The Call for a New *Diagnostic and Statistical Manual of Mental Disorders* Diagnosis: Addictive Disorders

W. Bryce Hagedorn

Process addictions affect individuals, families, and society in powerful ways. Without a consensually validated definition and a set of diagnostic criteria, counselors lack the necessary assessment and treatment tools. This article presents the position of the International Association of Addictions...

For the estimated 22.6 million individuals who abuse or are dependent on substances (Substance Abuse and Mental Health Services Administration [SAMHSA], Office of Applied Studies, 2007), there are more than 17,000 treatment facilities (SAMHSA, Office of Applied Studies, 2006). This represents a ratio of 1 treatment facility for every 1,300 people in need. Although authors have called for an extension of the definition of addiction to include behaviors (e.g., Armstrong, Phillips, & Saling, 2000; Goodman, 2001; Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002), often known as *process addictions*, little has been accomplished in formally recognizing disorders that affect millions of clients and their families. Information gathered by the International Association of Addictions and Offender Counselors (IAAOC) Committee on Process Addictions was used to determine the extent and treatment of process addictions and the need for a new diagnostic category.

The following ratios of facilities to potential clients suggest that individuals with process addictions and their families are underserved.

1. Eighty-eight treatment centers (National Eating Disorders Association, n.d.) exist for 14 to 26 million individuals who have an eating disorder (American Psychiatric Association [APA], 2000; Hudson, Hiripi, & Pope, 2007; Tenore, 2001). If one takes the midpoint of this range, that translates to 1 center for every 227,000 people.
2. Thirty facilities (Addiction Resource Guide, n.d.-a) are available for the 6 to 9 million individuals with a compulsive gambling disorder (APA, 2000). Again, if one takes the midpoint, that means 1 facility for every 250,000 clients.

© 2009 by the American Counseling Association. All rights reserved.
3. Twenty-five centers (Addiction Resource Guide, n.d.-c) exist for the estimated 17 to 37 million Americans who meet the criteria for sexual addiction (Carnes, 2001; Cooper, Delmonico, & Burg, 2000; Wolfe, 2000). The same formula results in 1.08 million people needing services at each facility.

4. Ten facilities (Addiction Resource Guide, n.d.-b) are equipped to handle the estimated 17 to 41 million people addicted to the Internet (Kaltiala-Heino, Lintonen, & Rimpelä, 2004; Young, 1999). Again, that equals to 2.9 million potential clients for each treatment center.

There is a disparity between the number of available treatment facilities and the estimates of potential clients. In addition, the prevalence rates for substance use disorders (SUDs) and selected process addictions (e.g., pathological gambling) are more precise than are the estimates for emerging addictive disorders, such as Internet addiction. The disparities and difficulties in estimating populations contribute to the inability of the mental health treatment community to adequately address addictive disorders that are affecting millions of people in society.

To address some of the reasons for the aforementioned inequities, the IAAOC created the Committee on Process Addictions. This committee was tasked, in part, with establishing the rationale for the creation of a new diagnosis: the addictive disorders. The basic premise of the addictive disorders category assumes that addiction-like behavioral manifestations that meet criteria similar to those for SUDs are, in fact, addictive disorders. As such, the Committee on Process Addictions asserts that these disorders should be assessed and treated similarly to chemical disorders. The lack of a formal diagnostic category (i.e., addictive disorders), consensually validated by a Diagnostic and Statistical Manual of Mental Disorders (DSM) work group or related professional body, has contributed to problems in diagnosis and treatment, inability to access services, and a lack of financial resources among prospective clients covered by health insurance plans.

The purpose of this position paper is fourfold. First, the rationale and need for a new diagnosis is explored. Then, arguments against this diagnosis are reviewed and critiqued. Third, feedback from a brief needs assessment of surveyed clinicians is provided to substantiate the need for the proposed disorder. Finally, the proposed definition, diagnostic criteria, and subtypes are presented. The end result of this position paper is to advocate with APA for the inclusion of an addictive disorders diagnosis in the fifth edition of the DSM (DSM-V), due to be released in 2012.

