Psychotherapy for Substance Use Disorder (SUD) & Behavioral Addictions

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The following CME planners and faculty do not have relevant financial relationships with ineligible companies:

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Learning Objectives

- Identify diagnostic criteria for substance use disorders (SUD) and behavioral addictions
- Name at least two evidence based behavioral treatments for SUDs and behavioral addictions
- Describe how harm reduction may be incorporated into psychotherapy for SUD and behavioral addictions
- Specify at least two behavioral techniques to reduce symptoms of substance use and/or addictive disorders.

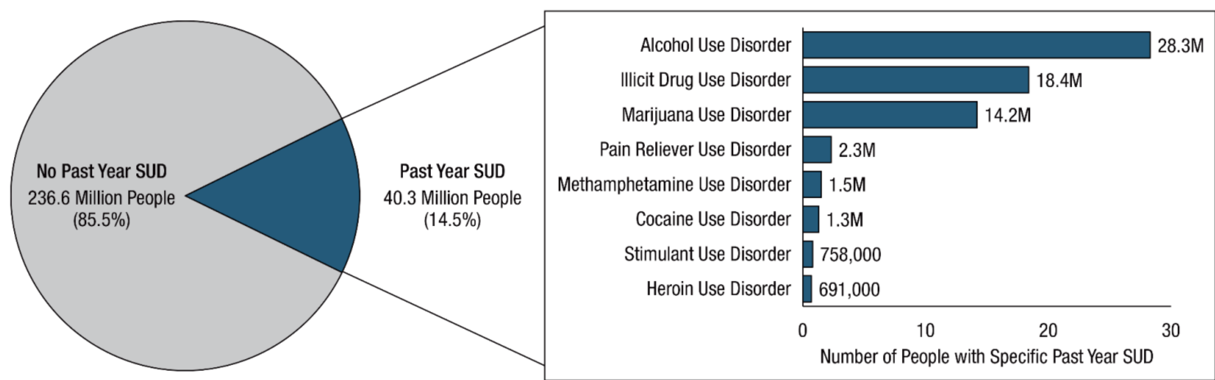
SUD Prevalence

- 40.3 million people (aged 12+)
  - 28.3 million alcohol use disorder (AUD)
  - 18.4 million other substance use disorder
  - 6.5 million had both AUD & illicit drug use disorder

SAMHSA, 2020

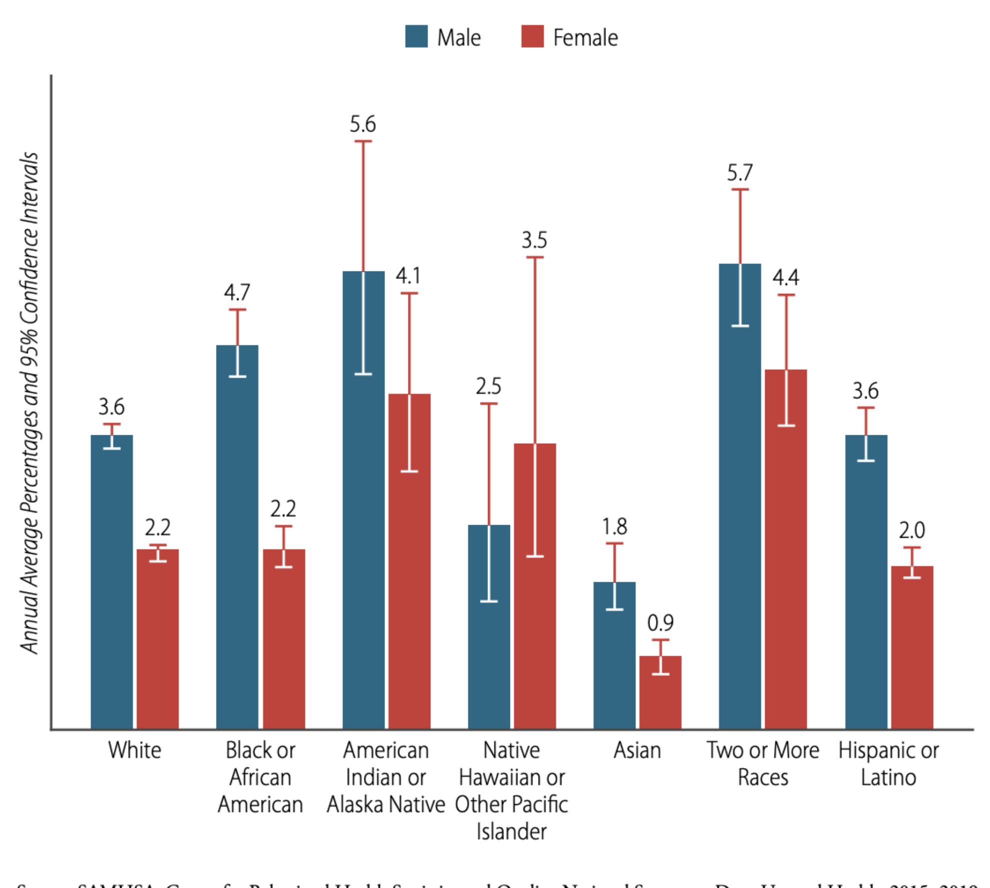
SUD Prevalence by Substance

People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2020



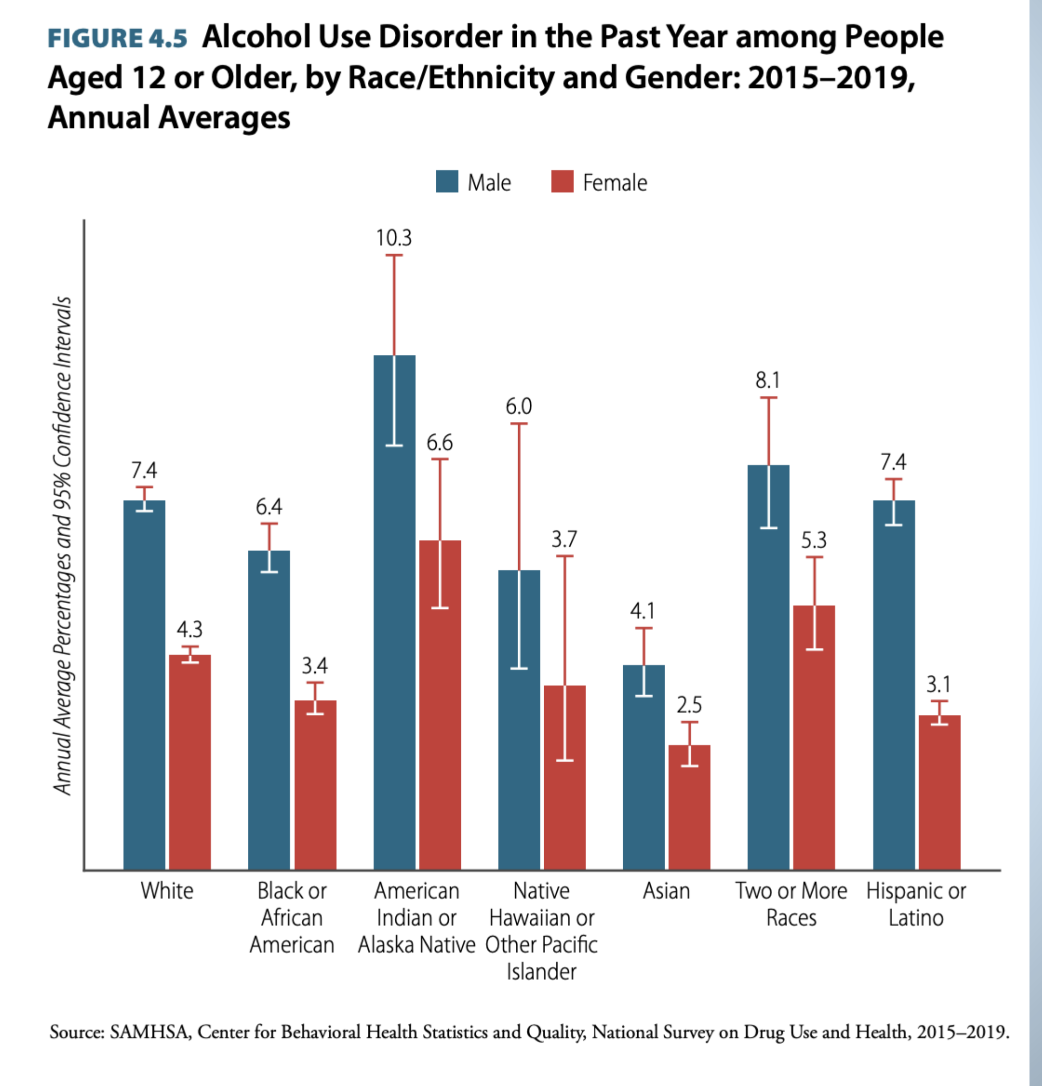
Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

SUD Race/Ethnicity x Gender Differences



Center for Behavioral Health Statistics & Quality, 2021.

