CHAPTER 17

TREATMENT OF GAMBLING, EATING, AND SEX ADDICTIONS

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I. INTRODUCTION

Advances in research on the neurobiochemistry of addiction have shown a number of stimulatory and inhibitory pathways to be operative within and on a pleasure/satiety center, currently thought to be innervated by the medial forebrain bundle and located in the nucleus accumbens. Sexual disorders are often obsessive and compulsive in nature, with fantasy, euphoric recall, magical thinking, and ritualized behavior presenting as significant contributing factors. Mood-altering behavior may be seen in the substance addict who experiences an anticipatory "high" or feeling of well-being after obtaining a supply of the preferred drug (such as cocaine or heroin), even before the agent is administered. Fantasy, urge, and behavior-induced mood alterations are well documented and closely associated with compulsive gambling, sexual and/or romantic relationships, and binge eating; these are referred to as the *process addictions*. Urges or behaviors in these areas may be combined or alternated with substance abuse or addiction. Many will refer to this as dual addiction or cross-addiction. In other patients, the behavioral addiction remains a circumscribed personal expression of powerlessness and unmanageability devoid of association with substance use, abuse, or dependence.

A. A Family Disease. These are primary disorders that tend to run in families; the evolution of compulsive and maladaptive behaviors is often learned in the family system. Most patients suffering from one of these addictive disorders come from families where chemical addiction or alcoholism is found. Many sex addicts and gamblers will be found to have substance abuse or dependency themselves. Profound shame, unconscious denial, unspoken secrets, and rationalization abound within the family. Family members find behaviors that help them escape from the obvious problems at home. For example, in one family, the father's alcoholism may have led the mother to try to bolster self-esteem through excessive involvement in work or children's activities or through episodes of compulsive shopping.

One child may have become the family hero and eventually a compulsive

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worker who speculates on commodities and periodically flies off to Las Vegas—with disastrous financial consequences, evolving into a pathologic gambler. Another child may have developed an eating disorder, while a third may have indulged in a series of devastating sexual affairs. Of course, all the children vowed that "I will never become an alcoholic," and family shame and consternation are reinforced when yet another family member succumbs to addictive disease.

Some individuals from an addiction-based family system may have a propensity for behavior that provides a sense of excitement, such as gambling, using stimulants, or participating in high-risk stunts. Others may prefer sedation through self-medication with alcohol or satiation through sexually exploitative relationships or compulsive overeating. Still others escape via fantasy, use of psychedelic drugs, preoccupation with work, or compulsive religious practice pursued to excess. When kept in balance, these activities may provide comfort and status, assuaging the sense of unworthiness. But when carried to extremes, they often represent a personal variation on the theme of addiction. Flawed self-perceptions may result in self-destructive or self-defeating actions or judgments that harm self or others.

II. ADDICTIVE SEXUAL DISORDERS

A. Presentation. Patients who have an addictive sexual disorder will commonly present to the clinician in one or more of the following ways:

1. Signs and symptoms of a substance-related disorder. In the course of evaluation or treatment of chemical dependence or alcoholism, the patient reveals a sexual history consistent with an additional diagnosis of an addictive sexual disorder.
2. A pattern of multiple substance addiction relapses. In the process of intensive review, addictive sexual behavior is found to be a significant factor associated with or preceding substance relapse.
3. Acute relationship crisis precipitated by disclosure or discovery of secret sexual behavior outside the relationship, particularly when this is a recurring theme.
4. Unexpected diagnosis of an STD in the patient or sexual partner.
5. Legal consequences resulting from impropriety in personal life (e.g., arrest for solicitation, public indecency, sexual assault, or domestic violence associated with "marital rape").
6. Professional or work-related consequences (e.g., a sexual harassment complaint; professional sexual misconduct; loss of position, status, or employment associated with physical absences; or lost productivity related to sexual activity or desire).
7. Financial crisis associated with diversion of resources for telephone sex lines, pornography, prostitution, "keeping" or "entertaining" sexual partners, or payments made (bribery or extortion) to keep sexual indiscretions from becoming known.

B. Diagnostic Criteria for Addictive Sexual Disorder. Each of the following should be present:

1. *DSM-IV* criteria met for one of the following: paraphilia, sexual disorder not otherwise specified (NOS), or impulse control disorder NOS.
2. Addictive features present as indicated by (a) loss of control over a sexual behavior, (b) continued sexual behavior despite significant adverse consequences, *and* (c) obsession or preoccupation with the fantasies, urges, or behavior.
3. Has reached the establishment phase of addictive behavior for a period of at least six months (see Section II.G., below, on natural history).
4. The focus of attachment is usually on relationships wherein the partners are viewed as narcissistic projection—objects to be used for self-aggrandizement and self-gratification and then discarded when they are no longer needed. The goal of entering a relationship is to have sex or romance, rather than sex or romance being part of a relationship. The patient may identify with the term "love" or "relationship" addict. Types of nonparaphilic compulsive sexual behavior include compulsive cruising and multiple partners, compulsive fixation on an unattainable person, compulsive masturbation, compulsive multiple love relationships, and compulsive sexuality within a relationship.

C. Physical Manifestations. Sexual addicts may present with a variety of complications to their physical health such as genital injury as a direct result of sexual activity; STDs including hepatitis, HIV infection, herpes simplex, gonorrhea, syphilis, and chlamydia; physical injuries associated with engagement in high-risk sexual behaviors or sadomasochistic activity; unnecessary surgeries (such as breast implants, hair transplants, plastic surgery, liposuction) used to enhance sexual appeal; binge–purge cycles in an attempt to regulate weight; abuse of agents reputed to be sexual performance enhancers (amyl nitrite, other inhalants, yohimbine, papaverine); and unwanted pregnancies or the complications of abortions.

