Behavioral Addictions in 2022: Where to Draw the Lines?

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Western Doctors In Recovery
2022 Annual Meeting
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DISCLOSURES

Research Support

Creative Care

Connections In Recovery

Off-label use of medications will be discussed.

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EDUCATIONAL OBJECTIVES

At the conclusion of this session, participants should be able to:

1. State the clinical characteristics of gambling disorder, hypersexual disorder, internet gaming disorder
2. Demonstrate improvement in screening and assessment techniques for behavioral addictions
3. Describe current treatment options for behavioral addictions

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Terms

- Behavioral Addiction
- Non Substance-Related Disorders
- Process Addictions
- Non Substance-Addictions
- Compulsive Spectrum Disorders
- Impulse Control Disorders
- Hedonistic Dysregulation Disorder
- Appetitive Disorders

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Behavioral Addictions

- Recognized in DSM-5
  - Gambling Disorder
- Kind of Recognized (conditions for future)
  - Internet Gaming Disorder
- Not recognized
  - Hypersexual disorder / sex addiction
  - ICD-10 (Compulsive Sexual Behavior Disorder)

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Where Do We Draw The Line?

- When does a behavior become a "disorder"?
  - Disrupts functioning (impairment)
  - Leads to significant physical and emotional distress
  - Reliable biopsychosocial findings
    - Bio: Genetic, biomarkers, consistent changes in structure and functioning
    - Psychological: Consistent patterns of clinical course, seen throughout the world; more similar to other addictions
    - Social: Peer influence, norms, standards

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Behavioral Addictions: Gambling

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Case Vignette

- 44 year old Korean male, trauma surgeon
- Wife comes for intake due to his gambling "addiction"
- He spends large sums in Las Vegas and with online sports betting accounts
- Financially very thin, with little saved and paycheck-to-paycheck
- High levels of conflict, tension
- She has contemplated leaving but is worried for him, her well-being and children's future

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Case Vignette

- He refuses to seek treatment, says gambling is part of his culture and he deserves it
- By all accounts, his work performance is "standard of care" but his reputation is declining
- She fully believes he is addicted but that he will never accept the diagnosis

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Case Vignette

- How can a a diagnosis be made?
  - When is it a hobby / habit vs addictive disorder?
- What should the wife do?
- How does gambling impact his ability to practice medicine?
  - Is he fit for duty?
- What could the Medical Board of California say or do?

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Gambling News 2022

- Traditional Gambling Activities
  - Sports Betting Explosion (30+states)
  - Impact of COVID
  - Internet Gambling Options Thriving
- Blurring lines between gaming and gambling
  - Social Casinos (gambling or gaming?)
    - In-App Purchases
  - Video Games
    - Loot Boxes
  - Financial Trading Software and Apps

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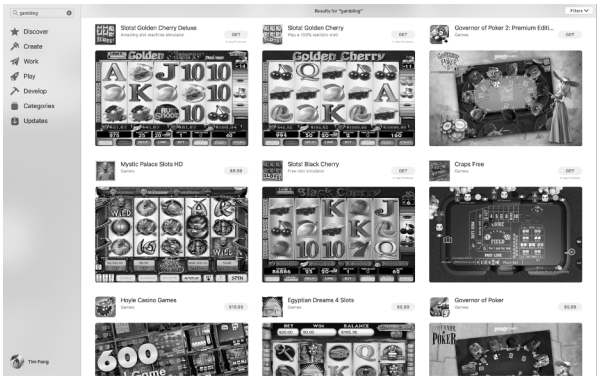

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DSM-5 : Gambling Disorder

- Formerly known as:
  pathological gambling, compulsive gambling, gambling addiction
- Formerly housed in Impulse Control Disorder
- Currently housed in Substance Related and Addictive Disorders

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Summary of DSM-5 Criteria for Gambling Disorder

A. Persistent and recurrent maladaptive gambling behavior as indicated by four (or more) of the following in a 12 month period:

Preoccupation	Lying
Tolerance	Withdrawal
Chases	Bailed Out
Can't stop	Lost opportunities
	Gambles when distressed

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Summary of DSM-5 Criteria for Gambling Disorder

B. The gambling behavior is not better accounted for by a Manic Episode

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Severity

- **Mild:** Exhibit only 4 or 5 of the criteria, with preoccupation with gambling most frequent criteria
- **Moderate:** Exhibit more of the criteria (6 or 7).
- **Severe:** Individuals with the most severe form will exhibit all or most all of the nine criteria.