AUD Race/Ethnicity x Gender Differences

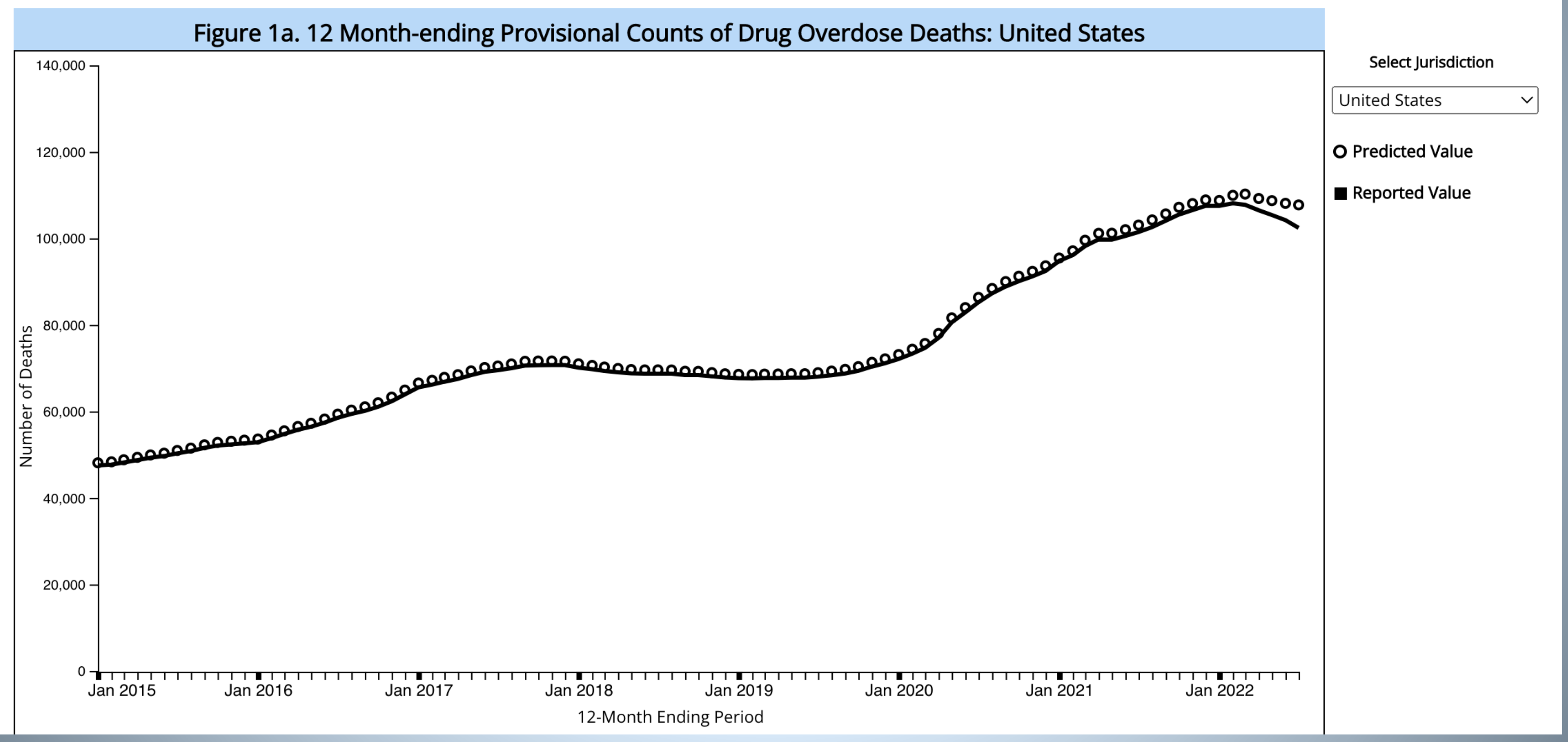


Center for Behavioral Health Statistics & Quality, 2021.

Treatment Gaps & Health Disparities

- 85.1% of people with SUD receive no treatment (SAMHSA, 2020)
- SUD treatment disparities (CBH Stats, 2021):
  - whites receive treatment 23.5% of the time
  - Black individuals receive treatment 18.6% of the time
  - Latinx individuals receive treatment 17.6% of the time
- Opioid Use Disorder:
  - Women wait longer (Marsh et al., 2021)
  - Women have lower treatment completion, even lower odds with Black and Latina women (Guerrero et al., 2021)

Drug Overdose Death Counts



Ahmad et al., 2022

Monthly alcohol related deaths during pandemic

10000
8000
6000
4000
2000
0

Alcohol-related deaths per mo

January 31, 2020
US declares the SARS-CoV-2 virus a public health emergency

March 19, 2020
First US state issues a stay-at-home order

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun

2019 2020 2021

Monthly Alcohol-Related Deaths Among People 16 Years and Older

White et al., 2022

SUD Diagnostic Criteria

Two or more of 11 symptoms across four criteria categories (DSM-5; APA, 2013):

- Impaired control over use
- Social impairment
- Risky use
- Pharmacologic (i.e. tolerance and withdrawal)

Impaired Control Over Use

- Consuming the substance in larger amounts and for a longer amount of time than intended.
- Persistent desire to cut down or regulate use. The individual may have unsuccessfully attempted to stop in the past.
- Spending a great deal of time obtaining, using, or recovering from the effects of substance use.
- Experiencing craving, a pressing desire to use the substance.

Social Impairment

- Substance use impairs ability to fulfill major obligations at work, school, or home.
- Continued use of the substance despite it causing significant social or interpersonal problems.
- Reduction or discontinuation of recreational, social, or occupational activities because of substance use.

Risky Use

- Recurrent substance use in physically unsafe environments.
- Persistent substance use despite knowledge that it may cause or exacerbate physical or psychological problems.

Pharmacologic

- **Tolerance:** Individual requires increasingly higher doses of the substance to achieve the desired effect, or the usual dose has a reduced effect; individuals may build tolerance to specific symptoms at different rates.

- **Withdrawal:** A collection of signs and symptoms that occurs when blood and tissue levels of the substance decrease. Individuals are likely to seek the substance to relieve symptoms. No documented withdrawal symptoms from hallucinogens, PCP, or inhalants.

- *Note*: Individuals can have an SUD with prescription medications, so tolerance and withdrawal (criteria 10 and 11) in the context of appropriate medical treatment do *not* count as criteria for an SUD.