D. Comorbid Mental Disorders

1. Commonly associated *DSM-IV* Axis I comorbid mental disorders include mood disorders, posttraumatic stress disorder, dissociative disorders, and adjustment disorders.
2. Self-destructive and self-defeating behavior is not unusual, including suicidal ideation or suicide attempts, substance abuse, or progression to dependence, attempts at "geographic cures" (believing that a change in environment will solve the problem), and engagement in other high-risk behaviors.
3. Addictive sexual disorders are frequently associated with significant maladaptive personality traits or meet the criteria for an Axis II personality disorder. "Defects in character" discovered in the 12-step approach to treatment commonly include narcissistic, hysterical, borderline, dependent, or antisocial features. Many cases involving sexual impropriety are associated with and at least partially attributable to characterologic pathology, particularly when exploitation, assault, or sexual offense is involved. It is sometimes appropriate to diagnose a personality disorder during assessment or treatment. This can be the primary diagnosis, or the patient can be viewed as having comorbid conditions involving an Axis I diagnosis and an Axis II diagnosis of characterologic pathology. Defects of character and other types of self-destructive or self-defeating behaviors are often seen as part of addictive disease. If a patient is capable of honesty and at least

partial insight, able to identify characterologic defects, and work with them in steps 4–9 of a 12-step program, such defects are treatable utilizing addiction model treatment and therapy. Dramatic characterologic change is not infrequently seen as part of personal transformation achieved through dedicated participation in 12-step programs, insight-oriented or analytic therapy, and other avenues that promote spiritual awakening.

E. Comorbidity with Substance-Related Disorders. Many patients who satisfy these criteria are found to have active substance addiction and require treatment for both addictions in order to prevent relapse to either. The use of alcohol and other drugs in conjunction with sexual activity is associated with an increased risk of HIV infection, even when drugs are not injected. Common associations between substance abuse and addictive sexual disorders can be seen in Table 17.1.

F. Cultural and Gender Differences. Because certain sexual behaviors (e.g., multiple extramarital affairs or use of prostitutes) may be normative in some cultures but less acceptable in others, diagnosis of an addictive sexual disorder must take into consideration the cultural milieu. Gender and sexual orientation differences in the definition of normative behaviors are also relevant. For example, dressing in clothing of the opposite gender, and emphasizing one's sexual body parts by wearing revealing clothing are behaviors much more acceptable in women than in men. Addictive sexual disorders are found in both sexes, although men seeking treatment outnumber women 3 : 1. Men and women differ somewhat in the addictive sexual patterns they display: Using Carnes' (1991a, pp. 42–43) categories of behavior patterns, sexually addicted men are more likely than women to have anonymous sex, pay for sex, participate in voyeurism, have paraphilias, or engage in sexual exploitation. Women are more likely than men to engage in fantasy sex, seductive role sex, trading sex, and pain exchange. Women are more likely than men to refer to themselves as "relationship" or "love" addicts and may identify as "women who love too much," a term popularized by Norwood (1985). With regard to characterologic pathology, sexually addicted women are markedly less likely than men to have antisocial personality disorder, but have a higher incidence of dependent, borderline, and hysterical personality features (Carnes, 1991a).

TABLE 17.1. Cross-Addiction

Drugs are used ritualistically as part of addictive disease to
- Reenact sexual scenarios from movies, books, fantasy, or past experience
- Create mood and enhance sexual pleasure
- Decrease inhibitions and fears
- Treat sexual dysfunction or performance anxiety
- Permit, excuse, or rationalize expression of sexual aggression
- Provide an excuse for shameful or objectionable behavior

Drugs are given to potential sexual partners to
- Re-enact sexual scenarios from movies, books, fantasy, or past experience
- Increase vulnerability or decrease inhibitions
- Overcome resistance or objections
- Manipulate and control events
- Promote emotional numbness
- Distort reality and memory
- Provide compensation for services

G. Natural History of Untreated Addiction. Carnes (1989, p. 77) described the progression of untreated sexual addiction. The initiation phase is characterized by an exceptionally intense impact of observed or experienced sexual activities during development as an adolescent and young adult. At some point, sex becomes the "drug of choice," used to escape or cope. Catalytic environments and catalytic experiences lead to the establishment phase, in which there is repetition of an addictive cycle of preoccupation, ritualization, and sexual acting out, then despair, shame, and guilt, which are alleviated by renewed preoccupation. With time, the addiction may escalate, with greater intensity, more frequency, more risk, and greater loss of control. Intermittently the behavior may deescalate, at times through the means of substituting another addictive behavior (such as a period of heavy drug use), or it may progress to the acute phase where the individual becomes alienated from significant others and is constantly preoccupied with the addiction cycle. In some, the addiction becomes immutable and behavior is limited only by opportunity, physical consequences, or incarceration.