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DSM-5 Notes

Most Common Symptoms:

- Preoccupation and Lying

Symptoms that Reflect Higher Severity

- Jeopardizing relationships or career opportunities due to gambling
- Relying on others to provide money for gambling losses

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California Prevalence Study (2006)

n=7,121 respondents, 18 years and older

Problem gambling 2.2%

Pathological gambling 1.5%

~1,000,000 problem/pathological cases

Highest Risk: African-Americans, Disabled, Unemployed, Men

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Behavioral Addictions:

Clinical Characteristics of Gambling Disorder

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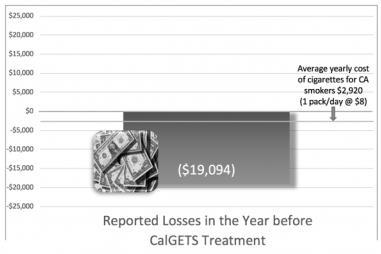
Financial Impact of Gambling for Problem Gamblers in CalGETS Treatment



Source – *Outpatient Gamblers:* CalGETS Fiscal Year 2016-17 dataset, prepared for the California Department of Public Health, Office of Problem Gambling by the University of California Los Angeles Gambling Studies Program. CalGETS treatment participants were asked: "In the past 12 months, on the days that you gambled, about how much money have you lost gambling?"
Source – *Cigarette costs:* Glover, M. (2017, March 30). Think cigarettes cost too much? Wait until Saturday. *The Sacramento Bee*. Retrieved from: https://www.sacbee.com/news/business/article141834509.html

July 2018

In California, problem gamblers can receive no-cost treatment through CalGETS. Between July 1, 2016 and June 30, 2017, 879 problem gamblers entered outpatient treatment. We analyzed their reports of total gambling losses during the 12 months before they entered treatment.

On average, problem gamblers reported losing $19,094 in the past year. This is 6 times more costly than smoking in direct expenses to the consumer.

The combined total amount lost for gamblers entering outpatient treatment was **$16,592,905**.

If you or someone you know has a gambling problem, call 1-800-GAMBLER.

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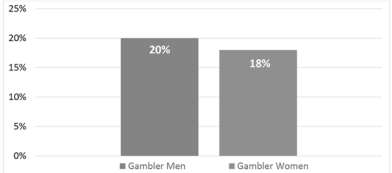
CalGETS Fast Facts

Problem Gamblers' Depression and Suicidal Thinking is a Public Health Concern | January 2021



Source – *Outpatient Gamblers:* CalGETS Fiscal Year 2019-20 dataset, prepared for the California Department of Public Health, Office of Problem Gambling by the University of California Los Angeles Gambling Studies Program. *CA Depression:* Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2019. [accessed Jan 26, 2021]. URL: https://www.cdc.gov/brfss/brfssprevalence/. *US Gambler Suicidal Ideation:* Séguin, M., Boyer, R., Lesage, A., McGirr, A., Suissa, A., Tousignant, M., & Turecki, G. (2010). Suicide and gambling: psychopathology and treatment-seeking. Psychology of Addictive Behaviors, 24(3), 541. *CA Suicidal Ideation:* Grant, D., Caldwell, J., Padilla-Frausto, D. I., Aydin, M., & Aguilar-Gaxiola, S. (2012). More than half a million California adults seriously thought about suicide in the past year. Policy brief (UCLA Center for Health Policy Research), (PB2012-4), 1–8.

Between July 1, 2019 and June 30, 2020, 606 problem gamblers entered CalGETS outpatient treatment.

At intake, 24% of these clients scored in the moderately severe to severe depression range as measured by the Patient Health Questionnaire (PHQ-9) compared to 15% of adult Californians reporting *any* depression diagnosis.

Among U.S. gamblers seeking treatment, between 20% and 40% report suicidal ideation and/or suicide attempts in the past year.

Among gamblers entering CalGETS outpatient treatment, 19% report suicidal thoughts in the ***past week***, which is 10 times higher than adults in California reporting suicidal thoughts in the past year (1.8%).

If you or someone you know has a gambling problem, call 1-800-GAMBLER. ○ National Suicide Prevention Lifeline, call 1-800-273-8255 (TALK).

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GD associated w/ increase in cardiovascular disease

- Review of NESARC Data
  - Focus on older adults (55+)
- GD status was associated with elevated odds for incident arteriosclerosis and heart conditions.
  - Increased risk beyond established risk factors
  - Increased incidence of cardiovascular conditions among older adults with pathological gambling features in a prospective study

J Addict Med. 2013 Nov-Dec;7(6):387-93. doi: 10.1097/ADM.0b013e31829e9b36.
Pilver CE1, Potenza MN.

