What are behavioral addictions?

Behavioral or process addictions can be as debilitating as substance use disorders

Focus is on a behavior, not a substance

- Eating Disorders
- Gambling
- Internet Gaming
- Sex and Love

Symptoms

- Continue the behaviors despite consequences
- Powerless to stop behaviors
- Disruptive of everyday life
- Can impact relationships
- Affects health, well-being and quality of life

Gambling Addictions

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress.

- Only 8% ever receive help
- 5 Million in US affected
- Men are 2-3 times more likely to have a gambling addiction than women

Gambling Addiction is frequently comorbid with other disorders...

of all patients co-occurring psychiatric disorder

3-5 X

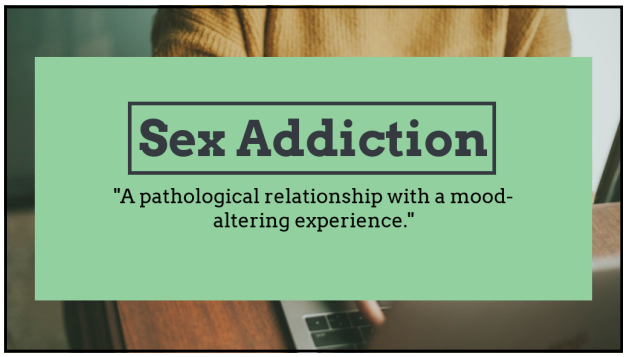
Rates of gambling addiction in people who have been arrested are 3-5 times higher than in the general population

of all patients had co-occurring Alcohol Use Disorder

Josephson, et al. 2016


Signs of gambling addiction
Increasing preoccupation with gambling
The need to bet more money more frequently
Restlessness or irritability when attempting to stop,
"Chasing" losses,
Continuation of the gambling behavior despite consequences
Family and job disruption


Risk Factors for Gambling Addiction
Neurochemistry
Compulsive gambling, also known as pathologic gambling, triggers physical and emotional reactions that are similar to the responses to drug or alcohol use
Family History
Increased risk if one or more close relatives have an addiction
Frequent participation in gambling activities that are continuous in nature and involve an element of actual or perceived skill
Males, young adults, low-income and non-married people
Co-occurring mental health or substance use issues
Indigenous and some ethnic minority groups


Sex Addiction
"A pathological relationship with a mood-altering experience."

Sex Addiction

- Loss of control
- Preoccupation with acting out sexual behaviors to the point of obsession
- Significant adverse consequences
- Continuation despite consequences

350 million with problem gambling

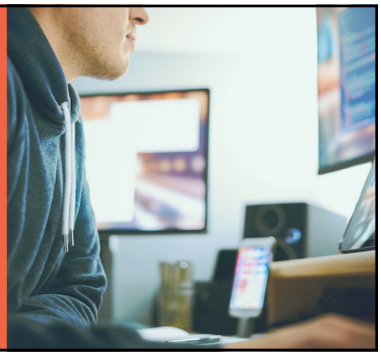
Behaviors Associated with Sex Addiction

1. Hour after hour of **porn and/or webcam use**, with or without masturbation.
2. Losing oneself in **hookup apps** and similar technologies—dating sites, video chat, sexting, etc.
3. Constantly **"hunting" for sex**—cruising in the car for sex partners, surfing online for sex partners, hanging out in the steam room at the gym, etc.
4. An ongoing pattern of intense and **highly sexualized affairs or brief "serial" relationship**s.
5. Consistently having **casual and/or anonymous sex** with people met online or in-person.
6. Consistently visiting strip clubs, adult bookstores/theatres, and other **sex-driven environments**.
7. **Paying for (or being paid for) sex**, sensual massage, eroticized domination, etc.
8. A pattern of **unsafe sex**—unprotected sex, sex with strangers, sex in public, etc.
9. Consistently **seeking sex without regard to consequences**—damaged relationships, financial issues, arrest, etc.

Sex Addiction is Not About Sex

Sex addiction is about:
1. Numbing out
2. Escaping stress or emotional distress
3. Dealing with depression, anxiety, etc.
4. Coping with early life trauma

Sex addicts can spend hours a day high on the goal/idea of having sex—without ever engaging in any concrete sexual act.



What Sex Addiction is Not

Sex addiction is not the same as sexual offending

It's possible to be a sex addict and a sexual offender but they are not the same thing. Most sex addicts do not become offenders.

Sex addiction is not an excuse for bad behavior.

Sex addicts are not absolved of the consequences of their behaviors.

Sex addiction is not related to sexual orientation.

Sexual addiction is not defined by who or what it is that turns you on.