H. Assessment. A diagnostic workup includes the following elements:

1. The basic database needed for evaluation includes a medical history and physical examination; biopsychosocial history; relationship history and marital status, family, growth, and development history; and a comprehensive sexual history. The Sexual Addiction Screening Test [SAST (Carnes, 1989)] is helpful as a self-evaluation tool. The more comprehensive Sexual Behavior Inventory is particularly useful and may be obtained from Patrick Carnes, c/o Del Amo Hospital, Torrance, CA. In addition, the clinician should administer a substance use screening self-evaluation such as the MAST (Michigan Alcohol Screening Test) supplemented by a clinical interview and corroborating information from collateral sources.
2. Psychological testing is particularly contributory with patients presenting with strong defenses or denial. The MMPI-2 and/or MCMI-II or III, and a cognitive screening test, such as the Shipley, have been commonly employed. The MMPI (Minnesota Multiphasic Personality Inventory) will commonly indicate elevations on scale 4 (PD), which should initially be considered manifestations of the sexual behavior. Some clinicians have found that other minor subscales such as the McAndrews are helpful.
3. Advanced assessment approaching forensic standards is required when legal problems or professional sexual misconduct are involved. Additional psychologic testing should include projectives such as the Rorschach (comprehensive system), TAT (Thematic Apperception Test), Sentence Completion, and the DeRogatis or Abel Screen. Multidisciplinary assessment is strongly encouraged in these situations.
4. Optional tests that are of value in selected

I. Differential Diagnosis. A variety of other mental disorders are associated with excessive sexual behavior. Frequent and infrequent *DSM-IV* Axis I diagnoses associated with sexual excesses are presented in Table 17.2. It is helpful to complete the differential diagnosis on Axis I before considering Axes II and III. Sexual disorders, impulse control disorders, and paraphilias, when identified, should be described as precisely as possible. If the NOS category is utilized, it is important to use appropriate descriptors that define the features seen. In our experience the most frequent features noted in addition to specific paraphilic behaviors are those of addiction, exploitation, predation, romantic attachment, coercion, professional misconduct, sexual offense, and sexual assault. The severity of the disorder, duration, current level of activity, and amenability to treatment should also be presented. In the differential diagnosis of sexual improprieties and excesses, Axis II characterologic disorders and traits are often contributory, or may be considered the primary etiology especially of paraphilic sexual behavior.

J. Treatment. Because a large percentage of persons with addictive sexual disorders are also chemically dependent, the initial decision often facing the treatment professional is which addiction to treat first. By the time many sex addicts seek help for this disorder, they are already in recovery from their substance dependence. If not, then regardless of which addiction is primary, the substance dependence must be treated first and intensively, or else sex addiction treatment is unlikely to be successful.

1. Initial treatment. Decisions about inpatient versus outpatient primary care for addictive sexual disorders can be based on criteria analogous to the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. Inpatient admission is appropriate for those who are unlikely to be able to engage in treatment as

TABLE 17.2. Differential Diagnosis of Excessive Sexual Behaviors

Common
Paraphilias
Sexual disorder NOS
Impulse control disorder NOS
Bipolar affective disorder (type I or II)
Cyclothymic disorder
Post-traumatic stress disorder
Adjustment disorder (disturbance of conduct)
Infrequent
Substance-induced anxiety disorder (obsessive-compulsive symptoms)
Substance-induced mood disorder (manic features)
Delusional disorder (erotomania)
Obsessive–compulsive disorder
Gender identity disorder
Delirium, dementia, or other cognitive disorder

outpatients, are a danger to themselves or others, or have significant concurrent medical or psychiatric conditions requiring closer observation and intensive treatment. Early treatment, both inpatient and outpatient, is similar to that of chemical dependence, comprising education about addiction in general and about sex addiction in particular, a combination of group and individual therapy, introduction to 12-step programs and to mutual-help meetings, and, if possible, involvement of family members in a family program of education and confrontation. Shame, a major issue for sex addicts, is best addressed in a group, where other recovering persons can provide support, confrontation, and shame reduction. Early in the treatment it is suggested that patients refrain from all sexual activities, including masturbation, for 30–90 days. This enables them to learn that they can indeed survive without sex, and allows them to get in touch with feelings that have been avoided and covered up with sexual activity. When they stop all sexual activity, some addicts report psychological withdrawal symptoms.

2. Psychotherapy. This is often of significant value folowing primary treatment, especially ongoing therapy for shame, childhood trauma, false beliefs, and the consequences of past actions; all can facilitate recovery. In the early recovery period, sex addicts and their partners frequently have sexual and interpersonal difficulties, often to a greater degree than they had during the active addiction phase. Therapists can provide support and reassurance during this phase. If the compulsive sexual behavior was same-sex, as is quite common even among men who identify themselves as heterosexual, therapists can help patients work through conflicts regarding sexual orientation.

Sex therapy is generally most effective at a later stage of treatment, in the second year and beyond. When treating patients with addictive sexual disorders, sex therapists may need to set aside some of their beliefs (views on masturbation, for example) and countertransference. It is important to carefully define and rigorously monitor the recovery boundaries of clients and of the professional–client relationship.

By the time sex addicts seek help, their marriage or relationship is often in great turmoil. Communication is lacking, and distrust, anger, and resentment are pervasive. Couples counseling by a therapist supportive of the sex-addiction treatment model can facilitate forgiveness and rebuilding of trust. Such counseling is unlikely to be effective, however, as long as the significant other persists in viewing himself/herself solely as the victim. The significant other should be encouraged to obtain individual therapy to deal with their own dependence issues, fear of abandonment, external locus of control, and low self-esteem, as revealed through therapy and supplemented by participation in their own mutual help recovery program.