Severity and other specifiers

- Severity: mild, any 2 or 3 criteria; moderate, any 4 or 5 criteria; severe, any 6 or more criteria
- Early remission = meeting no criteria except craving for ≥3 months <12 months
- Sustained remission = meeting no criteria except craving for ≥12 months

Practice Guidelines for SUD Treatment

SUD	Psychosocial Interventions	Medications
Alcohol	-Behavioral Couples Therapy -CBT -Motivation Enhancement Therapy (MET) -Twelve Step Facilitation (TSF) -Community Reinforcement Approach	Strong evidence: -Naltrexone -Topiramate Weak evidence: -Acamprosate -Disulfiram -2nd line: Gabapentin
Opioids		Strongest evidence: -Buprenorphine/naloxone -Methadone Weak evidence: -Injectable Naltrexone (Vivitrol)
Cannabis	CBT/MET	
Stimulants	Cocaine: CBT & Contingency Management (CM) Amphetamine/Methamphetamine: CM	

https://www.healthquality.va.gov/guidelines/mh/sud/

Psychotherapies for SUD

- CBT-SUD
  - Modify thinking and behavior related to substance use and other related life areas
  - Improve coping skills, mood, interpersonal functioning
- Relapse Prevention Model
- Identify and avoid triggers:
  - External (i.e. people, places and things)
  - Internal (i.e. negative and positive affective states; waning motivation)
- Need to incorporate other coping when triggers can't be avoided (i.e. coping strategies, managing environment, creating "roadblocks")
- Small effect sizes, larger for cannabis use and among women (Magill & Ray, 2009)

Psychotherapies

- Community Reinforcement Approach:
  - CBT approach with goal of building more environmental contingencies (increase positive reinforcement through employment, positive rewarding behaviors, involve significant others)
  - Develop healthy life that competes with substance use
- CRA is highly effective for alcohol use disorder compared to other treatments (Meyers et al., 2011)
- Has been adapted for adolescents, families, in a number of settings

Behavioral Couples Therapy

- Based on CBT
- Goal to improve relationships between family members when one member has SUD
- Relationships often very degraded
- Reduce punitive response to substance use
  - Avoid nagging or complaining about past
  - Withdraw positive behaviors when use occur
- Facilitate medication use when indicated
- Train family members to reward change
  - Taking meds, attending treatment, attending 12-step
  - Notice and appreciate positive behaviors of the person
- Moderate to large effect sizes for males with AUD; 2 small studies also showing success with women (McGrady et al., 2009; Schumm et al., 2014)
- Unknown how well BCT works for other substance use, only recommended for alcohol

Motivational Enhancement Therapy (MET)

- Normal to have ambivalence about treatment
- MET is 4 sessions of MI including assessment of SUD and feedback
- Techniques: compare substance use to norms, non-judgmental, rolling with resistance, open questions and reflective listening, empathy, develop discrepancies and increase change talk
- Cochrane review (2011) of 59 studies (Smedlund et al., 2011):
  - MI superior to no treatment though effects diminish over time; not better than active treatment
  - MI is added to CBT seems to improve outcomes
  - No consistent evidence that it works better for low motivation
  - Better MI leads to better change talk, but change talk does not predict better SUD outcomes (Magill et al., 2014)

12 Step Facilitation

- 12 Step Facilitation – 4-12 sessions actively facilitating participation in 12 step, providing education, linking to treatment, tracking attendance
- Performs as well as other treatments (Kelly et al., 2020)
- Led to more 12 step attendance and high rates of abstinence
- Attending more 12 step predicts better outcomes
- Less costly than other treatments

Contingency Management

- Contingency Management (CM): Uses rewards for abstinence verified by drug screens. Rewards increase with repeated negative tests
- Patients test 2-3x/week
- Most effective treatment for stimulant use though most effects fade quickly when reinforcement ends (Benishek et al., 2014)
- CA is first state to cover CM as a Medicaid benefit

Mindfulness & Acceptance and Commitment Therapy (ACT)

- 3rd wave CBT treatments Mindfulness and ACT – focuses on increasing acceptance of distress and cravings without drinking or using
- Mindfulness – small meta-analysis compared to active control showed small effect sizes on reducing days of use (Li et al., 2017)
- ACT – small meta-analysis shows comparing ACT to active control shows medium effects on SUD outcomes (Lee et al., 2015)
- Pending further evidence may be included in next practice guidelines

Opioid Use Disorder (OUD)

- Psychotherapy is not evidence based treatment for OUD
- Medications are only evidence based treatments
  - Increase survival, treatment retention, employment, birth outcomes among pregnant women with OUD
  - Decrease substance use, criminal activity, risk for HIV & HCV

Xylazine

- Xylazine is FDA-approved for use in animals as a sedative and pain reliever
- Known as “tranq,” “tranq dope” or “zombie drug” an adulterant that lengthens short duration of fentanyl injection
- Noted in drug supply in Puerto Rico, then Philadelphia, identified in 10 other jurisdictions (Friedman et al., 2022)
  - 6.7% of overdose deaths in 2020, but not well identified or tracked
  - Highest prevalence in Philadelphia (25.8% of deaths), Maryland (19.3% of deaths), Connecticut (10.2% of deaths)
- FDA alert from 11/8/22
  - Be cautious of possible xylazine inclusion in fentanyl, heroin, and other illicit drug overdoses
  - Naloxone may not be able to reverse its effects
  - Risks of severe, necrotic skin ulcerations, possible withdrawal symptoms, and interference with successful treatment of opioid overdoses
- FDA encourages reporting of adverse events with possible illicit xylazine exposure to FDA’s MedWatch Adverse Event Reporting program:
  - www.fda.gov/medwatch/report.htm

Harm Reduction

- Part of National Drug Control Strategy

https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf

- Integrating harm reduction is necessary to save lives and increase access to treatment
- Improve treatment engagement – meet people where they are (i.e. primary care; digital therapies) and provide coverage of services
- Ensure plentiful supply of naloxone
- Support harm reduction training for workforce
- Facilitate low barrier access to buprenorphine for OUD
- X waiver removed: Omnibus bill removes federal requirement for x-waiver

Integrating Harm Reduction

- Use de-stigmatizing language (Volkow et al., 2021):
  - use person with substance use disorder (avoid ”addict, alcoholic, substance abuser”)
  - use negative or positive urine tests (avoid clean v. dirty)
  - use medication for SUD not “medication assisted treatment/MAT”
- Use patient centered goals which may or may not include abstinence
- Consider medications, if OUD then primary goal of psychotherapy should be medication
- <u>Do not discontinue treatment for substance use</u> though you may consider change in treatment plan (i.e. adding medication, more intensive treatment or residential)
- For opioids and other sedating drugs as well as stimulants (possibly laced with sedatives):
  - Never use alone
  - Recovery position and movement
  - Naloxone
- Promote and help coordinate wound care if needed

Motivation Enhancement Technique

Importance

1. Ask about importance: *How important would you say it is for you to [target behavior]? On a scale from 1 to 10, where 1 is not at all important and 10 is extremely important, where would you say you are?*

1	2	3	4	5	6	7	8	9	10
NOT AT ALL IMPORTANT									EXTREMELY IMPORTANT

2. Backwards question: *Why did you pick a 4 and not a 1?* This question is used strategically to elicit change talk from the Veteran. The number that the Veteran chooses is not important. It is the direction of the question that is important. If the question were to asked differently *(i.e., Why did you pick a 1 and not a 4?)* it would likely elicit sustain talk.
3. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
4. Forwards question: *What would need to happen for you to get from a 4 to an 8?*

DeMarce et al., 2014

Motivation Enhancement Technique

Confidence

1. Ask about confidence: *Let's say you decided to make this change. How confident are you that you could do it? On the same scale from 1 to 10, where 1 is not at all confident and 10 is extremely confident, where would you say you are?"*

1	2	3	4	5	6	7	8	9	10
NOT AT ALL CONFIDENT									EXTREMELY CONFIDENT

2. Backwards question: *Why did you pick a 6 and not a 2?* This question is used strategically to elicit change talk from the Veteran. The number that the Veteran chooses is not important. It is the direction of the question that is important. If the question were asked differently *(i.e., Why did you pick a 1 and not a 4?)* it would likely elicit sustain talk.
3. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
4. Forwards question: *What would need to happen for you to get from a 6 to a 9?*
5. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
6. Ask: *What would you add? or What else?*

After going through the above steps for one or both of the rulers, ask the Veteran about next steps:

- *Where does that leave you now?*
- *I wonder what you're thinking about _______ at this point.*
- *What's the next step?*
- *How does ____________ fit into your future?*

DeMarce et al., 2014

Decisional Balance

	Drinking & Using	Stopping
Benefits	-helps me sleep -better social life -fit in with friends -reward -get rid of cravings	-legal problems improve -save money -improved health
Costs	-legal problems -relationship problems -health problems -expensive -low self-esteem -poor mood	-loss of a crutch -nothing to manage anxiety -friends won't want to socialize -boredom -lose a feeling of freedom -have to address problems I've been avoiding

Identifying Triggers

Exploring Triggers				
Triggers What sets me up to use?	**Thoughts and Feelings** What was I thinking? What was I feeling?	**Behavior** What did I do then?	**Positive Consequences** What positive things happened?	**Negative Consequences** What negative things happened?
Before bed- hard to sleep	Fall asleep, no dreams	Drank beer, took shots	Fall asleep right away, sometimes no dreams	Wife doesn't like it, often have a headache in the morning
At work where coworkers are smoking pot	Reduce anxiety and boredom	Smoked a joint with co-worker	Didn't rock the boat	Expensive, bad for health, potential legal issues

Urge Monitoring & Urge Surfing

Urge Monitoring Card Sample

Date/Time	Situation	Rating (0-100%)	How I responded
Sept 12 2:10	Talking about what it was like using with friends. Started to feel a little antsy.	40%	Practiced riding out the urge and using the surfing instructions. Did not use.