**Rationale and Need for a New Diagnosis**

The designation of an addictive disorders diagnosis would serve several needs, particularly those of the (a) academic and treatment communities, (b) clients with process addictions, and (c) society at large (Hagedorn, 2003;
Juhnke & Hagedorn, 2006). Once a set of criteria is established, educational and training programs could be designed to provide a systematic format for the dissemination of material necessary for the recognition and treatment of addictive disorders. Graduate students in counseling (particularly those entering the clinical mental health counseling specialization) are typically trained to recognize addictions to such substances as alcohol, cocaine, nicotine, or caffeine (because all have DSM-IV-TR [APA, 2000] diagnoses for dependence). Similarly, given that students in programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) are required to demonstrate competence in diagnosing and treating various mental disorders (CACREP, 2001), they are exposed to the problems of gambling and eating disorders because these are also diagnosable disorders. Unfortunately, students are not trained effectively to assess and treat other process addictions (Hagedorn, 2000; Hagedorn & Juhnke, 2005).

Given the lack of training to assess and treat the addictive disorders, it is no wonder that there are a lack of prepared clinicians and an insufficient number of treatment programs to address the growing population of clients with process addictions (Manley & Koehler, 2001; Ragan & Martin, 2000). The inclusion of the addictive disorders diagnosis within the DSM-V would encourage graduate-level educators, training programs, and researchers to focus on the diagnostic features, subtypes, prevalence, and course of these disorders to prepare the next generation of competent clinicians.

Universal standards of care could promote professional and public awareness of addictive disorders. Moreover, increased research funding and more frequent treatment reimbursement to qualified clinical providers may result. Finally, given the complexity of treating addictive disorders (e.g., the high comorbidity rates with other addictive and psychiatric disorders; see Merta, 2001; Rowan & Galasso, 2000), clinicians who have been fully educated and trained to treat all addictions will be better prepared to successfully treat this client population.

As a result of a greater clinical and educational focus, the needs of clients with process addictions and their families will be better met. Currently, given the lack of an established diagnosis, many clients (a) do not meet established criteria for treatment, (b) do not have the funds to support their own treatment (because third-party payments do not cover these disorders), and/or (c) avoid treatment altogether (given that a hallmark of addictive disorders in the first place is to minimize their impacts). Clearly, without such an addition to the DSM-V, clients are likely to continue to experience the problems associated with their addictions.

Similarly, the literature has firmly established the fact that clients with an addiction are not the only ones affected by their behaviors. Family members such as spouses and children also experience relationship difficulties, domestic violence, mental illnesses, codependency, financial hardships, all forms of abuse, and even their own addictive disorders (Davis, Flett,
& Besser, 2002; Ledgerwood, Steinberg, Wu, & Potenza, 2005; Schneider, 2000). Individuals and family members living with process addictions have the right to effective mental health treatment, including professional counseling tailored to addressing addictive disorders.

The positive impact on society is the final rationale for the inclusion of a new addictive disorders diagnosis. Similar to SUDs, whose societal impacts are well documented (e.g., lost productivity, violence and crime, social welfare, and exacerbated mental health outcomes), process addictions place a heavy toll on a community’s resources. Take, for example, sexual addiction, gambling, and Internet addiction. Sexual addiction negatively affects those in the workplace, increases the likelihood of sexually transmitted diseases, places a burden on the legal system, and perpetuates the detrimental consequences of those trapped in the adult entertainment industry (Benotsch, Kalichman, & Pinkerton, 2001; Goodman, 2001; Laino, 2002; National Council on Sexual Addiction and Compulsivity, 2000). Gambling has its own legal and financial impacts, including bankruptcy, embezzlement, and fraud (Florida Council on Compulsive Gambling, 2004). Finally, addictive use of the Internet causes interpersonal problems, decreased productivity, and legal issues (Calhoun, 2005; Snoddy, 2000; Young, 1999).

It has been conservatively estimated that the aforementioned process addictions (sex, gambling, and the Internet) cost society more than $285 billion annually (Calhoun, 2005; Hagedorn, 2005; Juhnke & Hagedorn, 2006; National Opinion Research Council, 1999). These numbers do not include costs attributed to addictive eating, spending/shopping, or exercise. If these addictive disorders were formally recognized, monies could be allocated for both prevention and treatment with the intended outcome of reducing negative impacts on communities.