3. Pharmacotherapy. Pharmacotherapy has a definite place in the treatment of addictive sexual disorders. Some addicts report that the selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, sertraline, paroxetine, and fluvoxamine modulate the intensity of their sexual preoccupation and suppress compulsive fantasies, and allow them to fully participate in treatment and self-help groups. For others, the tendency of the SSRIs to inhibit orgasm is a benefit. SSRIs are also useful in treating concurrent primary clinical depression. Some clinicians have found that other classes of antidepressants, including MAO (monoamine oxidase) inhibitors and bupropion have been helpful when other agents have been ineffective. Valproic acid, carbamazepine, and lithium hydrochloride are useful especially when cyclothymic or bipolar affective disorders are present. Progestational agents are occasionally used in the treatment of sex offenders.

4. Recovery. Recovery from sexual addiction is sometimes viewed as more analogous to recovery from eating disorders than to recovery from chemical dependence. Unlike the goal in treatment of chemical dependence, which is abstinence from use of all psychoactive substances, the therapeutic goal in addictive sexual disorders is abstinence only from compulsive self-destructive, and self-defeating, sexual behavior. Development of healthy sexuality is a primary goal that is usually achieved only through commitment to a program of continued recovery and therapy.

K. Continuing Recovery

1. Course of recovery over time. Compared with recovery from drug dependence, there is generally a greater period of time before improvement in the quality of life in recovery is experienced. The first year is often characterized by great turmoil (Carnes, 1991). Most relapses, if they occur, take place in the second 6 months. Health, legal, occupational, and relationship consequences of the addiction take their greatest toll during the first year. Because sex addicts were often sexually abused as children and because they have distorted ideas about sex, they generally lack experience that facilitates development of healthy sexuality. In the second and third years of recovery, significant growth can be seen. There is improvement in career status, finances, friendships, and self-esteem. It is possible to define and work for healthy sexuality and intimacy in relationships. In the fourth and fifth years, relationships with the significant other, with parents, and with children mature.

Partners of sex addicts follow a similar path, except that they experience their worst health problems and relapses to other addictions during the first 6 months of their partner's treatment. By the second 6 months partners begin experiencing improvement in self-image, career status, and communication with the partner. This means that for a couple working for recovery in the first year, each may be at a different phase, contributing to relationship stress. Couples need to be counseled to avoid making relationship decisions during this period; the couple relationship typically finds significant improvement only after this time.

2. Contingency contracting. In the process of defining and appreciating ritualized behaviors and awareness of powerlessness over compulsive sexual thoughts and actions, patients become ready and able to define certain sexual behaviors they are willing to avoid as part of a continuing care contract. Engagement in one of these behaviors is considered either a "slip" or a relapse, depending on the behavior involved and the circumstances. The use of behavior modification, such as the use of "the three-second [3-s] rule" to limit the length of time one focuses on an object or thought associated with sexual desire, and the use of arousal reconditioning, are also useful for some recovering addicts. Delineating healthy and necessary boundaries in a written contract is usually therapeutic.

Some subgroups of sexually exploitative professionals have a better prognosis than others for return to professional practice. In contrast to professionals who have exhibited exploitative behavior primarily as an expression of Axis II characterologic disorder, sexually addicted professionals who have successfully completed comprehensive assessment and primary treatment can often return to work without compromising public health and safety.

Irons (1991) published a set of proposed contractual provisions for reentry. Such a contract can be part of a binding legal stipulation between the professional and a state professional licensing board or other regulatory agency, and can define a standard of care for potentially impaired healthcare professionals

3. Mutual support groups. Like other addicts, sex addicts need ongoing support for establishing and maintaining a healthy lifestyle and avoiding relapse. Regular attendance at 12-step meetings (see below) significantly reduces the risk of return to addictive sexual behavior. The 12 steps of Alcoholics Anonymous have been adapted for use in programs for sexual disorders. Programs modeled after Al-Anon, the mutual-help program for families and friends of alcoholics, are also available in many cities. Group support can be a powerful tool for overcoming the shame that most sex addicts and their family members feel. As with other relatively new 12-step programs, caution is in order because some meetings are less healthy than others. Table 17.3 provides the addresses of the national offices of the 12-step programs. Because recovery from addictive sexual disorders includes abstinence only from the addictive behaviors, the definition of "sexual sobriety" has room for interpretation. The various 12-step programs listed differ primarily in their definition of sexual sobriety. For Sexaholics Anonymous (SA), it is limited to sex within marriage. In the other programs, members define their own recovery plans and determine which behaviors to avoid. The members of Sexual Compulsives Anonymous (SCA) are primarily gay men and lesbian women. The two recovery programs for family members, S-Anon and COSA, have no significant differences. Recovering Couples Anonymous (RCA) is a program for couples recovering from all addictions; approximately 50% of the members are recovering from addictive sexual disorders. Attendance at 12-step programs for partners of sex addicts can facilitate recovery.

4. Relapse management and prevention. Lapses and relapses in the addictive sexual disorders often have more severe consequences than in substance dependence; for instance, a single recurrence of exhibitionism may lead to arrest or imprisonment, or another sexual encounter may precipitate the end of a marriage. Accordingly, relapse prevention is a key component of treatment of sex addiction. The value of contingency contracting is often discov-

TABLE 17.3. 12-Step Programs for Sexual Addiction

For addicts

- Sexaholics Anonymous, P.O. Box 11910, Nashville, TN 37222-1910, (615) 331-16901
- Sex Addicts Anonymous, P.O. Box 70909, Houston, TX 77270, (713) 869-4902
- Sex & Love Addicts Anonymous, P.O. Box 119, New Town Branch, Boston, MA 02258, (617) 332-1845
- Sexual Compulsives Anonymous, Old Chelsea Station, P.O. Box 1585, New York, NY 10013-0935, (800) 977-HEAL

For family members

- S-Anon, P.O. Box 111242, Nashville, TN 37222-1242, (615) 833-3152
- COSA, P.O. Box 14537, Minneapolis, MN 55414, (612) 537-6904
- Co-SLAA, P.O. Box 1449, Brookline, MA 02146

For couples

- Recovering Couples Anonymous, P.O. Box 11872, St. Louis, MO 63105, (314) 830-2600

ered through confrontation of violations of the agreement prior to major relapse. "Tightening" and revision of contracts are important aspects of relapse management.