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UCLA Gambling Sleep Study - Results

- National Epidemiological Survey: (N=3412)
  - Prevalence 0.9% (n=31) for pathological gambling behavior and 2.5% (n=85) for problem gambling behavior
  - GDs were almost 3.5 times more likely to experience a sleep problem compared to individuals who did not have a gambling problem
- Community Survey: (N=120)
  - GDs experience significantly poorer sleep quality and increased daytime sleepiness relative to those that recreationally gamble.

Parhami, Iman, et al. "Pathological gambling, problem gambling and sleep complaints: An analysis of the National Comorbidity Survey: Replication (NCS-R)." *Journal of Gambling Studies* 29.2 (2013): 241-253.

Parhami, Iman, et al. "Sleep and gambling severity in a community sample of gamblers." *Journal of addictive diseases* 31.1 (2012): 67-79.

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Similarities to SUD Treatment

- Biopsychosocial Approaches
  - Medications Strategies Similar
  - Various forms of psychotherapies have been tested (CBT, MI, RP)
  - 12-Step, Mutual Help support (GA)
- Treatment Delivery Systems
  - Funding aligned with SUD treatment
  - Providers usually from SUD backgrounds

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Differences from SUD Treatment

- Definitions of successful outcome
  - How does harm reduction apply?
  - What is sobriety from gambling?
- What are the targets of treatment?
- How do you overcome shame / stigma?
- Cognitive distortions not seen in SUD
- How do you monitor response to treatment?

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Evidence-Based Treatments for Pathological Gambling

- Medications (No FDA-Approved)
- Brief Interventions
  - Helplines, Self-Help Workbooks, 1-2 sessions,
- Psychotherapy
  - CBT, MI, Psychodynamic, Supportive
- Gambler's Anonymous

Petry, N. M., Ginley, M. K., & Rash, C. J. (2017). A systematic review of treatments for problem gambling. *Psychology of Addictive Behaviors*, *31*(8), 951.

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Pharmacologic Treatment

- Comprehensive review published by Jon Grant and colleagues: *"Pharmacological treatments in pathological gambling"* (British Journal of Clinical Pharmacology 2014)
- Antidepressants
- Opioid antagonists
- Mood stabilizers
- Atypical antipsychotics
- Other Agents

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Pharmacologic Treatment

- Strongest Research Evidence for:
  - Naltrexone
    - PO, no IM
  - Nalmefene
  - Lithium (BP Spectrum)

"Pharmacological treatments in pathological gambling" (British Journal of Clinical Pharmacology 2014)

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SELF HELP: Freedom From Problem Gambling Workbook

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Digital Therapeutics

- Blocking software / apps (GamBan)
- Therapeutic Apps
  - Tracking signs and symptoms
  - Tracking progress and feedback
  - Real time recovery activity
- 24/7 connection to recovery groups
- 24/7 access to licensed therapists

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California Gambling Education and Treatment Services (CALGETS)

problemgambling.ca.gov

CALIFORNIA CalGETS Gambling Education and Treatment Services OFFICE OF PROBLEM GAMBLING

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1-800-GAMBLER

CALIFORNIA CalGETS Gambling Education and Treatment Services OFFICE OF PROBLEM GAMBLING

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Summary: Gambling Disorder

- Gambling Disorder is prevalent but hidden
- Use screening tools to inform assessment
- Know local gambling trends
- Medications and psychotherapy work
- Focus on building recovery strength not elimination of gambling behavior

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Behavioral Addictions:
Hypersexual Disorder

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Dr. Jones

32 year old neurology resident seeks help for "pornography addiction"

Excessive use of pornography resulting in marital conflicts, lost time, lost productivity, distress about viewing, inability to stop viewing

No formal treatment

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Dr. Jones

- Once pandemic started, he worked from home more and the stress of work / COVID / work-life imbalance and isolation led to increased viewing of pornography at home.
- This lead to increased pornography use at work started up on hospital computers
- Hospital IT discovered and reported it to residency education which took limited action
- Behavior repeated and 2nd time he was discovered by nursing staff, which was greatly upsetting to them and filed sexual harassment

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Dr. Jones

- He is performing all clinical duties well and is in good standing
- No other psychiatric conditions identified
- Describes his viewing of pornography as automatic, like a reflex, recognizes it is not professional but unable (or unwilling) to contain or limit
- What should happen to him in the residency program?

