



AMERICAN PSYCHOLOGICAL ASSOCIATION
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ADDICTION SCREENING IN PSYCHOTHERAPY

Too often, psychologists miss the signs of addiction. Here are ways to improve their recognition.

By Marilyn Freimuth

What are your initial diagnostic impressions of this case?

Phyllis is a 45 year-old married middle-school teacher who in recent months has experienced insomnia, irritability, recurrent stomach discomfort and decreased appetite, although her weight is stable. Ulcers were diagnosed as part of a recent medical workup. The physician found no physical basis for her other concerns. Although she complains about the stress of her job, seeing a psychologist is presented as being primarily her husband's idea. He is concerned about her irritability and distractibility. Recently she fell and sprained an ankle on the stairs and has left important papers at home that she needed at school. They have also been fighting about how much time she spends alone in the evening in her study grading papers and preparing for classes. She often stays there until after he goes to bed. She is willing to meet with a therapist in order to learn how to manage stress better so she is less irritable and distracted. She has no psychiatric history.

What is addiction?

Addiction is not included in DSM-IV, but it will return in DSM-V, due out in 2013. Substance-related disorders will be identified as substance addiction and, for the first time, the manual will recognize that addiction can develop in relation to a behavior. Pathological gambling, currently an impulse control disorder, is slated to be the only behavioral addiction in DSM-V. Internet addiction will be included in an appendix for further study. Behaviors consistent with a sexual addiction will belong to a new diagnosis -- hypersexuality -- which is a sexual disorder. Exercise, work, eating, buying and other behaviors that have been discussed as addictive (Freimuth, 2009; Orford, 2002) will continue to be considered compulsions.

An addiction, whether to a substance or behavior, is characterized simply by repetitiveness, high frequency or excess. Reading books or texting frequently and for long time periods does not make a person addicted. Rather, addictive behavior is characterized by a unique set of attributes. Usually, these attributes are taken from the most addiction-like disorders in DSM-IV: substance-dependence and/or gambling. Young (1998) has combined both to define the attributes of Internet addiction.

Shaffer provides a more parsimonious and easy to remember set of attributes that characterize any addiction (Shaffer, LaPlante, LaBrie, Kidman, Donato and Stanton, 2004): 1) continuing the behavior despite adverse effects; 2) loss of control, which includes difficulty cutting back, meeting self-defined limits or stopping once the behavior starts; and 3) cravings or urges to do the behavior.

Another unique feature of addictive behaviors that facilitates their identification in clinical settings is psychoactive effects. Like a compulsion, an addictive behavior may serve to reduce anxiety. However, it also has the capacity to create strong desirable shifts in subjective experience that are commonly associated with positive feelings and improved mood or self-esteem. For example, recreational gamblers whose gambling serves a mood-altering function are more likely to progress to become pathological gamblers (Nelson, Gebauer, LaBrie, & Shaffer, 2009).

The appeal of addictive behaviors to both remove pain and provide pleasure is aptly captured by William Cope Moyers in his autobiography "*Broken*" (2006): "Whether I used them to highlight pleasure or blot out pain, alcohol and other drugs did for me what I could not do for myself. They gave me confidence, boosted my self-esteem, erased my shame, and eased my despair" (p.80). A person who has few or no other means of coping, managing difficult experiences or creating good feelings will repeatedly return to the substance or behavior for its effect.

Some substances and behaviors create these kinds of experiences better than others (e.g., gambling, Internet, methamphetamines, alcohol). We are more likely to become addicted to shopping than lawn mowing. But theoretically any substance or behavior that has desired psychoactive effects can become addictive.

Addictions in mental health settings

The 12-month prevalence rate for alcohol dependence, the best known addiction, is 5 percent. Prevalence rates for sex, Internet and work addiction equal or exceed this number (Freimuth et al. 2008). These figures for community samples are usually doubled in mental health settings (Kessler et al., 1997). Mental health providers cannot avoid treating substance and behavioral addictions given that they frequently co-occur with mental health problems and most people are treated for addictions in mental health settings rather than specialized treatment settings (Freimuth, 2009).