5. Other Resources. Professionals seeking additional information on addictive sexual disorders can contact the National Council on Sexual Addiction and Compulsivity, located at P.O. Box 161064, Atlanta, GA 30321-19998. Their help-line telephone number is (770) 968-5002. Patients seeking information for themselves and family members can be referred to the books for laypersons by Carnes (1989), Earle and Crow (1989), Kasl (1989), Schneider (1988), and Schneider and Schneider (1991).

III. COMPULSIVE GAMBLING

A. Presentation. While pathologic gambling does not involve the use of a substance, research completed by numerous investigators has noted its addictive features. Pathologic gamblers will customarily indicate that what they seek is "action." The term refers to an aroused, euphoric state comparable to the euphoria or "high" obtained from the use of cocaine or other drugs. They also describe a "rush" commonly associated with adrenergic symptoms and tachycardia, often experienced during a period of anticipation of a winning result or in preparation for gambling. Elevated levels of norepinephrine have been found in compulsive gamblers, consistent with an aroused, hyperadrenergic state of sure betting. Recovering gamblers have described their disorder as being "hooked on their own adrenaline." Patients who have a gambling disorder will commonly present to the clinician with problems in one or more of the following areas:

1. Signs and symptoms of a substance-related disorder. A history of high-risk behavior in the course of evaluation and treatment of chemical dependence or alcoholism reveals the presence of compulsive gambling. In a patient presenting a history of multiple relapses into substance use, compulsive gambling, secrecy, and social isolation are found to be significant contributory factors.
2. A pattern of multiple financial crises and unexplained disappearance of significant sums of money or valuable possessions. The individual may also engage in "bailout" behavior, turning to family or others for help with a desperate financial situation that was caused by gambling.
3. Acute relationship crisis precipitated by disclosure of secret squandering of family assets, or resources squandered while engaging in "bailout" or "chasing losses." Sexual infidelities are not uncommon. Patients often present themselves after most, if not all, significant family and personal relationships have been alienated or destroyed through financial and emotional exploitation.
4. Legal consequences resulting from inability to meet demands for payments on debts or other financial obligations. At this juncture, the patient has usually exhausted credit resources and the patience of creditors. Ready means to raise cash through manipulation and exploitation of friends and relatives as well as pawn shops and credit cards have been maximized. In desperation, the patient may resort to antisocial behavior such as forgery, fraud, theft, or embezzlement, to obtain money. Arrest and/or incarceration may bring about reflection on the true cause of affliction and an earnest desire to find sobriety.

recently jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling. Speculation in stocks, commodities, or other high-risk financial ventures is not unusual. This may cause patients to recall past losses and unexplored grief, bringing them to the experience of powerlessness, and a desire for assistance.

6. Health crisis associated with the pain and suffering associated with the consequences and repercussions from gambling behavior. Mood disorders, anxiety disorders, and other manifestations of impulse control may become acute and require immediate care. Stress-related medical disorders may become symptomatic or poorly controlled despite medical management. During evaluation, the presence of pathologic gambling as a primary contributing factor may be discovered.

B. Diagnostic Criteria for Addictive Gambling Disorder

1. *DSM-IV* criteria met for "pathologic gambling" require the presence of 5 of 10 identified types of behavior, and the absence of mania or hypomania. The essential feature of pathologic gambling is persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.
2. *Addictive features:* Each of the diagnostic criteria for pathologic gambling from the *DSM-IV* reflects one of the following features commonly seen in substance dependence:
   a. Progression and preoccupation
   b. An indication of tolerance
   c. Withdrawal
   d. Use as an escape
   e. Chasing losses analogous to gulping drinks
   f. Lies and deception
   g. Illegal acts
   h. Family and/or job disruption
   i. Desire for rescue
   j. Loss of control

   Identification of multiple addictive features associated with powerlessness and unmanageability meets these criteria.
3. The individual must have reached the *losing or desperation phase* of addictive behavior for a period of at least 6 months (see Section III.G., on natural history)

C. Physical Manifestations. Compulsive gamblers may present with a variety of physical complaints or signs associated with stress-related disorders (such as hypertension or ulcer disease), substance-related disorders, or the result of physical trauma sustained as a consequence of failure to make payments to creditors.

D. Comorbid Mental Disorders

1. Commonly associated *DSM-IV* Axis I mental disorders include depressive disorders, posttraumatic stress, dissociative disorders, adjustment disorders, and anxiety disorders. Individuals with pathologic gambling tendencies will often be found to have a variety of significant symptoms that may require treatment. In two studies of male inpatients (one outpatient treatment study, and the other a Gamblers Anonymous survey), 50–76% of the respondents were found to meet the diagnostic criteria for major depression or a bipolar affective disorder. There is a higher

2. Self-destructive and self-defeating behavior is not unusual, including suicidal plans, substance abuse or progression to dependence, attempts at geographic cures, and engagement in other high-risk behaviors. Studies have identified suicide attempt prevalence rates as high as 15–24%.
3. Addictive gambling disorders are often associated with sufficient significant maladaptive personality traits or meet the criteria for an Axis II personality disorder. "Defects in character" discovered in the 12-step approach to treatment are commonly found to include narcissistic, hysterical, borderline, dependent, or antisocial features.