-Urge surfing proposes that urges are like waves in the ocean that start small, peak and fade

-Train yourself to stay with the urge, make space for it. Take inventory, notice where it is in the body, monitor changes in the sensation.

-Craving will dissipate but the goal is to experience it in a different way and rewire your response.

DeMarce et al., 2014

Managing Triggers

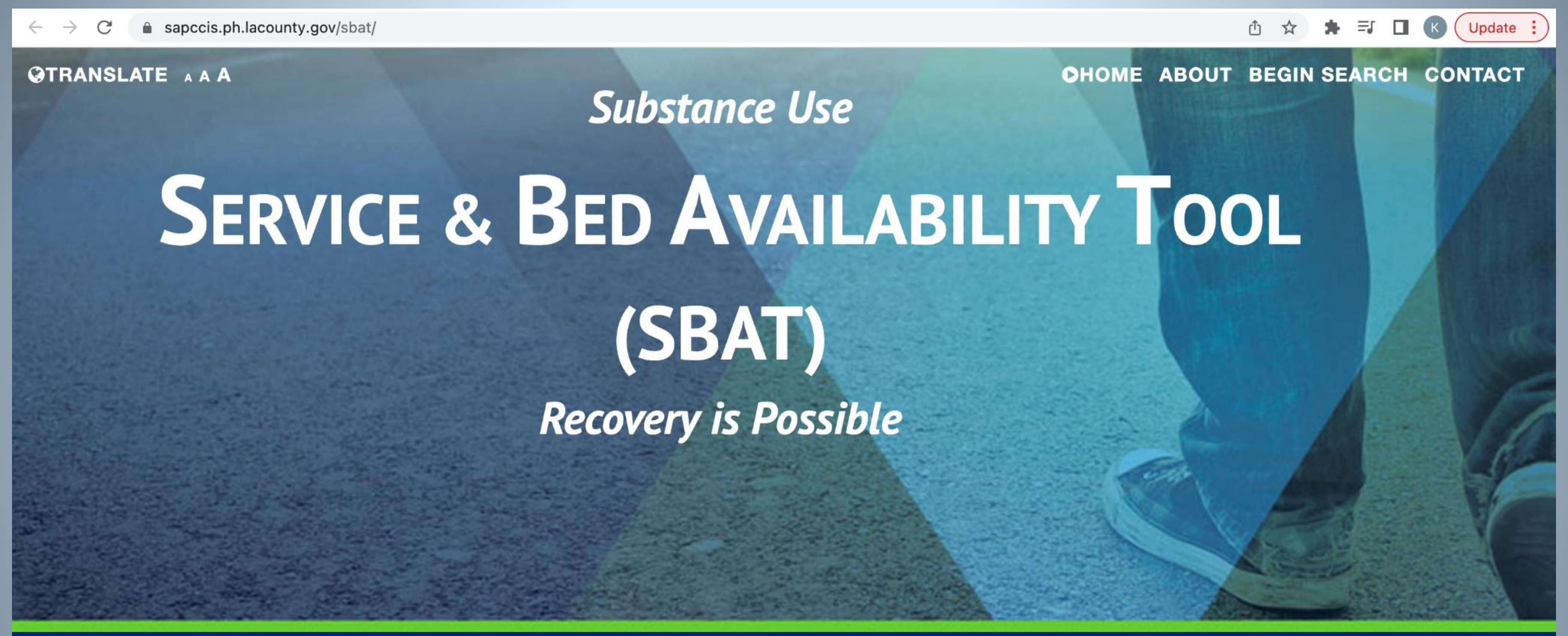
Avoid	• Avoid those triggers that can be avoided. Those who successfully modify substance use typically avoid the triggers they can, especially early in the process. • Get rid of substances at home and in other common places (e.g., car, boat, worksite). • Stay away from parties or places where use occurs. • Reduce contact with friends who use and meet them only in substance free contexts.
Escape	• Have a plan for getting out of a situation as quickly as possible if strong urges occur. • Have the means for escape ready – do not get stranded. • Plan for what to say.
Distract	• Prepare a list of reliable distracting activities so that when confronted with triggers there is a line of defense (e.g., walking, running, biking, reading, calling someone, making something, going to a movie).

DeMarce et al., 2014

Other Behavioral Techniques

- Cognitive restructuring – identify permission giving thoughts, euphoric recall, and add contamination thoughts
- Identify roadblocks that make it more difficult to access substances
- Schedule healthy activities
- Practice refusal skills