Sex addiction is not fun.

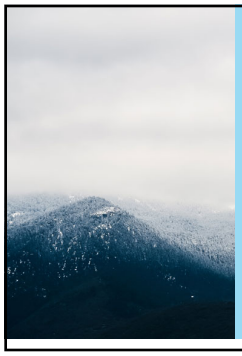
Sex addiction leads to shame, depression, anxiety, and a wide variety of negative consequences

Sex addiction is not just a guy thing.

Women are affected by sex addiction but tend to talk about it in terms of relationships, not sex.

Sex addiction is not the spouse's fault.

This is like blaming orange juice for alcoholism ("If OJ tasted better, I wouldn't have to cut it with vodka.")



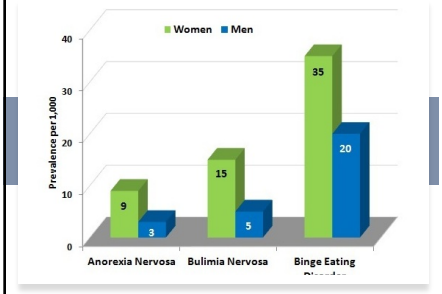
Co-occurring sex addiction and substance addiction

1. Chemsex addicts use stimulant drugs
2. Chemsex addicts are less likely to practice safe sex (increased risk for STDs"
3. Chemsex addicts may also abuse benzodiazepines, alcohol, other to "come down" after they party

https://iitap.com/page/Assessment

https://www.recoveryzone.com/tests/sex-addiction/SAST/index.php

Eating Disorders



Prevalence of eating disorders

Eating Disorders

- Anorexia nervosa
  - **inability to maintain** a minimally normal **weight**
  - a devastating **fear of weight gain**
  - relentless **dietary habits that prevent weight gain**
  - disturbance in the way in which body weight and shape are perceived, **undue influence of body weight or shape on self-evaluation**, or persistent lack of recognition of the seriousness of the current low body weight

In young women, the risk of developing anorexia is 0.5 to 1 percent, and mortality is estimated at 4 to 10 percent.

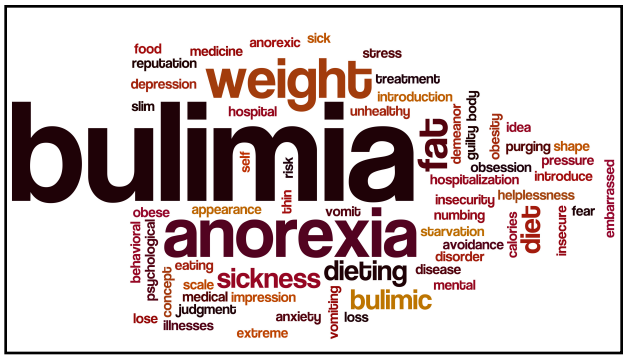
- 2 Sub-Types of Anorexia
  - **Restricting**, in which severe limitation of food intake is the primary means to weight loss
  - **Binge-eating/purging type**, in which there are periods of food intake that are compensated for by self-induced vomiting, laxative or diuretic abuse, and/or excessive exercise

Risk Factors

- **Traits**
  - Perfectionism
  - Desire for academic success
  - Lack of age-appropriate sexual activity
  - Denial of hunger in the face of starvation
- **Psychiatric characteristics**
  - Excessive dependency
  - Developmental immaturity
  - Social isolation
  - Obsessive-compulsive behavior
  - Constricted affect
  - Comorbid depression and dysthymia

Eating Disorders

- Have one of the highest mortality rates of all psychiatric diagnoses
  - SMR = 11.6 for anorexia; 1.3 for bulimia
  - SMR for suicide in anorexia = 56.9
  - Severity of alcohol use was associated with increased risk for mortality
  - Hospitalization for an affective disorder was protective from mortality
    - Keel PK, et al. Arch of Gen Psych. 2/2003;60(2)
- 24.9% (for AN), 15.7% (for AN-R), **44.1% (for AN-BP)** for suicide attempts
  - Udo T, et al. 2019
- 1 in 5 of those who died with AN, died by suicide
  - Arcelus J, et al. 2011
- **Psychache vs. Interpersonal theory**
  - Shneidman (1996)



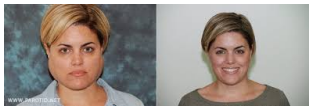
DSM-V Criteria for Bulimia Nervosa

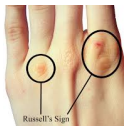
- Recurrent episodes of binge eating. Eating more than the average person in a 2-hour period, accompanied by a sense of loss of control.
- Repetitive inappropriate compensatory behaviors to avoid weight gain such as excessive exercise, fasting, laxative use, and diuretic use.
- This eating behavior occurs at least once a week for a period of 3 months.
- Body shape and weight influence self-evaluation.
- This does not occur specifically with episodes of anorexia nervosa.