E. Comorbidity with Substance-Related Disorders. Many patients who satisfy these criteria are found to have active substance addiction and require treatment for both addictions in order to prevent relapse to either. Published studies on pathologic gamblers have revealed prevalence rates of alcohol and other substance-related disorders ranging from 47 to 52%. The use of alcohol and other drugs in conjunction with gambling distorts reality, decreases inhibitions, helps rationalize or justifies losses, and is used to celebrate wins. Survey investigations of patients in chemical-dependence treatment have found that 9–14% could be diagnosed as pathologic gamblers, and an equivalent percentage as problem gamblers.

F. Gender Differences. According to Dr. Sheila Blume, men tend to gamble for the action and women are more likely to gamble for escape or to cope with depression. Women also feel more stigmatized and are even more reluctant to seek help than are male gamblers.Women are underrepresented in treatment programs and constitute only 2–4% of the membership of Gamblers Anonymous.

G. Natural History of Untreated Addiction. The individual may be preoccupied with gambling, often through recalling past gambling experiences, planning the next gambling venture, or thinking of ways to get money with which to gamble. Most pathologic gamblers say that they are seeking "action" even more than money. Increasingly larger bets, or greater risks, may be needed to continue to produce the desired level of excitement. Pathologic gamblers often continue to gamble despite repeated efforts to control, cut back, or stop the behavior. There may be restlessness or irritability when attempting to cut down or stop gambling. The individual may gamble as a way of escaping from problems or to relieve feelings of helplessness, guilt, anxiety, or depression. A pattern of "chasing" one's losses may develop, with an urgent need to keep gambling, often with larger bets or the taking of greater risks, to undo a loss or series of losses. The individual may abandon his/her gambling strategy and try to win back losses all at once. Although all gamblers may chase for short periods, it is the long-term chase that is more characteristic of pathologic gamblers. As the disorder progresses, the individual may lie to family members, therapists, or others to conceal the extent of involvement with gambling. Dr. Robert Custer described three classic phases in compulsive gambling: the winning phase, the losing phase, and the desperation phase. These phases are not uniform or sequential in all cases. Stock market and commodity speculators represent over 20% of the gamblers he has diagnosed. So many compulsive gamblers are employed within the brokerage field that it should be considered an occupational hazard. What often pushes gamblers over the edge into desperation is an illogical loss. Bettors lose by what they consider a fluke, or suffer large losses when they abandon their usual strategies or self-imposed

alized behaviors. These personal rituals take on increasing importance with daily life becoming increasingly focused around their maintenance.

H. Assessment. A diagnostic workup includes the following elements.

1. Basic database. This includes medical history and physical examination; biopsychosocial history; relationship history; family, growth, and developmental history; employment history; and a comprehensive history of gambling and other high-risk behavior. Factual data, including credit reports, commodity and stock trading records, as well as checking account and credit card records, is often of great benefit in confronting denial and resistance. Without sufficient information from collateral sources, it is often difficult, if not impossible, to define the nature and extent of pathologic gambling, nor the severity of the disorder. Self-evaluation tests, such as the South Oaks Gambling Screen or the 20 questions offered in the "Combo" book of Gamblers Anonymous, are very useful.

2. Differential diagnosis. This includes attention-deficit/hyperactivity disorder, the manic phase of bipolar affective disorder, and engagement in professional gambling wherein the risks are limited and discipline regarding the behavior is maintained.

I. Treatment. Most compulsive gamblers cannot acknowledge the need for help until their addictive behavior has made their lives intolerable. This may include any number of consequences such as the loss or threatened loss of family, job, or possessions. Loss of freedom, fear of prosecution, overwhelming debts, bankruptcy, or IRS (Internal Revenue Service) consequences may result in hitting bottom. Some come to a total loss of self-respect, or attempt to drown their self-pity in alcohol or other drug use and find themselves in chemical-dependence treatment or detoxification centers, afraid to return to old patterns. Others suffer stress-related medical or psychological illnesses that can no longer be ignored and know that unless they stop their gambling compulsion, nothing will change. Reaching a crisis point is usually the event that leads to an acceptance of powerlessness over gambling and the willingness to accept help. Pathologic gambling is a treatable illness.

1. Initial treatment. The best-known treatment center in the country is at South Oaks Hospital in Amityville, New York. Sheila Blume, M.D., the Clinical Director at South Oaks, can be reached at (516) 264-4000. U.S. military veterans can often get inpatient services through the VA (Veterans Administration) system. One such facility offering treatment is in Miami, Florida. Most insurance carriers will not pay for treatment. In Gamblers Anonymous, completion of a fearless and searching financial inventory is as important as the customary 12-step moral inventory. These inventories identify areas important to the newcomers. Defects can be recognized, and growth can be measured. Because money is an integral part of pathologic gambling, the compulsive gambler must use the financial inventory, together with the moral inventory to begin and continue true characterologic change and promote spiritual awakening. The initial financial inventory and participation in GA usually sets the stage for a "pressure group" meeting, wherein new members can receive experience, strength, and hope from the group in preparation for putting their lives in order. Without complete honesty and accuracy, such meetings and other types of interventions are generally useless, and omissions of crucial data often become an excuse to return to gambling or for geographic escape. Compulsive gamblers are at least initially fiscally irresponsible, and until they have

time in recovery and learn how to handle money responsibly, they should be relieved of as many financial duties and credit privileges as possible.