Psychologists overlook addictions

To treat an addiction requires that it be recognized. Several studies demonstrate that mental health providers do not recognize even the most common form of addiction, alcohol use disorders. One-half of the intake reports in a college counseling center made no mention of alcohol abuse even though students' self-reported level of use merited concern (Matthews, Schmid, Conclaves, & Bursley, 1998).

Phyllis' presenting problems in the above vignette are typical for a person who seeks psychotherapy. They also are typical for a person who has an addiction or is at-risk of becoming addicted. In all likelihood, her addiction, an alcohol use disorder,¹ will be overlooked. When psychotherapists were asked to provide an initial impression of a similar patient, almost 50

¹ Possible signs of an alcohol use disorder include husband recommending treatment, irritability, sprained ankle, forgetting papers at home, isolating in the evenings, avoiding her husband by going to bed after he does, sleep problems, less hunger with no weight loss, and stomach problems associated with ulcers.

percent offered depression, 26 percent suggested anxiety while only 7 percent thought she might have an addiction (Freimuth, 2008a).²

The face of addictions is one major reason why addictions are so often overlooked in mental health settings. As with Phyllis, the consequences of addiction often mimic common mental health symptoms. Sedating substances, such as alcohol, pathological gambling, and addiction to shopping and Internet create symptoms consistent with depression (Freimuth, 2008b). When listening to a new patient report anxiety, lack of energy or low self-esteem, a psychologist's thoughts often turn to typical psychological disorders when, in fact, each of these symptoms can represent adverse effects of an addictive behavior.

The misdiagnosis of addiction also results from mistaken impressions about what it means to be addicted and who becomes addicted. Professional training in addiction, with its emphasis on salient adverse effects and diagnostic criteria, supports the impression that addiction is readily apparent. For many psychotherapists, Phyllis's functionality is inconsistent with an alcohol use problem. For others, her gender veils the addiction. While more men than women have alcohol use problem, the 3:1 ratio probably is overestimated (Becker & Walton-Moss, 2001). Like Phyllis, a woman's problematic use does not have the more apparent adverse effects (such as DUIs or arrests) that are more typical for men (Freimuth, 2009). Within health-care settings, alcohol use disorders are most often missed in women, people who are insured, employed and Caucasian patients (Schottenfeld, 1994).

Behavioral addictions also go undetected because of clinicians' mistaken beliefs. Who is more likely to be a shopping addict? Research shows it is equally common to men as women (Koran, Farber, Aboujaoude, Large, & Serpe, 2006). There is a strong association between anti-social behavior/personality and addiction, yet most addicted people will not have this co-occurring issue. Sexual addiction is assumed to lead to sexual offences or be limited to paraphilic interests. In one study, the typical sexually addicted person was a 34-year-old man from a Catholic background whose sexual activity involved prostitutes or online sex sites (Goodman, 2008).

Addictions can also be overlooked if a provider assumes that the patient will offer this as the presenting problem. Research shows that only one in 10 people whose alcohol use is problematic recognize it as a problem (Substance Abuse and Mental Health Services Administration, 2002). Lack of awareness is even greater for behavioral addictions about which people know much less.

I find it fascinating that when an addicted patient does not self-diagnose, he or she is said to be "in denial." Addiction is, after all, known as "the disease of denial." While some patients deny addiction, an equally viable explanation for not self-identifying an addiction is that a patient is influenced by the same factors that mask the clinician's ability to see an addiction. Like psychotherapists, people hold mistaken beliefs about what an addiction looks like:

"I thought to be an alcoholic, a person had to be in terrible trouble...I was fine...I thought that alcoholics were told again and again by their friends and doctors that they should stop drinking. No one had ever said much about my drinking. (Cheever, 1999, p. 123).