SUD Resources

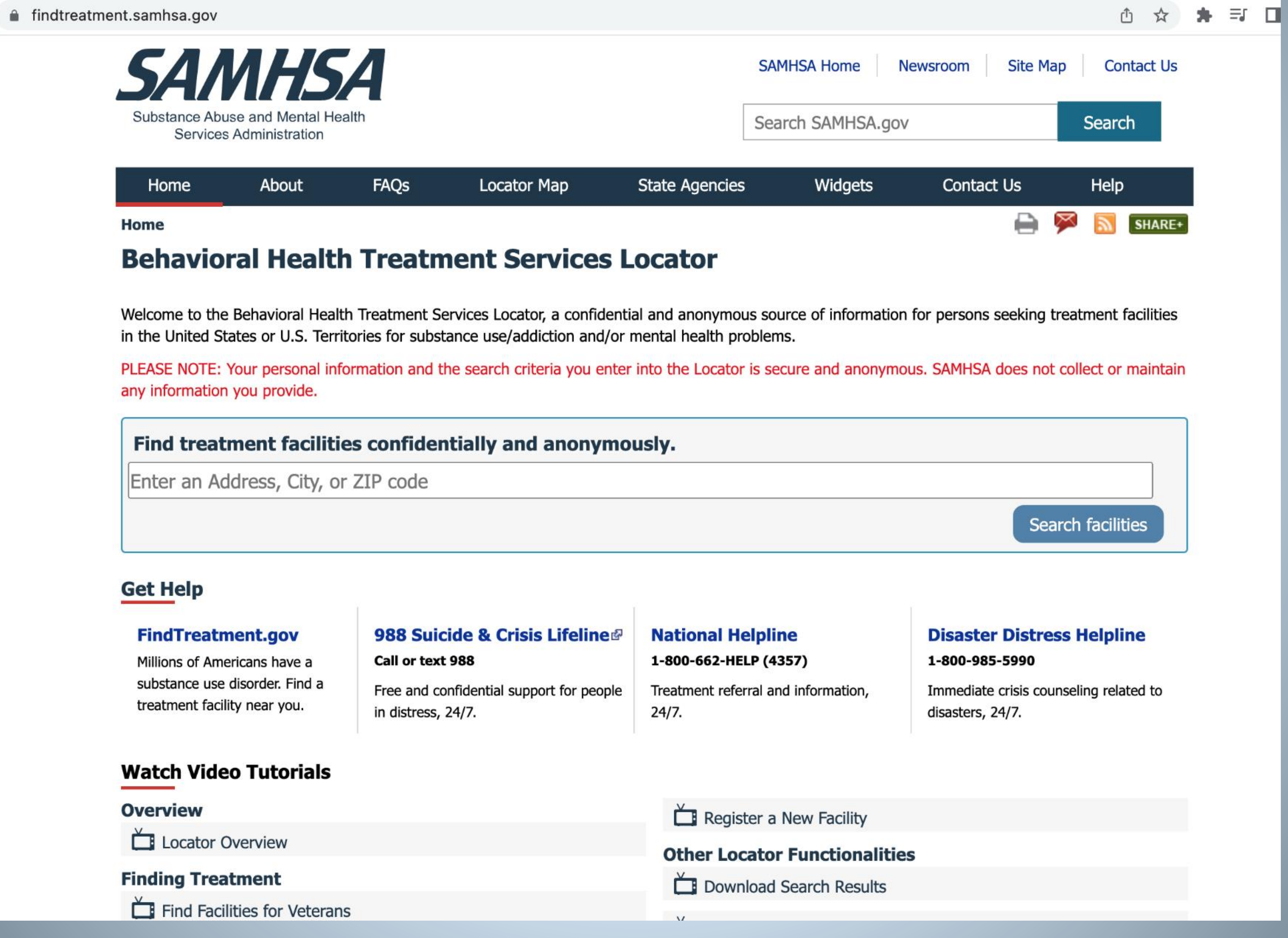


ABOUT

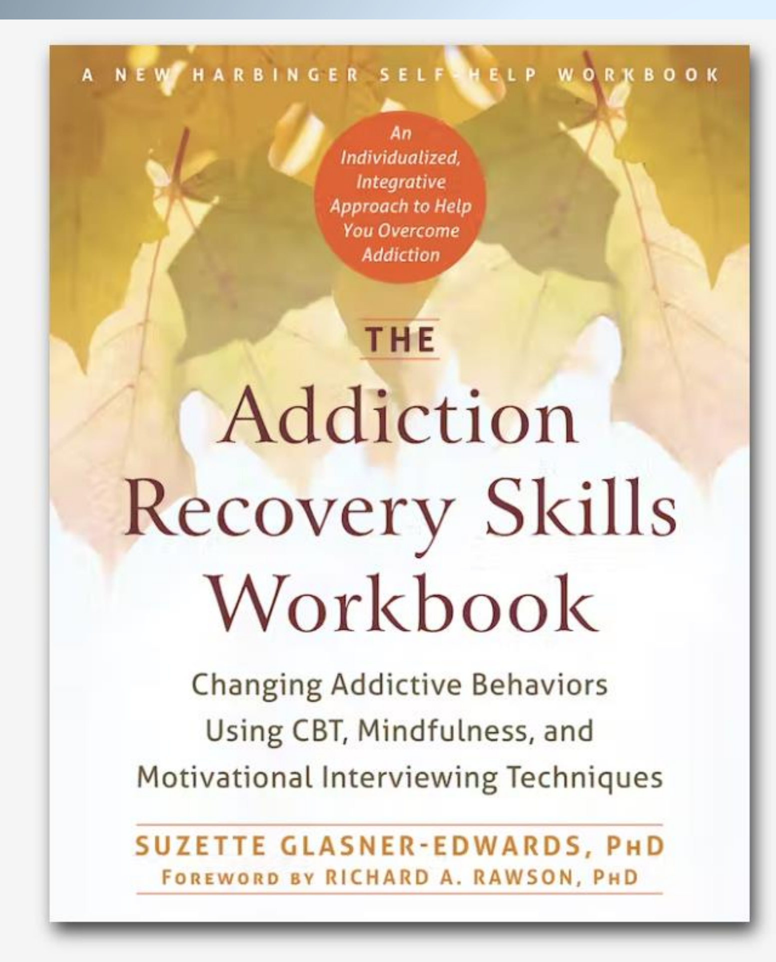
The Service & Bed Availability Tool (SBAT) can help you find the substance use services you, your client, or loved one is looking for.

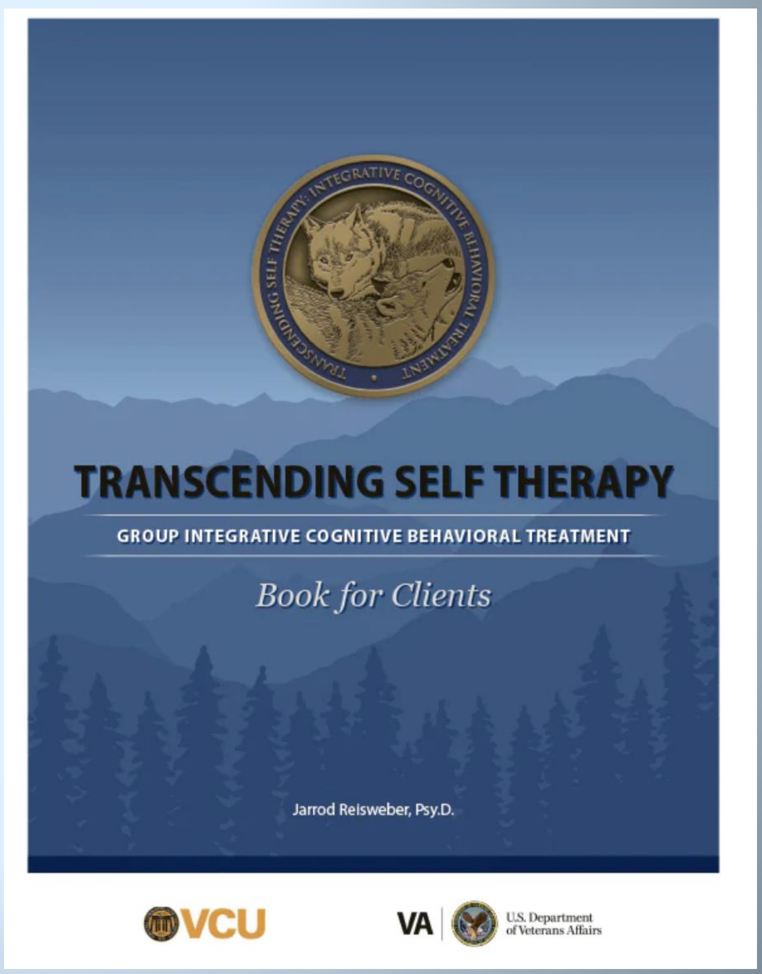
The SBAT is a web-based tool that provides a dashboard of available substance use services throughout Los Angeles County, including: outpatient and intensive outpatient treatment, different levels of residential treatment, withdrawal management, Opioid Treatment Programs (methadone clinics), Recovery Bridge Housing, and DUI programs.