2. Psychotherapy. Individuals seeking counseling are encouraged to seek a therapist who has been trained and certified in the treatment of pathologic gambling.

3. Pharmacotherapy. The use of selective serotonin reuptake inhibitors (SSRIs) in this disorder has met with variable success. Antianxiety agents, particularly benzodiazepines, should be used with caution and in limited quantities because of the propensity for medicating feelings associated with consequences, and the risk of iatrogenic addiction.

J. Continuing Recovery

1. Contingency Contracting. Contingency contracting as described in the section on addictive sexual disorders is often crucial and often of significant benefit in the treatment of pathologic gambling. The contract should be geared to foster and promote establishment of responsibility and honesty in the gambler, with positive reenforcement for constructive progress. It should be made clear that the contract does not constitute a bailout. Concrete provisions regarding supervision of financial affairs and possession of money or negotiable financial instruments such as credit cards are crucial, as well as those regarding the payment of debts and family expenses, and addressing actual or potential legal problems.

2. Monitoring. The behavioral parameters to be monitored must be outlined with precision, and the individuals assigned to the monitoring role must be prepared to invoke the defined consequences for noncompliance. Most compulsive gamblers will at some point test the contract and the conviction of those in control or authority to enforce the terms.

3. Mutual support groups. Available resources, including regional counseling and treatment options, may be obtained by calling the Florida Council on Compulsive Gambling at (800) 426-7711, or the National Council on Compulsive Gambling national hotline at (800) GAMBLER. They can provide information on local meetings of Gamblers Anonymous and Gam-Anon, the organization that offers help and support for spouses, families, or close friends of compulsive gamblers.

4. Relapse management. Compulsive gambling is viewed as a chronic relapsing disease. Relapse is not uncommon, and often has severe consequences. The patient may relapse through a switching of addictions to a different type of high-risk behavior or may resort to the use of mood-altering substances. The desire to use geographic, occupational, or relationship changes to "cure" current distress is extremely common. As in other addictive disorders, relapse can be a source of education and growth in recovery if properly appreciated by the patient, managed by the clinician, and disclosed to the patient's sponsor and GA homegroup.

IV. EATING DISORDERS

The *DSM-IV* describes only two specific eating disorders—*anorexia nervosa* and *bulimia nervosa*—and in addition, describes a proposed new diagnosis, *binge-eating disorder*. However, eating disorders can also be considered within an addiction model framework, within which eating disorders occur on a

continuum, from rigid control over intake at one end, to loss of control on the other. In all cases there is marked preoccupation with food and weight, and continuation of the behavior despite significant adverse consequences. Like alcohol and substance abuse, eating disorders have very high rates of chronicity, relapse, recurrence, and psychosocial morbidity. For obesity, as for alcoholism, a genetic component is clear; several studies of twins and adoptees show that obesity is significantly influenced by genetics (Bouchard et al., 1990; Stunkard et al., 1986, 1990).

Patients who experience loss of control over their eating or starvation continue abnormal eating behaviors despite adverse consequences; are obsessed with food, cooking, and eating rituals; demonstrate the essential features of addiction; and may be usefully treated for their eating disorder within the addiction model. This is particularly true for those patients who have other comorbid addictions. Some studies have shown high levels of endogenous opiates in the CSF (cerebrospinal fluid) of anorectics and a weight gain when opiate effect is inhibited by naltrexone administration, suggesting that anorexia is, in effect, an addiction to fasting. Like alcoholics and other addicts, anorectic patients often deny the illness, making it difficult to prevent relapse even after treatment.

A. Presentation. Eating disorders that alter body morphology are immediately apparent, although patients with anorexia tend to conceal their emaciation by dressing in multilayered clothing. Anorexia nervosa and bulimia nervosa are primarily disorders of young women. The prevalence of anorexia is approximately 1% in the United States. The average age at presentation is 17 years, although it can also be first identified in middle age. Anorectics have a distorted body image, believing they are fat even when objectively they are emaciated. They tend to be brought in by concerned family members. Bulimia is a much more common disorder, with a lifetime prevalence of 3–5% in the general population and up to 20% in certain groups of young women. Bulimics, who are often of normal weight, can conceal their disorder more successfully, and generally present with gastrointestinal and other somatic complaints.

B. Diagnostic Criteria

1. Anorexia nervosa. There are two types: the *restricting type*, in which the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or misuse of laxatives or diuretics), and the *binge-eating/purging type*, in which the person has regularly engaged in these behaviors. The *DSM-IV* criteria are:

a. Refusal to maintain body weight at or above a minimally normal weight for age and height (approximately 85% of expected).
b. Intense fear of gaining weight or becoming fat, even though underweight.
c. Disturbance in the way in which one's body weight or shape is experienced, such as "feeling fat" even when emaciated, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
d. In postmenarcheal females, amenorrhea (i.e., absence of at least three consecutive expected menstrual periods).

2. Bulimia nervosa. Bulimia nervosa can be either of the purging type, when there is self-induced vomiting or the misuse of laxatives, diuretics, or enemas, or the nonpurging type, where other inappropriate compensatory

behaviors are used, such as fasting or excessive exercise, but not purging. The *DSM-IV* criteria are

a. Recurrent episodes of binge eating, which includes both (1) eating a definitely larger amount of food than usual over a short time period (e.g., 2 h) and (2) a sense of lack of control over eating during the episode.
b. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
c. The binge-eating and inappropriate compensatory behaviors both occur on average, at least twice a week for 3 months.
d. Self-evaluation is unduly influenced by body shape and weight.
e. The disturbance does not occur exclusively during episodes of anorexia nervosa.