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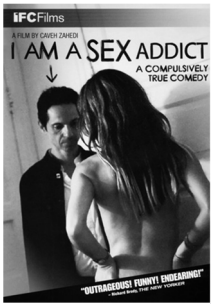
Terminology: A Constellation of Adjectives

Hypersexual impulsivity, sexual compulsivity, sexual addiction, sexual dependence, unrestrained sexual desire, sexual disinhibition, hypersexuality, sexual torridity, sexual sensation seeking, sexual desire disorders, excessive sexual desire disorder, hyperlibido, hyperactive sexual behavior, uninhibited sexual desire, paraphilia-related disorders, non-paraphilic sexual disorders, Don Juanism, erotomania, nymphomania, and satyriasis.



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Hypersexual Behaviors

- Non-Paraphilic
  - Pursuit of multiple partners
  - Pornography
  - Masturbation
  - Paying for sexual activities
- Paraphilic
  - Non-conventional
    - Objects, situations, individuals

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Models of Hypersexuality

- Addiction
- Impulse Control Disorder
- Compulsive Spectrum Disorder
- Extension of Existing Psychiatric Disorder (e.g. Mania)
- Sexual Desire Disorder
- Not a Legitimate Disorder at All

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ICD-11: Compulsive Sexual Behavior Disorder

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Compulsive Sexual Behavior Disorder (CSBD)

- Compulsive sexual behavior disorder is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behavior.
- PARENT is Impulse Control D/O

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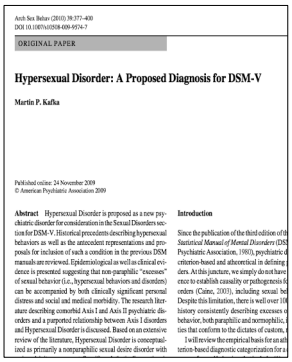
DSM-5 Proposal for Hypersexual Disorder

- Collaborative effort by Kafka and others on the DSM-5 workgroup for Sexual and Gender Identity Disorders wherein they drafted proposed criteria based on an extensive review of the the empirical literature.
- Kafka published his proposed criteria in the *Archives of Sexual Behavior* in 2010



Arch Sex Behav (2010) 39:377–400
DOI 10.1007/s10508-009-9574-7

ORIGINAL PAPER

Hypersexual Disorder: A Proposed Diagnosis for DSM-V

Martin P. Kafka

Published online: 24 November 2009
© American Psychiatric Association 2009

Abstract Hypersexual Disorder is proposed as a new psychiatric disorder for consideration in the Sexual Disorders section for DSM-V. Historical precedents describing hypersexual behaviors as well as the antecedent representations and proposals for inclusion of such a condition in the previous DSM manuals are reviewed. Epidemiological as well as clinical evidence is presented suggesting that non-paraphilic "excesses" of sexual behavior (i.e., hypersexual behaviors and disorders) can be accompanied by both clinically significant personal distress and social and medical morbidity. The research literature describing comorbid Axis I and Axis II psychiatric disorders and a purported relationship between Axis I disorders and Hypersexual Disorder is discussed. Based on an extensive review of the literature, Hypersexual Disorder is conceptualized as primarily a nonparaphilic sexual desire disorder with

Introduction

Since the publication of the third edition of t
Statistical Manual of Mental Disorders (DS
Psychiatric Association, 1980), psychiatric d
criterion-based and atheoretical in defining
ders. At this juncture, we simply do not have
ence to establish causality or pathogenesis f
orders (Carnes, 2003), including sexual be
Despite this limitation, there is well over 10
history consistently describing excesses o
behavior, both paraphilic and nonparaphilic,
ties that conform to the dictates of custom,
I will review the empirical basis for an att
tention-based diagnostic categorization for a

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Reid, R. C., Carpenter, B. N., Hook, J. N., Garos, S., Manning, J. C., Gilliland, R., ... & Fong, T. (2012). Report of findings in a DSM-5 field trial for hypersexual disorder. *The journal of sexual medicine*, *9*(11), 2868-2877.

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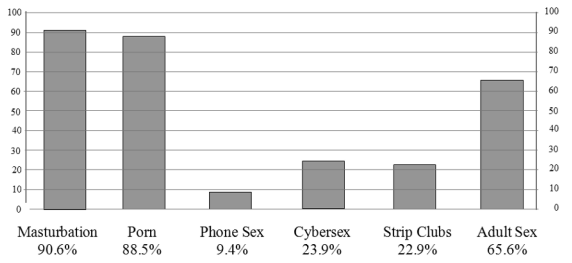
Manifestations of Hypersexual Behavior

Table 4. Report of Subtypes among Hypersexual Patients (Lifetime & Current)



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What Else Was Learned from DSM-5 Field Trial?