SUD Resources

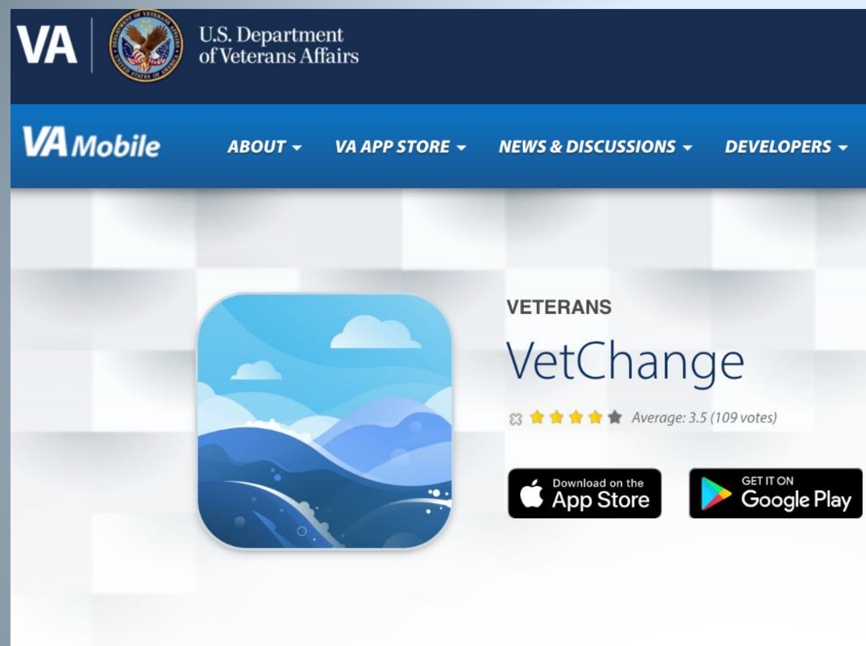


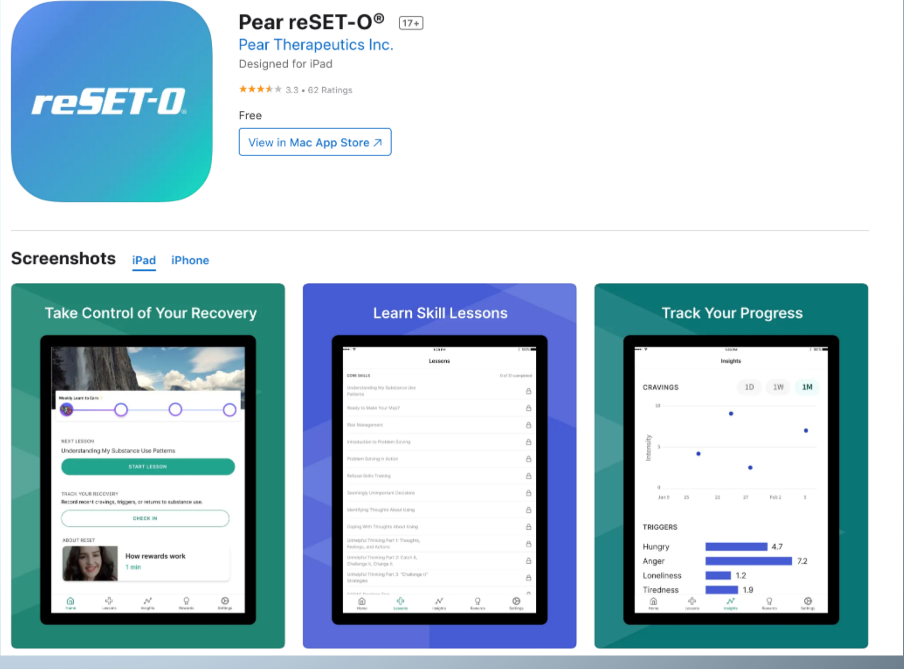
Books for SUD





Apps





Gambling Disorder

- First behavioral addiction to be included in DSM previously categorized “Impulse Control Disorder” since 1980
- Prevalence 0.1-2% of the population (Petry, 2016)
- Highly co-morbid with substance use (Hasin et al., 2018)
- 76.3% with gambling disorder have SUD (Kessler 2008 – put ref in and below)
- 47.8% of those with gambling disorder have AUD (Petry, 2005)

Gambling Diagnostic Criteria

Four or more of the following:

- Need to gamble with increasing amounts to achieve the desired excitement.
- Restless or irritable when trying to cut down or stop gambling.
- Repeated **unsuccessful efforts to control**, cut back on or stop gambling.
- **Preoccupation** or frequent thoughts about gambling (such as reliving past gambling or planning future gambling).
- Often gambling when feeling distressed.
- After losing money gambling, often returning to get even. (This is referred to as "chasing" one's losses.)
- **Lying** to hide gambling activity.
- Risking or losing a close relationship, a job, or a school or job opportunity because of gambling.
- Relying on others to help with money problems caused by gambling

Not better explained by mania

Structured interviews can diagnose (i.e. AUDASIS, NODS)

Demographic risk factors

- Gender – 72% are male (Petry, 2005)
  - Men are more likely to have hx
  - Men and women with hx are equally likely to develop a problem
- Age inversely related
  - 18-44 are five times more likely to develop disorder compared to 45+ (Kessler et al., 2008)

Ethnic & Cultural Differences

- More prevalent among African-Americans v. European-Americans (Kessler et al., 2008; Petry, 2005; Welte et al., 2001)
- Higher rates among Indigenous and Asian American groups (Petry, 2003; Wardman et al., 2001)
- Lower SES over represented among those with gambling disorder (Kessler et al., 2008; Welte et al., 2001).
  - Also true across all race/ethnicity (Day et al., 2020)

Race/Ethnic Differences

2.5
2
1.5
1
0.5
0

Native/Asian
Black
White
Latinx

Alegria et al., 2009

Psychotherapies & Treatments

- Less than 10% seek treatment (Slutske, 2006)
- CBT, MI & MET show promise though more high quality studies needed (Petry, 2016)
- SUD providers may have this training but often aren't skilled in providing financial assistance
- Gamblers Anonymous (GA) -- little data on effectiveness
  - After 1 year, 8% remained engaged and abstinent (Stewart & Brown, 1988)
  - Good outcomes when combined with CBT with a counselor (Petry, 2005)
- Self-directed treatments likely less effective than professional (Petry, 2005)
- No FDA approved medication

Cognitive Behavioral Therapy (CBT) for Gambling

- CBT Topics:
  - Identification of triggers
  - Functional analysis of gambling
  - Self-management of triggers
  - Coping with urges to gamble
  - Gambling refusal skills
  - Dispelling cognitive distortions (i.e. overestimating odds of winning; feeling able to predict when a win is due)
  - Relapse prevention

Motivational Interviewing (MI) for Gambling

- Designed as minimal intervention
- Typically 2-4 sessions
- Attempt to highlight discrepancies in desire to continue v. reduce gambling
- Increase motivation to reduce or stop
- RCT showed MI + CBT workbook led to greater reductions in gambling compared to waitlist or CBT workbook alone (Hodgins et al., 2009)

Harm Reduction for Gambling

- Harm depends on amount of time and financial resources available
- Seeking to establish lower risk gambling levels
- Reduce the number of gambling formats used (Brosowski et al., 2012)
- Stricter limits for online gambling because risk of harm is higher (Brosowski et al., 2021)

Harm Reduction for Gambling

RESPONSIBLE GAMBLING GUIDELINES

If you're concerned that gambling is becoming more than a game for you, try using these guidelines to moderate your play:

Think of the money you spend as the cost of your entertainment.

Set a dollar limit and stick to it.

Set a time limit and stick to it. Leave when you reach your limit whether you're winning or losing.

Understand that you'll probably lose, and accept the loss as part of the game.

Don't borrow money to gamble.

Don't let gambling interfere with or become a substitute for family, friends or work.

Don't chase losses. Chances are you'll spend even more trying to recoup your losses.

Don't use gambling as a way to cope with emotional or physical pain.

Know the warning signs of problem gambling behavior.

Need help? Someone is waiting to talk to you 24/7.

Call **1-800-GAMBLER** (426-2537)
Text **SUPPORT** to **53342**
Chat **800gambler.chat**

CDPH

-Prevention Strategies

-Address co-occurring smoking 24% of problem gamblers in CA are smokers (CALGETs, 2018) higher than non-gamblers

-Address depression and suicidality: 20-40% of problem gamblers have suicidality in the last year (Seguin et al., 2010)