² Autobiographies by Koren Zailckas (2005), Sue William Silverman (2001), Caroline Knapp (1996), Elizabeth Wurtzel (2002) provide real life examples of health care professionals' failure to see an addiction.

Like psychotherapists, a person's attention is drawn to the psychological symptoms created by addictive behavior. As a result, help is sought for low mood, anxiety, worry or poor sleep. Too often, mental health providers take these symptoms at face value and the underlying addiction goes undetected.

Improving identification

Administering an addiction screening tool at the start of treatment is an important first step in improving identification of addictive disorders. Screening, by itself, has been shown to decrease the behavior (Kypri, Langley, Saunders, & Cashell-Smith, 2007). However recommending that psychologists do routine screenings is far from a cure all for overlooked or misdiagnosed addictions.

Some clinicians will not conduct screenings because they are inconsistent with their approach to practice. Others hesitate to screen because of the stigma attached to addiction. Historically being addicted has been associated with negative attributes such as being immoral or impulsive. The disease model has helped lessen the stigma although health-care providers still express concern that a patient will be offended or get angry if asked about addictive behaviors (e.g., Weisner & Matzger, 2003). At least in medical settings, these concerns are not warranted; few patients object to completing an alcohol use screening (Vinson, Galliher, Reidinger, & Kappus, 2004).

Even if screenings are conducted routinely, many addictions will remain undetected, for several reasons:

1. **Responses to addition screens are easy to fake.** With a few exceptions (e.g., SASSI for substance use) screening tools are face valid. While denial is much less common than assumed (Howard, McMillen, Nower, Elze, Edmond, & Bricout, 2002), for this group face validity means that answers can be easily faked.
2. **Too many addictions and too few screening tools.** The vast majority of screening tools focus solely on substance use, with most screens identifying only alcohol use disorders. Brief screens that are simple to administer and score, such as the CAGE, AUDIT and Quantity/Frequency questionnaires, are required in some settings. A positive screening sets the stage for further assessment to determine if diagnostic criteria are met.

Because co-addictions are the norm, initial screenings confined to alcohol use can leave other substance and behavioral addictions unrecognized. A patient can be addicted to several substances, have several behavioral addictions, or a behavioral addiction co-occurs with a substance related disorder. One-third of people with a substance use disorder have a co-occurring gambling or sexual addiction. For those who consider eating disorders an addiction. 25% of patients have a co-occurring substance use problem (Freimuth et al. 2008).

The Shorter PROMIS Questionnaire (Christo Jones, Haylett, Stephenson, LeFever, & LeFever, 2003) is an efficient means to screen simultaneously for 16 different substance and behavioral addictions. Given that any behavior that has a mood-altering affect has the potential to become addictive even this tool will fail to identify some addictions.

3. **Addictions can emerge during treatment.** A patient who enters treatment relying on a substance or behavior to regulate emotions or cope can develop an addiction over the course of therapy. Or, one addiction may emerge to replace another (Carnes, Murray, & Charpentier, 2005).

For example, a patient being treated for sexual addiction may dissolve the anxiety of withdrawal by increased consumption of alcohol. An engaging book that illustrates how addictions shift and change over the course of treatment is Susan Shapiro's aptly titled book. *Lighting Up: How I Gave Up Smoking, Drinking, and Everything Else I Loved Except Sex* (Delacorte Press, 2004).

4. Diagnosis is the focus of screening and assessment. Once a clinician suspects there is an addiction, a screening and diagnostic assessment can ensue. However, by focusing solely on diagnosable conditions, a clinician will not be able to identify an addictive behavior that is subclinical or an addiction that emerges gradually over the course of therapy until it is severe enough to warrant a diagnosis. Mental health providers can do more than identify and treat a full-fledged, diagnosable condition. As advocates of secondary prevention, clinicians can identify emerging problems before they become severe and initiate an early intervention.