Table 6 Onset, course, and escalation trajectories among hypersexual patients (N = 123)*

Trajectories	Hypersexual patients
Onset	
Before age 18†	54.1%
Age 18–25	30.3%
After age 25	15.6%
Rapid/acute ≤ 90 days	17.4%
Gradual, several months, years	82.6%
Course	
Continuous	48.6%
Episodic	51.4%
Escalation	
Amount of time	83.5%
Frequency or intensity	81.7%
Venues/manifestations	62.4%
Associated risk	60.6%

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What Else Was Learned from DSM-5 Field Trial?

Table 5 Consequences associated among patients with an HD diagnosis (N = 127)*

Has happened several times	Has happened once or twice	Hypersexual Behavior Consequences Scale (sample items from the HBCS)
1.6%	15.7%	Caused job loss
16.5%	22.8%	Ended a romantic relationship
5.5%	22.0%	Contracted a sexually transmitted infection
0.8%	16.5%	Caused legal problems
29.1%	23.6%	Experienced unwanted financial losses
67.7%	22.0%	Emotionally hurt a loved one
66.9%	11.0%	Interfered with ability to experience healthy sex
73.2%	20.5%	Negatively affected mental health

*Missing data reduced this sample from 138 to 127.
HD = hypersexual disorder

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Treatment Options

- Psychopharmacological
- Group Psychotherapy / 12-Step Support
- Cognitive Behavioral Therapy
- Mindfulness Based Stress Reduction
- Cultivating Sexual Health
- Enhancing Cognitive Flexibility / Emotional Regulation
- Stress Management / Coping Skills

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Pharmacotherapy

- SSRI –
  - Multiple case reports; cohort studies
  - Citalopram 20-60mg vs. placebo in 28 men with Compulsive Sexual Behavior (CSB)
    - Significant decrease ($p<0.05$) in sexual drive, masturbation, pornography use
- Naltrexone – Case reports; case series
  - Dose ranges of 50-150mg daily
- Topiramate
  - Case reports
  - Dosages up to 50mg daily

Malandain, L., Blanc, J. V., Ferreri, F., & Thibaut, F. (2020). Pharmacotherapy of Sexual Addiction. *Current Psychiatry Reports, 22*, 1-8.

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12-step Groups for Hypersexual Disorders

- Sexual Addicts Anonymous (SAA)
- Sex and Lover Addicts Anonymous (SLAA)
- Sexual Compulsives Anonymous (SCA)
- Sexaholics Anonymous (SA)

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Summary: Hypersexual Behaviors

- Frequently seen but rarely studied well
- Individual, family and societal consequences can be substantial
- Screening, recognition and assessment is the best intervention for clinicians
- Principles of addiction treatment are most commonly applied

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Internet Gaming Disorder (IGD)

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Terminology

- Internet dependency
- Internet compulsivity
- Pathological Computer Use
- Problematic Internet Use
- Video Game Addiction
- Technology Addiction
- Digital Addiction
- Compulsive Digital Gaming

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Diagnostic Criteria

- Persistent and recurrent use of the Internet to engage in games, often with other players, leading to clinically significant impairment or distress as indicated by five (or more) of the following in a 12-month period:

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IGD Criteria

Preoccupation
Tolerance
Lost opportunity
Can't control
Continued use despite harm
Lying / Deceives
Withdrawal
Escape / Relieves
Loss of interest

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APA: IGD

- At this time, the criteria for this condition are limited to **Internet gaming** and do **not** include general use of the Internet, online gambling or social media.
- The condition can include gaming on the internet, or on any electronic device, although most people who develop clinically significant gaming problems play primarily on the internet.

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WHO and ICD-11

2017 Inclusion

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Gaming Disorder (considered an addiction)

- Gaming disorder is characterized by a pattern of persistent or recurrent gaming behavior ('digital gaming' or 'video-gaming'), which may be online (i.e., over the internet) or offline, manifested by: 1) impaired control over gaming (e.g., onset, frequency, intensity, duration, termination, context); 2) increasing priority given to gaming to the extent that gaming takes precedence over other life interests and daily activities; and 3) continuation or escalation of gaming despite the occurrence of negative consequences. The behavior pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. The pattern of gaming behavior may be continuous or episodic and recurrent. The gaming behavior and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

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Summary

- Behavioral addictions / non-substance related disorders are hidden and carry more stigma
- Technology will increase opportunities for behavioral addictions to emerge
- Physician health and wellness should address these activities during training and throughout the career

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Question and Answer

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