-Address other SUDs

-Cannabis use on the rise among CA gamblers

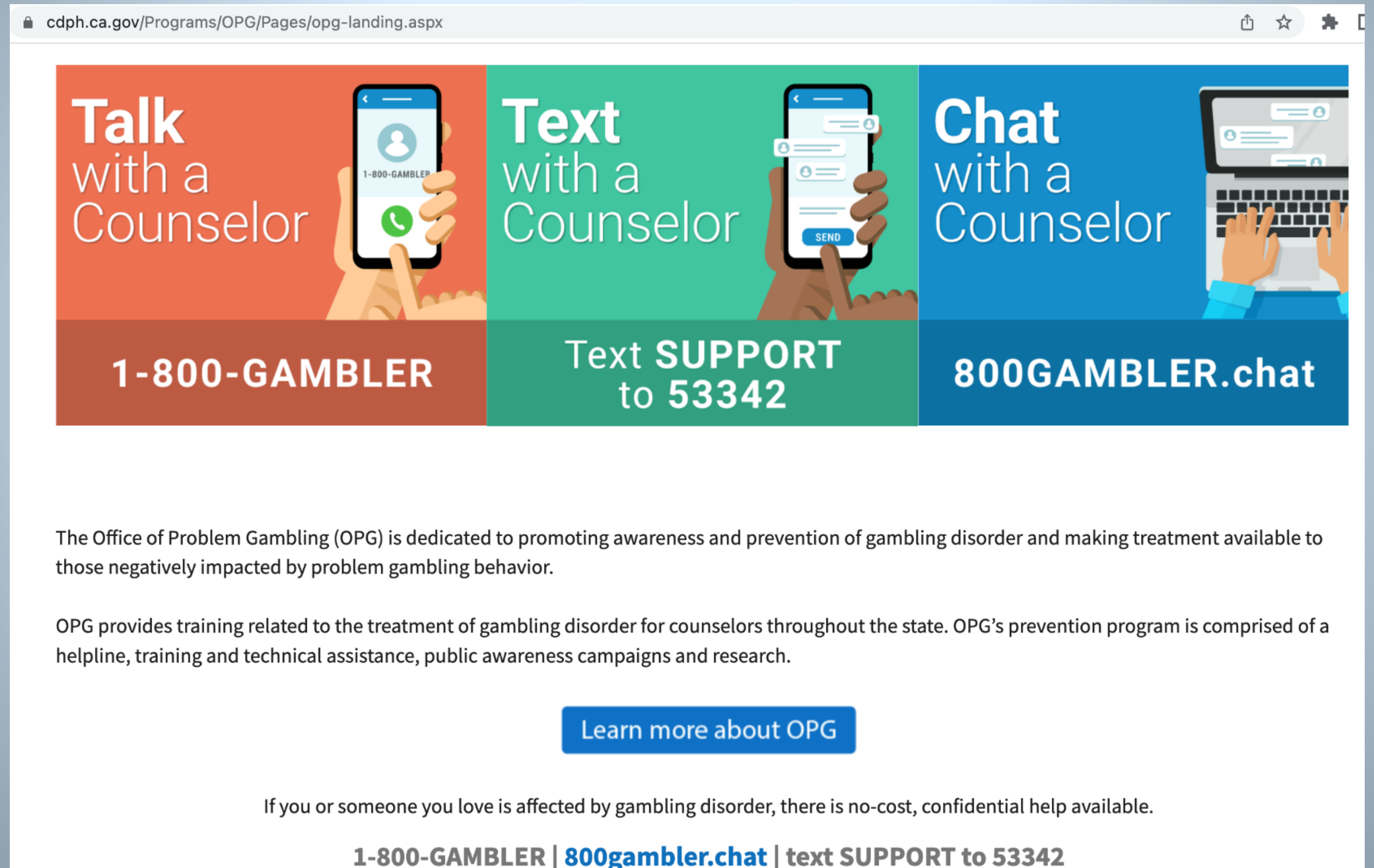
Behavioral Techniques for Gambling

- Motivation rulers & decisional balance
- Examine and identify all debts
- Set a goal i.e. abstinence, cutting back, sticking to budget
- Limit access to money (cancel credit cards, limit atm access, route wages to spouse or family member, only take money out that you need for the day, tell people not to lend to you)
- ID triggers
- Address cognitive distortions
- ID healthy substitutions and healthy supports

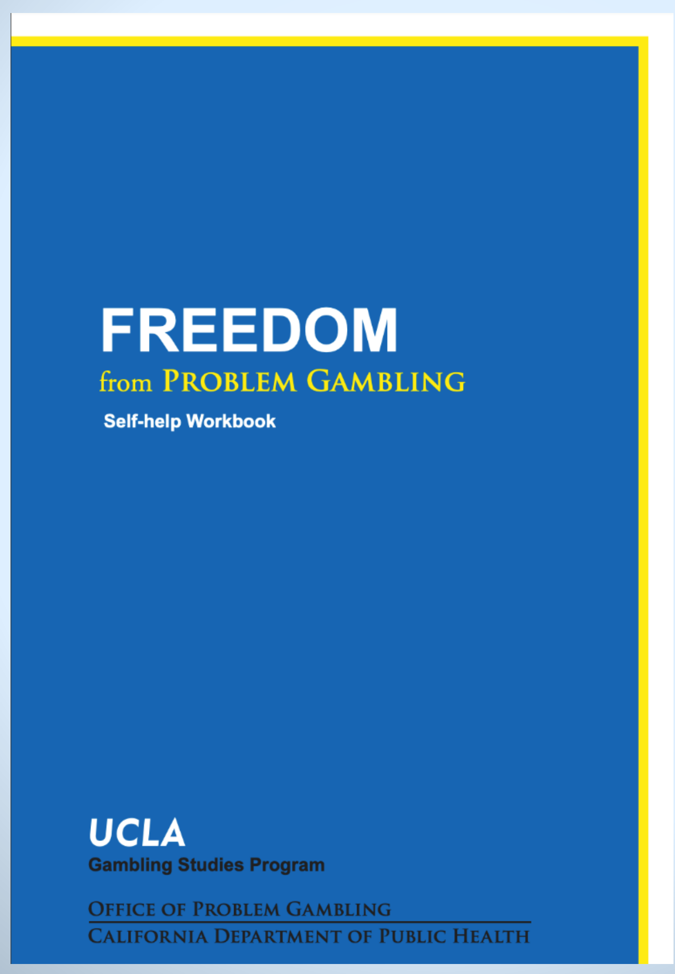
Recommendations & Future Directions

- Screen for gambling in SUD populations
- Offer Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI) & Motivational Enhancement Therapy (MET) plus assist with financial concerns
- Develop brief screening
- Assess natural lifetime course of gambling with and without treatment to ID predictors of recovery
- Standardize outcomes
- Study prevention strategies
- ID neurobiological and genetic markers to develop targeted prevention and treatment

Gambling Resources



Free self-help workbook



Other Behavioral Addictions

- No other behavioral addictions included in DSM Substance related and Addictive Disorders
- Internet gaming is named as a condition for further study
- DSM-5 work group found (Piquet-Pessoa, 2014):
  - no standard diagnostic criteria
  - only limited data were available on prevalence, course, or brain functioning
  - no substantial number of studies supporting a relationship of reward-based behavioral conditions to substance use disorders
- ICD-11 does include diagnoses for Gaming Disorder and Compulsive Sexual Behavior Disorder

Internet Gaming

- Video game addiction, may be on or offline
- DSM-5, Section 3: Conditions for further study
- Distinct from gambling, is not associated with risking money
- Excessive use is a frequent phenomenon
- Growing body of evidence suggesting risk of impairment
- Gaming Disorder defined in ICD-11 (impaired control, increasing priority of gaming over other activities, escalation despite negative consequences for at least 12 months)

Potential Diagnostic Criteria

- Hx of nonstandard criteria, too much variability across studies
- DSM-5 suggests 9 possible criteria to stimulate further research
- Suggest endorsing 5+ in the last 12 months to avoid over diagnosis:
  1. Preoccupation with games (while not playing)
  2. Withdrawal symptoms when gaming not possible
  3. Tolerance – need to spend increasing amounts of time engaged in games
  4. Unsuccessful attempts to control participation
  5. Loss of interest in previous hobbies and entertainment as a result of, and with the exception of games
  6. Continued excessive use despite knowledge of psychosocial problems
  7. Deceit of family members, therapists, or others regarding amount of gaming
  8. Use of games to escape negative mood
  9. Risk or loss of a significant relationship, job, or educational or career opportunity because of participation in games

Prevalence

- No screening tool
- Estimated prevalence is 1.8 to 8.5% based on 8 studies with large samples (4 German; 1 US; 1 Norwegian; 1 Hungarian; 1 Australian)
- US study found 8.5% of those ages 8-18 exhibit pathological gaming (Gentile, 2009)
  - Overestimated prevalence, consequences of game playing were not severe (i.e. neglecting household duties)
- Prevalence 0.2-0.5% among German adults (Festl et al., 2013)

Risk factors

- Male gender
- High impulsivity
- Low capacity for empathy
- Low social competence
- Unknown association with SUD