A "new look" in addiction screening

The last 10 years have seen a major shift in thinking about the goal of alcohol use screenings. The National Institute on Alcohol Abuse and Alcoholism initiative on harmful drinking emphasizes the importance of addressing alcohol use before the problem merits a formal diagnosis. Moving beyond dichotomous thinking -- a person is alcohol dependent or not -- providers are encouraged to incorporate the concept of harmful or risking drinking into their assessment procedures.

Harmful drinking is by far the most common form of problematic alcohol use and accounts for more harm to self and others than substance dependence (Spurling & Vinson, 2005). Table One contains the screening tool for and definitions of harmful drinking.

The subclinical or at-risk side of alcohol use is defined based on the quantity of alcohol consumed. It is difficult to imagine quantifying other potentially addictive substances or behaviors. Just how much cocaine is harmful? How much sex, gambling or shopping can be considered risky? As an alternative to quantification, I have developed a clinical heuristic drawing from the theoretical and empirical literature on addiction development, autobiographies of addiction, and interviews with addiction professionals about the early warning signs of addiction (Freimuth, 2008b, 2009). The side of the continuum with diagnosable conditions was informed by recent research for DSM-V on dimensional approaches to substance use disorders and gambling (Saha, Chou, & Grant, 2006; Strong & Kahler, 2007) and research distinguishing highly engaging behaviors from addictions (Charlton, 2002). This research shows that tolerance and ruminations are common to both highly engaging behaviors and addictions and that loss of control over a substance or behavior marks the transition from at-risk to early addiction. The resulting heuristic (see Table Two) describes distinct attributes of recreational, at-risk, problematic and fully dependent forms of addictive behavior.

The steps along this continuum are illustrated below for Internet addiction. When screening for Internet addiction, it is necessary to distinguish whether it is the primary disorder; that is, the activity was not addictive until practiced online. In other cases, what appears to be an Internet addiction is an off-line addiction that has migrated to online as can occur with sex, buying, shopping, work and gambling.

Recreational level: Use of the Internet is goal oriented (e.g., get information, make a purchase, communicate with others). There is no problem with control; time online may vary but this is a function of the task. Negative consequences are rare and a direct result of being online (e.g., sore neck, dry eyes, not studying).

At-risk level: Time online is increasingly without a defined goal. Rather, the Internet is used because it provides reinforcing effects (e.g., enjoyment, novel stimulation, altered state). Negative consequences are the same as the recreational level but have occurred enough times to be predictable. More significant adverse effects, if they occur at all, come as a surprise (e.g., being online longer than expected). At-risk users can show tolerance, think a great deal about computing and even get a buzz from the activity. For some, but not all people, other addictive features will emerge with time (Charlton, 2002).

Problematic level: The reinforcing effects of the at-risk level are discovered to serve a psychoactive function (e.g., escape, manage mood) that is not easily achieved in other ways. Time online is increasing. Secondary negative consequences develop where self or others react to the direct negative consequences (e.g., feeling guilty about lower grades due to not studying; children have a very late dinner because of being online). Internet based activities begin to interfere with off-line interactions (e.g., gambling online replaces socially oriented bus trips to the casino).

Fully addicted level: Internet use is difficult to control and being online is becoming the focus of daily life. If not online, agitation, irritability, and anxiety can occur (i.e., withdrawal). Direct and secondary negative effects are mounting and coalescing into impaired role functioning (e.g., failing out of school, losing a relationship, major depression).

For screening tools that yield an outcome along a continuum see Freimuth 2008b, 2009.

Best practices in recognizing addictions

To become more adept at identifying substance and behavioral addictions, mental health providers need to take stock of any mistaken beliefs they hold about addictions (e.g., addictions create obvious symptoms, a new patient will self-identify an addiction). For the most common substance and behavioral addictions, clinicians need accurate demographic information along with an understanding of the many ways in which an addiction can be disguised behind symptoms that are shared with common mental health problems.