3. Compulsive overeating. This can consist of either discrete binging episodes or a generalized loss of control over eating, so that amounts larger than needed for weight maintenance are regularly eaten despite a desire to limit one's food intake. Recurrent episodes of binge eating in the absence of regular use of compensatory behaviors is currently classified in the *DSM-IV* as "eating disorder not otherwise specified (NOS), but is described in the research section as "binge-eating disorder." Addictive features are present as indicated by (a) loss of control over eating behavior, (b) continued overeating despite adverse consequences, and (c) obsession or preoccupation with obtaining, preparing, and consuming food.

C. Physical Manifestations

1. Anorexia nervosa. Malnutrition may be so severe that hospitalization is required. Death may ensue. Malnutrition may result in loss of heart muscle, arrhythmias (bradycardia, atrial flutter, and atrial fibrillation), hypotension, congestive heart failure, and sudden death. Fatigue, weakness, dehydration, constipation, intolerance to cold temperatures, and increased susceptibility to viral and bacterial infection may occur. Prepubertal patients may experience growth delay. In postpubertal patients, menses cease when percent body weight drops below a minimum. Decreased fertility and amenorrhea are associated with lowered levels of luteinizing hormone (LH) and follicle-stimulating hormone (FSH). In the absence of menstrual periods, osteoporosis tends to develop. Laboratory abnormalities can include low white cell count; low glucose, cortisol, and serum zinc levels; as well as hypokalemia, hyponatremia, hypocalcemia, and hypochloremic alkalosis and elevated serum amylase levels of salivary origin.

2. Bulimia nervosa. Although body weight may be normal, unexpected weight fluctuations are often seen. Laboratory abnormalities can include electrolyte disturbances, low serum magnesium, and elevated serum amylase. Symptoms include abdominal pain due to gastric and esophageal irritation, and abdominal distention. Physical signs include erosion of dental enamel caused by stomach acid in a person who vomits, enlargement of the parotid gland, resulting in "chipmunk" facies, esophageal tears, and abrasions of the dorsum of the hand (sustained during repeated thrusting of the finger into the throat). Laxative abuse can cause irritation of the colon. Peripheral muscle weakness and cardiomyopathy can result from recurrent use of ipecac to induce vomiting.

3. Compulsive overeating associated with obesity. Obesity increases the risk of insulin resistance, diabetes mellitus, hyperlipidemia, hypertension, gallbladder disease, sleep apnea, chronic hypoxemia and hypercapnia, and degenerative joint disease (especially of the knees). Upper-body obesity is an independent risk factor for heart disease.

D. Comorbid Mental Disorders.

Among patients with anorexia, 50–75% have comorbid major depression and/or dysthymia; 10–13% have obsessive–compulsive disorder (OCD), with symptoms focusing primarily on symmetry and exactness. Recovered anorexics continue to score high on perfectionism scales. Family members have an increased incidence of generalized anxiety, obsessive–compulsive personality disorders, and OCD. Among patients with bulimia, 43% were reported to have anxiety disorders; 12%, bipolar disorder; and 50–75%, personality disorders or significant personality-trait disturbances. Obese binge eaters when compared with obese non–binge eaters exhibit more psychiatric disorders, primarily affective disorders.

1. Commonly associated *DSM-IV* Axis I mental disorders include depressive disorders, posttraumatic stress disorders, dissociative disorders, adjustment disorders, and anxiety disorders.
2. Self-destructive and self-defeating behavior is not unusual, including suicidal ideation or suicide attempts, substance abuse or progression to dependence, attempts at geographic cures, and engagement in other high-risk behaviors.
3. Addictive eating disorders are frequently associated with significant maladaptive personality traits. Food becomes a substitute for love, relationships, and a primary means of coping. A history of significant physical, emotional, or sexual abuse is not uncommon.

E. Comorbidity with Substance-Related Disorders.

There are substantial rates of multiple addiction among eating-disordered persons, particularly bulimics. Rates for alcohol and other drug dependence appear to increase with age and range from 13–22% for high-school students and college freshmen to a prevalence of concurrent or prior substance abuse of approximately 50% in several studies completed on women in their 30s and 40s. Among patients with anorexia, alcohol and drug addiction seem to cluster in the bulimic subgroup rather than the restrictor subgroup. The incidence of alcohol and drug-abuse problems is higher in the families of patients with bulimia nervosa than in families of controls (Hudson et al., 1987). Women undergoing chemical-dependence treatment had a 15% lifetime prevalence of anorexia or bulimia, which is significantly higher than expected (Hudson et al., 1992). Some patients tend to binge-eat when intoxicated, while others tend to substitute binge eating for alcohol and drug use. During treatment of one of these disorders, the other commonly worsens. Additionally, in dually diagnosed patients there is a high likelihood that either disorder can precipitate the other.

F. Cultural and Gender Differences.

Eating disorders are a contemporary epidemic, limited to societies where food is plentiful and fueled by the Western cultural ideal of slenderness in women. Poverty and lower educational level are associated with increased rates of female obesity. Blacks, Hispanics, and Native Americans have an increased prevalence of obesity. Two-thirds of teenage women think that they are fat. Eating disorders are approximately 10 times as common in females than in males. Among men, they are more common in models, athletes, flight attendants, gymnasts, wrestlers, jockeys, runners, and swimmers—those engaged in activities that require weight control.