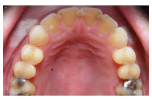
Signs and Symptoms

- Gastrointestinal symptoms: pain, pharyngeal irritation, blood in vomitus, esophageal tears, bloating, constipation, GERD, **Mallory Weiss tear**
- Dizziness, palpitations, dry skin, orthostatic hypotension
- Amenorrhea, irregular periods
- Electrolyte abnormalities
- Cardiac - Edema; EKG changes such as QT prolongation, increased PR interval, increased P wave amplitude, widened QRS, depressed ST segment

Signs and Symptoms







Poor Outcomes

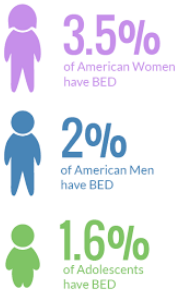
- Higher age at first presentation
- Co-occurring Substance Use Disorder
- Alcohol use disorder + lower BMI + older age at first presentation
- Cluster B personality disorders: include antisocial **personality disorder**, borderline **personality disorder**, histrionic **personality disorder** and narcissistic **personality disorder**.

Bulimia Nervosa

Prognosis
- 29.9% to 34.5% achieved abstinence
- 60% of those with BN fail to abstain from core behaviors

Pharmacotherapy
- Prozac
- Treatment of co-occurring mood and anxiety disorders

Jane Fonda



Binge Eating Disorder (BED) Criteria (from DSM-V)

- 1. Eating, in a discrete period of time within any 2-hour period, an amount of food that is definitely larger than what most people would eat in a similar period under similar circumstances
- 2. A sense of lack of control over eating during the episode, the episodes occur on average at least once a week for at least 3 months,
- There is no compensatory purging
- Three or more of the following factors are also present:
  - Eating much more rapidly than normal
  - Eating until feeling uncomfortably full
  - Eating large amounts of food when not feeling physically hungry
  - Eating alone because of feeling embarrassed by how much is being eaten
  - Feeling disgusted with oneself, depressed, or very guilty afterward

What you see

- Food disappearing, empty wrappers and containers
- Uncomfortable eating around others
- Fad diets, cutting out food groups
- Steals or hordes food in strange places
- Arranges lifestyle around binges
- Extreme concern with weight and shape
- Fluctuations in weight

Predictive Factors

- Female sex
- Being identified as "overweight" at age 10
- Eating, weight or shape concerns at age 14
- Hereditability
  - 41%–57%
- Asian Americans > Whites report binge eating
- Most common ED in African Americans

Complications

Suicide risk
- 1/3 had thought about suicide
- 22.9% had attempted suicide in their lifetime
- 10.1% with suicidality in the last year

Health consequences
- Cardiovascular disease
- Type 2 Diabetes
- Insomnia or sleep apnea
- Hypertension
- Gallbladder disease
- Muscle and/or joint pain
- Gastrointestinal difficulties
- Depression and/or anxiety
- Stomach rupture from binges
- Sleep Apnea

Medication

- Prozac – approved for binge eating and vomiting behaviors
- Vyvanse – approved for moderate-severe BED
- Dasotraline (Sunovion) – recently approved by FDA for new drug application (dopamine and norepinephrine) – for moderate-severe BED

Risk factors for Binge Eating Disorder

- Adverse childhood experiences
  - Sexual and physical abuse
- Parental factors:
  - Parental depression
  - Minimal affection, parental criticism
- Self-harm
- Vulnerability to obesity
- Repeated exposure to negative comments about shape, weight and eating from family members

Genetics – BED and Obesity

- Binge Eating Disorder
  - Binge-eating disorder is a familial disorder caused in part by factors distinct from other familial factors for obesity
  - Hereditability estimated at 57% (Javaras KN, et al. 2007)
- Obesity / Compulsive Overeating
  - Hereditability estimated at between 40-70% (Deckelbaum 2001)

Other Specified Feeding and Eating Disorders – OSFED (formerly ED-NOS)

- **Atypical Anorexia Nervosa**: All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.
- **Binge Eating Disorder (of low frequency and/or limited duration)**: All of the criteria for BED are met, except at a lower frequency and/or for less than three months.
- **Bulimia Nervosa (of low frequency and/or limited duration)**: All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behavior occurs at a lower frequency and/or for less than three months.
- **Purging Disorder**: Recurrent purging behavior to influence weight or shape in the absence of binge eating.
- **Night Eating Syndrome**: Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g. BED).