Petry, 2016

Treatments

- No evidence based treatments
- Descriptions of approaches in the literature similar to tx for SUD & gambling
  - increase motivation to reduce
  - address cognitive and behavioral factors
  - increase social competence
- Meta-analysis of 17 low quality studies (n=745 participants) suggest CBT and Mindfulness (Kim et al., 2022
- One recent RCT of 4 session CBT based treatment in Germany for at risk youth showed reduction in symptoms but no change in incidence of gaming (Lindenberg et al., 2022)

Future Directions

- Use standardized criteria
- Develop screening instruments based on criteria, no single superior tool (King et al., 2020)
- Need more epidemiological studies to understand the natural course of problem and recovery
- Identify prevention strategies
- Increase rigor of treatment outcome studies
- Need more info on association with other psych disorders and SUD for purpose of classification and differential diagnosis

Hypersexuality/Compulsive Sexual Behavior Disorder

- Not included in DSM-5 due to lack of consensus and evidence
- Included in ICD-11 as Compulsive Sexual Behavior Disorder (CSBD) as an impulse control disorder :
  - devotes excessive time to sexual activities to the point of neglecting health, personal care, interests, and responsibilities,
  - experiences diminished control manifest by multiple unsuccessful efforts to reduce sexual behavior
  - continues sexual activity despite adverse consequences
  - continues engagement in sexual behavior even when little or no satisfaction is derived
  - experiences significant distress or impairment across life domains or important areas of functioning

Notes:

-distress due to moral judgments not sufficient to meet this requirement

-paraphilic disorders are exclusionary

-missing criterion about engaging in response to dysphoric mood states proposed for DSM and no qualification about whether substances are used (Kafka, 2010)

Criticisms

- Risks labeling adaptive behavior as a mental disorder
- Hypersexual behavior has high comorbidity with other conditions
- Possibly indicative of another disorder (i.e. substance use, bipolar disorder, BPD)
- Lack of consensus on how to conceptualize it

Prevalence and problems

- Lack of epidemiological studies given lack of consensus
- 3-6% estimate of general US population (c.f. Kuzma & Black, 2009)
- Increased risk of STIs, dissatisfaction in sexual relationships, increased separation and divorce, excessive financial costs, impairments in work and education
- Association with SUD, anxiety, mood disorders, and OCD, Axis II i.e. clusters B & C (Kafka, 2010)

Demographic Factors

- More prevalent among men, estimated 5:1 ratio (Kafka, 2010) though lack of research on women
- Little info on ethnic differences

Treatment

- No evidence based treatments
- SSRI/SNRIs have shown decrease in symptoms but larger trials needed (Marshall & Briken, 2010)
- Supportive therapy, ACT, experiential psychotherapy, CBT, relapse prevention, 12 step
- Not enough evidence to recommend specific psychotherapy, RCTs underway

Future Directions

- Differentiating hypersexuality from normal sexuality
- Standardize criteria, large epidemiological surveys needed
- Create standardized screening and assessment instruments
- Increase representation of women, gender minorities, sexual minorities and BIPOC groups
- Rigorous treatment outcome studies

Compulsive Shopping

- Descriptions for more than 100 years
- Not in DSM, “other specified impulse control disorder” in ICD-11
- Proposed criteria developed by expert consensus (Muller et al., 2021):
  - intrusive and/or irresistible urges and/or impulses and/or cravings and/or preoccupations for buying/shopping
  - diminished control over buying/shopping
  - excessive purchasing of items without utilizing them for their intended purposes
  - use of buying-shopping to regulate internal states
  - negative consequences and impairment in important areas of functioning due to buying/shopping
  - emotional and cognitive symptoms upon cessation of excessive buying/shopping
  - maintenance or escalation of dysfunctional buying/shopping behaviors despite negative consequences. Furthermore, support was found for a specifier related to the presence of excessive hoarding of purchased items.

Prevalence and problems

- Prevalence estimate 5.8% (Black, 2007)
- Some criteria have been embraced, while others critique a trend to medicalize behavior problems
- Must be distinguished from normal buying as shopping is a major pastime
- May be related to mood, anxiety, obsessive-compulsive or impulse control disorders, eating disorders, substance use
- Associated with family problems (i.e. separation & divorce, financial problems including bankruptcy, in some cases crime)

Risk factors

- Gender is mixed, some studies suggest female gender (Dittmar, 2004; Black, 2007)
- Others suggest no association (Mattos et al., 2016)
- Age, onset in late teens or early 20s (Black, 2007)
- No association with income, however, occurs in developed countries
- No info on race/ethnicity in US populations

Treatments

- No evidence based treatment
- Psychotherapies include psychoanalytic treatment, CBT, DBT, ACT, 12-step have been tried
- Per meta-analysis (Hague et al., 2016):
  - group psychotherapy using CBT shows promise
  - SSRI (i.e. citalopram) needs further study

Future Directions

- Standardize criteria, assessment and screening instruments
- Large epidemiological study to understand classification and differential diagnosis
- Increase rigor of treatment outcome studies

Food Addiction

- Not in DSM or ICD-11
- Primary assessment tool is Yale Food Addiction Scale (Gearhardt et al., 2009)
- 25 items based on SUD criteria from DSM-IV-TR
- Criteria:
  - For certain foods, eating more than intended
  - Persistent unsuccessful attempts to stop
  - Spending a lot of time eating and recovering
  - Eating instead of important social, occupational, or recreational activities
  - Continued consumption despite problems
  - Tolerance – eating more to manage feelings
  - Withdrawal – agitation, anxiety when cutting down (excluding caffeinated drinks or foods)
  - Experiencing significant problems in ability to function because of food and eating

Characteristics

- Comparing overweight and obese women who report compulsive eating v. not (Begin et al., 2012:
  - More severe binge eating
  - Greater impulsivity
  - Less self-directedness
- Comorbid with higher body weight, BED, and Bulimia (Gearhardt et al., 2012)
- Unclear whether food addiction is a separate entity from eating disorders or a subtype

Prevalence & Risk Factors

- 4% in normal weight female undergrads (Meule et al., 2012)
- 56.8% in adults with obesity and BED (Gearhardt et al., 2012)
- Associated with female gender, age (>35), and overweight or obesity (Pursey et al., 2014)

Treatments

- No known efficacious treatments for overeating based on an addiction model
- Some clinicians employ 12 step approach to treating eating disorders
- CBT is recommended for BED
- Some suggestions include incorporating distress tolerance, ACT and mindfulness techniques with respect to food cravings
- Overeaters Anonymous (OA) 12 step may warrant more clinical investigation on efficacy for binge eating (Bray et al., 2021)

Future Directions

- Determine if food addiction is separate from eating disorders, or a more severe subtype
- If distinct, clarify criteria
- Rigorous studies of whether targeting addiction-like eating confers benefits beyond current treatments
- Explore prevention at individual and societal levels

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Frequently Asked Questions (FAQs)

1. Which behavioral therapies for SUD and behavioral addictions have the most scientific support?

Answer: Cognitive behavioral therapy, motivational interviewing and motivational incentives have been the most well studied and effective approaches to promote positive outcomes.

2. What is the role of medications in the treatment of substance use and behavioral addictions?

Answer: Medications are the gold standard treatment for opioid use disorders (OUD) and psychotherapies should not be used in lieu of medication for OUD. Medications may also play an important role in the treatment of alcohol use and would ideally be used in combination with psychotherapy. There are no FDA approved medications for other substance use disorders or behavioral addictions but they may be used effectively to treat related symptoms as part of a treatment plan that includes behavioral therapy.

FAQs

3. Can substance use and behavioral addictions be treated in a group modality?

Answer: Yes, psychotherapy for substance use and behavioral addictions respond well to group treatment approaches. Group approaches can effectively reduce stigma, shame, and enhance motivation. Some studies have shown group psychotherapy for substance use to be superior to individual approaches, though there are many studies demonstrating the effectiveness of individual treatment.

FAQs

4. How long should treatment for substance use and behavioral addictions be?

Answer: Studies have shown that at least 3 months of treatment is usually needed to reach treatment goals and maintain benefits. In general, time in treatment is a big predictor of success so the longer someone stays in treatment the better. Substance use and behavioral addictions are chronic, relapsing conditions so a return to use is common and bouts of treatment may be needed throughout the lifespan.

Thank you!