consequence of a wilful choice (e.g. high-level sports).'
3 'The behaviour can be characterised as a period of prolonged intensive involvement that detracts time and focus from other aspects of life, but does not lead to significant functional impairment or distress for the individual.'
4 'The behaviour is the result of a coping strategy.'

Box 1 Over-pathologising

Pathology is the scientific study of diseases and their causes and consequences. When we pathologise something we are describing it as a disease. The problem with this is that it is not always helpful to think over our experiences and behaviour as if they are diseases. Chicken pox, for example, is a disease. It has a known cause (the chicken pox virus) and has two main symptoms (spots and fever). When we think about many psychological and behavioural conditions then the position is not clear. They do not have a clear known cause and their symptoms vary a lot from one person to another. In this article, Mark Griffiths is suggesting that we see some behavioural addictions as an illness when that is not the best way of thinking about this behaviour. This is what we mean by over-pathologising.

If these criteria were applied to substance abuse, very few substance users would be classed as addicted. For instance, Kardefelt-Winther et al. proposed that any behaviour in which functional impairment results from an activity that is a consequence of wilful choice should not be considered an addiction. I cannot think of a single addictive behaviour that, when the person first started engaging in the behaviour (e.g. drinking alcohol, illicit drug-taking, gambling), was not engaged in wilfully. The key issue (as highlighted by Kardefelt-Winther et al.) is sustained harm, distress, and functional impairment in the behaviour (not excluding some behaviours *a priori*).

Also, not being classed as an addiction if the behaviour is secondary to another comorbid behaviour (e.g. a depressive disorder) or is used as a coping strategy again means that some other substance addictions (e.g. alcoholism) would not be classed as genuine addictive behaviours using such exclusion criteria because many substance-based addictions are used as coping strategies and/or are symptomatic of other underlying pathologies.

The pathways model of pathological gambling (Blaszczynski and Nower 2002) explicitly demonstrates that some types of gambling addiction are as a consequence of other more global comorbidities and that the behaviour is symptomatic of these more primary disorders. Saying that a behaviour cannot be considered a behavioural addiction if it is used for coping or arises as a consequence of other underlying disorders seems unduly stringent if no such exclusion criteria are applied to substance addictions.

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A conclusion

The similarities in core components are key to defining addictions. Applying the exclusion criteria by Kardefelt-Winther et al. to non-substance use behaviours makes it almost impossible for any behaviour to be classed as an addiction, yet many substance addictions are comorbid with other underlying disorders (e.g. depression), are engaged in wilfully during the initiation of the behaviour, and/or are engaged in as a coping response to counter-act other problems in the individual's life.

As argued above, behavioural addictions are a part of a biopsychosocial process and not just restricted to drug-ingested (chemical) behaviours. Evidence is growing that excessive behaviours of all types do seem to have many commonalities and this may reflect a common aetiology of addictive behaviour (Griffiths 2005). An eclectic approach to the studying of addictive behaviour appears to be the most pragmatic way forward in the field.

Mark Griffiths is Europe's only professor of gambling studies (Nottingham Trent University). Read his blog at **drmarkgriffiths.wordpress.com** and follow him on Twitter **@DrMarkGriffiths.**

challenge yourself

Complete these activities to check and extend your understanding of the article by Mark Griffiths

1 In his article, Griffiths suggests that conceptualising (i.e. defining and understanding) addiction has been a matter of great debate for decades. In 1957, the World Health Organization defined addictions simply as 'a state of periodic or chronic intoxication produced by repeated consumption of a drug, neutral or synthetic'. How does this earlier definition differ from the one provided by the author on page 18 and what does this suggest about our understanding of addictions over the last 60 years?

2 Explain in your own words why we should be careful not to 'over-pathologise' addictions. Use your understanding of a 'real' disease (e.g. chicken pox) to show how/in what way(s) addictions are more complex than this.

3 Griffiths suggests that all addictions can be comprised of six components (see pages 18–19). Select several addictions (e.g. smoking, gambling) and see if you can apply these six components to describing the addiction you have chosen. Are some components easier to apply than others? Do these components apply more easily to specific addictions than others? (Hint: perhaps consider biological versus more psychological addictions.)

4 Griffiths outlines some of the risk factors in vulnerability to specific addictions. Can you suggest why certain addictions may involve a different combination of risk factors than other addictions? For example, you might consider more biological addictions (such as smoking) versus psychological addictions (such as gambling). Give reasons for your answer.

5 Griffiths argues that addictions should share 'common' or 'core' components — in terms of excessive behaviours, for example — if they are to be labelled as an addiction. What do you think the author means therefore when he concludes by suggesting an eclectic approach to studying addictions? How might this best be achieved?

Anthony Curtis