Avoidant Restrictive Food Intake Disorder (ARFID)

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
  - Significant nutritional deficiency.
  - Dependence on enteral feeding or oral nutritional supplements.
  - Marked interference with psychosocial functioning.
- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

ARFID – RISK FACTORS

- People with autism spectrum conditions are much more likely to develop ARFID, as are those with ADHD and intellectual disabilities.
- Children who don't outgrow normal picky eating, or in whom picky eating is severe, appear to be more likely to develop ARFID.
- Many children with ARFID also have a co-occurring anxiety disorder, and they are also at high risk for other psychiatric disorders.

Genetics

Co-Occurring Disorders with ED

Disorder	Anxiety Disorders	Mood Disorders	Impulse Control Disorders*
Anorexia	48%	42%	31%
Bulimia	81%	71%	64%
Binge Eating	65%	46%	43%

SAMHSA.gov

Prognosis

- Morbidity rates = 10-20%
- 50% of patients make a complete recovery
- Of the remaining 50%: 20% remain emaciated and 25% remain thin
- 10% become overweight or die of starvation

PROGNOSIS: Eating Disorders

- 25-50-25
- Anorexia: Mortality 10-20%
  - Full weight restoration associated with lower relapse rates in anorexics
  - Age at onset > 11 but < 21 better
  - 50% fully recover, 20% remain emaciated, 25% are thin, 5-10% die of starvation
- Binge Eating Disorder –
  - After 6 years with treatment 50% improve, 30% intermediate outcome, 6% poor outcome, 1% die
- Treatment within the first five years is best for bulimia – 65-83% recovered; 36% abstinent
- Treatment by eating disorder professionals most successful

Screening – SCOFF Questionnaire

- Do you make yourself *Sick* because you feel uncomfortably full?
- Do you worry you have lost *Control* over how much you eat?
- Have you lost more than *One* stone* in a 3-month period?
- Do you believe yourself to be *Fat* when others say you are too thin?
- Would you say that *Food* dominates your life?

* One stone is approximately 14 lb, or 6.35 kg.

Screening Tool for ED

1. How many diets have you been on in the past year?
2. Do you think you should be dieting?
3. Are you dissatisfied with your body size?
4. Does your weight affect the way you think about yourself?

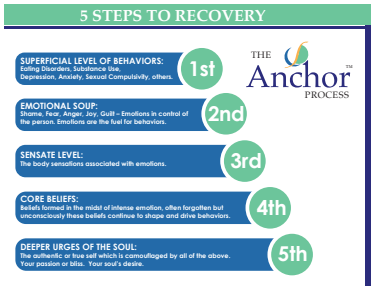
Anstine D et al. 2000

8 Cornerstones of an Integrative Medicine Approach

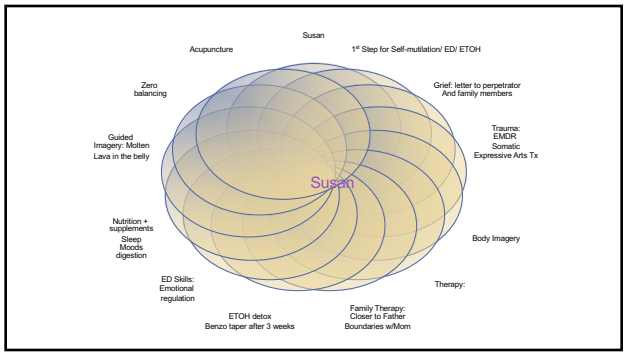
- **Nutrition Program:**
  - Shift relationship
  - Improve autonomy
  - Root cause
  - Digestion/Absorption
- **Psychotherapy**
  - Gain insight into behaviors
  - Food/mood
  - Body image
  - Getting at root causes
- **Exercise**
  - Learn healthy behaviors
  - Get in touch with physical body
  - Learn body cues
- **Nutraceuticals**
  - Support medication effects
  - Decrease side effects
  - Special qualities for Mental Disorders

8 Cornerstones (continued)

- **Psychometrics**
  - Early identification of Axis I and II diagnoses
  - Inform treatment approaches
- **Integrative Therapies**
  - Emotional release
  - Deep relaxation
  - Integration of mind-body
- **Psychotherapy**
  - What's the root cause vs. "Alligator closest to the boat"
- **DBT Skills training**
  - Practical skills
  - Treatment of Axis II issues



Case



Patient Art

- Patient art shared in the video is not available for the handouts due to patient privacy concerns

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