Clinicians should administer the Quantity/Frequency questionnaire for alcohol use at the start of treatment. If a client's recommended limits are exceeded, a clinician can conduct further assessment to determine whether alcohol use is subclinical (i.e., harmful) or merits a diagnosis. Given the wide array of behavioral addictions that are without screening tools, the clinician can conduct an informal screening by asking general lifestyle questions, such as: What do you do to have a good time? What do you do to relax when things get really stressful? Assess if a behavior has addictive attributes: Do you ever find yourself doing something and it is difficult to stop or you do it longer than planned? Is there any activity or behavior you do routinely that other people complain about?

Research shows that asking a person about his or her expectations about a behavior helps predict if the behavior is at-risk of becoming addictive. People addicted to the computer or exercise reported expecting mood altering effects from their behavior, while those who were not addicted focused on a goal (e.g., get information off the Internet, improve athletic skill) (Orzack & Ross, 2000; Thornton & Scott, 1995).

After an initial screening, a clinician should continue to listen to the clinical dialogue with the continuum of addiction in mind. Does a behavior seem to be increasing in frequency? Is a once social behavior now done alone? Is the behavior becoming indiscriminant? If an addiction at any

level of development is suspected, a screening tool that evaluates relative severity can be administered or a more structured assessment based on attributes in the continuum can be conducted.

Not every at-risk addictive behavior will become addictive. Sometimes the behavior is simply "highly engaging." Charlton (2002) discusses how to distinguish highly engaging behavior from an addiction. Factors that make it more likely that a subclinical behavior will progress to a diagnosable addiction are: the behavior serves a mood altering function; the person has few alternatives means of coping, lives under highly stressful conditions and/or has a high level of impulsivity (Freimuth, 2008b; Melville, 2009).

No matter which method a clinician prefers to identify an addiction, a more nuanced view of addiction severity is warranted. Extending our understanding of addictions to include risky or harmful occurrence can facilitate identification of an addiction that emerges gradually during treatment, as well as encourage providers to remain attentive to co-addictions. By opening the way to early recognition of addictions, this approach has the potential to save millions of lives and health-care dollars by facilitating identification and treatment of the problem before it is severe.

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TABLE ONE

Quantity/Frequency Questionnaire

1. On average, how many days per week do you drink alcohol?

Multiply drinking days by answer to question 2: Weekly consumption is not greater than 7 drinks for women and 14 drinks for men

2. On a typical day, when you drink, how many drinks do you have?

No more than one drink for women (or men over 65) and two drinks for men

3. What is the maximum number of drinks you have had on a given occasion during the past month?

Not to exceed three drinks in a row for women and four drinks in a row for men

Helping Patients Who Drink Too Much

<http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>

Resources (e.g., screening tools, forms, drink diaries) and training videos (receive CME) associated with the above guide:

<http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm>

TABLE TWO

Continuum of Addictive Behavior (Freimuth, 2008b)

Recreational level

- Controlled by the situation
- Frequency and intensity of behavior is relatively stable
- Negative effects are rare, unexpected, private and a direct effect of the behavior (e.g., hangover, sore back from sitting and gambling)

At-risk level

- Controlled by intrinsic reinforcement
- A once social behavior occurs alone or with "like-minded" others
- Negative effects are intermittent, a direct effect of the behavior, and not unexpected

Problematic level

- Doing the behavior is more important than the people it is done with
- Frequency and intensity of behavior is increasing
- Secondary negative consequences: physical, psychological, & social responses to direct negative effects (e.g., late to work due to hangover, others begin to notice there is a problem)

Fully Addicted level

- Behavior continues even after desired effect is achieved
- Behavior is indiscriminant
- Tertiary negative consequences (e.g., depression forms as a result of guilt and inability to control the behavior, risk of job loss as a result of lowered work performance/late to work due to hangovers).