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Classification and treatment of behavioural addictions

Key learning points:

- ▶ It is now becoming increasingly accepted that drug ingestion is not the only form of addiction
- ▶ There are several complex and interconnected factors that contribute to any addiction
- ▶ There is not a clear winner among the various forms of treatment

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, video-gaming, love, shopping, Internet use, social networking, and work.¹⁻³ Griffiths⁴ argues that all addictions – irrespective of whether they are chemical or behavioural – comprise six components (salience, mood modification, tolerance, withdrawal, conflict and relapse). More specifically:

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- **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 (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 (they experience an arousing ‘buzz’ or a ‘high’ or paradoxically a tranquillising feel 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 time they spend engaging in the activity every day.
- **Withdrawal symptoms** – These are the unpleasant feeling states and/or physical effects (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 (work, social life, hobbies and interests) or from within the individual (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.

CLASSIFICATION OF BEHAVIOURAL ADDICTION

In May 2013, the new criteria for problem gambling (now called ‘Gambling Disorder’) were published in the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5)⁵, and for the very first time, problem gambling was included in the section ‘Substance-related and Addiction Disorders’ (rather than in the section on impulse control disorders as had been the case since 1980 when it was first included in the DSM-3). Although most of us in the field had been conceptualising extreme problem gambling as an addiction for many years, this was arguably the first time that an



established medical body had described it as such. There had also been debates about whether or not 'Internet Addiction Disorder' 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' (IGD) in Section three (Emerging Measures and Models) as an area that required further research before possible inclusion in future editions of the DSM⁶. To be included in its own right in the next edition, research will have to establish the defining features of IGD, 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.⁷ Other than gambling and gaming, no other behaviour (sex, work, exercise, etc.) has yet to be classified as a genuine addiction by established medical and/or psychiatric organisations.

PREVALENCE AND RISK FACTORS OF BEHAVIOURAL ADDICTIONS

In one of the most comprehensive reviews of chemical and behavioural addictions, Sussman, Lisha and Griffiths⁸ examined all the prevalence literature relating to 11 different potentially addictive behaviours. They 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%). 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.

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 (situational characteristics such as accessibility and availability of the activity, the advertising 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.

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, depression, high anxiety, and stress all appear to be common among those with behavioural addictions.

TREATMENT OF BEHAVIOURAL ADDICTIONS

The last ten years has seen a large increase in the treatment of behavioural addictions, and almost all of these treatments utilise programs and approaches used in the treatment of chemical addictions (pharmacotherapy, cognitive-behavioural therapy, psychotherapy, and self-help therapy).

Pharmacotherapy: Pharmacological interventions basically consist of addicts being given a drug to help overcome their

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addiction. These are mainly given to those people with chemical addictions but are increasingly being used for those with behavioural addictions (gambling, sex, internet use). For instance, the use of opioid antagonists (such as naloxone or naltrexone) has been used in the treatment of gambling addiction. The main criticism of all these treatments is that although the symptoms may be being treated, the underlying reasons for the addictions may be being ignored.⁹

Cognitive-behavioural therapy: A more recent development in the treatment of behavioural addictions is the use of cognitive-behavioural therapies (CBTs). There are many different CBT approaches that have been used in the treatment of behavioural addiction including rational emotive therapy, motivational interviewing, and relapse prevention.⁹ The techniques assume that addiction is a means of coping with difficult situations, dysphoric mood, and peer pressure. Treatment aims to help addicts recognise high-risk situations and either avoid or cope with them without use of the addictive behaviour. Evaluation of CBT approaches to treating behavioural addictions is promising.

Psychotherapy: Psychotherapy can include everything from Freudian psychoanalysis and transactional analysis, to more recent innovations like drama therapy, family therapy and minimalist intervention strategies. The therapy can take place as an individual, as a couple, as a family or as a group and is basically viewed as a 'talking cure' consisting of regular sessions with a psychotherapist over a period of time.⁹ Most psychotherapies view maladaptive behaviour as the symptom of other underlying problems. If the problem is resolved, the addiction should disappear. In some ways, this is the therapeutic opposite of pharmacotherapy and behavioural

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therapy (which treats the symptoms rather than the underlying cause).

Self-help therapy: The most popular self-help therapy worldwide is the Minnesota Model 12-Step Program (Alcoholics Anonymous, Narcotics Anonymous) but has now extended to include behavioural addictions (e.g., Gamblers Anonymous, Overeaters Anonymous, Sexaholics Anonymous, etc.). Addicts attending 12-Step groups must accept personal responsibility and view the behaviour as an addiction that cannot be cured but merely arrested. To some it becomes a way of life, both spiritually and socially and compared with almost all other treatments it is especially cost-effective (even if other treatments have greater success rates) as the organisation makes no financial demands on members or the community. However, drop-out rates are very high and many do not like the spiritual elements.⁹

When examining all the literature on the treatment of behavioural addiction, there are a number of key conclusions that can be drawn:⁹⁻¹¹

- Treatment must be readily available;
- no single treatment is appropriate for all individuals;
- it is better for an addict to be treated than not to be treated;
- it does not seem to matter which treatment an addict engages in as no single treatment has been shown to be demonstrably better than any other;

- a variety of treatments simultaneously appear to be beneficial to the addict;
- individual needs of the addict have to be met (the treatment should be fitted to the addict including being gender-specific and culture-specific);
- clients with co-existing addiction disorders should receive services that are integrated;
- remaining in treatment for an adequate period of time is critical for treatment effectiveness;
- medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies;
- recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment;
- there is a direct association between the length of time spent in treatment and positive outcomes; and
- the duration of treatment interventions is determined by individual needs, and there are no pre-set limits to the duration of treatment.

CONCLUSIONS

This article has briefly demonstrated that 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 etiology of addictive behaviour. Such commonalities may have implications not only for treatment of such behaviours but also for how the general public perceive such behaviours.

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