With the rationale and need for the new addictive disorders category having been provided, it is appropriate to review critiques against the addition of the new diagnosis in the DSM-V.

Critiques of the New Diagnosis

There are several arguments against the professional recognition of process addictions as diagnosable disorders. These include (a) the belief that addiction occurs exclusively on a physiological level, (b) the conflict over what constitutes recovery from these addictive disorders, and (c) the assumption that these disorders are better encapsulated within other disorders already found in the DSM-IV-TR (APA, 2000). Each stance warrants a close review to provide the context for the legitimacy of the proposed diagnosis.

Physiology as Demonstrated by Tolerance and Withdrawal

Opponents of the addictive disorders proposal (e.g., Erickson, 2008; Erickson & Wilcox, 2006) believe that chemical dependence (avoiding the word addiction altogether) occurs solely on a physiological level, such as the brain’s functional dependence on alcohol or heroin. In fact, Apt and
Hulbert (1995) asserted that “a true addiction involves a physiological dependence on a particular substance that results from the habitual use of that substance. Sex [and other behaviors] is a form of interaction, not a substance on which the body comes to depend” (p. 104). These authors claimed that physiological dependence, as demonstrated by physical tolerance and withdrawal, are two of the hallmark criteria necessary for the designation of an addiction.

To address these concerns, one can begin by looking at the criteria necessary for the diagnosis of dependence. The *DSM-IV-TR* (APA, 2000) delineates that dependence can be diagnosed when three of the seven established criteria are met. Therefore, it is possible that individuals may (a) use more of the chemical than they had planned on using; (b) be unable to control, cut back, or stop their chemical use; (c) spend large amounts of time obtaining their chemical, using their chemical, or recovering from the chemical’s effects; (d) sacrifice social, occupational, or recreational activities; or (e) keep using the chemical even when they recognize its impacts on their health (Juhnke & Hagedorn, 2006). Therefore, five criteria would be met without having to meet criteria for tolerance or withdrawal at all. In fact, according to the *DSM-IV-TR*, “neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence” (APA, 2000, p. 194).

The tolerance discussion further involves the debate between whether it is the body’s or the mind’s need for more of a substance or behavior to obtain the same high (Juhnke & Hagedorn, 2006). Whereas tolerance to a chemical (e.g., alcohol, marijuana, or caffeine) would exhibit itself as the need for more of that substance to experience the same effects (APA, 2000), tolerance to addictive behaviors is demonstrated by the need for increased intensity or frequency of the behaviors to obtain the desired response (Goodman, 2001). Be it physical or psychological, tolerance occurs on many levels.

Withdrawal is the other side of the dependence debate. Typical withdrawal symptoms from such substances as caffeine, cocaine, and marijuana include anxiety; depression; suicidal ideations; dysphoric mood states; irritability; changes in appetite; sleep disturbance; fatigue or drowsiness; cravings; and significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000). These same psychological withdrawal symptoms are seen in individuals who cease addictive behaviors (Carnes, 2001; Goodman, 1998; Levin, 1999). To conclude, (a) addictive disorders may present some of the same withdrawal effects as those experienced with SUDs and (b) tolerance can be physiological or psychological. Therefore, the arguments that addictive disorders do not satisfy dependence criteria or that contemporary diagnostic criteria for addiction require physiological indicators are unfounded.

**The Recovery Process**

Defining the process of recovery is another argument against classifying problematic behaviors as addictive (e.g., Apt & Hulbert, 1995; Barth &
Kinder, 1987; Levine & Troiden, 1988). The majority of addiction treatment paradigms call for lifetime abstinence from all addictive substances (Laudet, 2007). Many process addictions, however, do not fit the same total-abstinence model. For example, lifetime abstinence from food is not expected given that food is necessary for life. Whereas sober sexuality may include a period of abstinence, recovery is often focused on building intimacy that is part of a healthy sexual relationship. Persons diagnosed with addictions to spending, exercise, and the Internet are not necessarily expected to exclude these activities for the remainder of their lives.

In response to the belief in the need for total abstinence, Goodman (2001) and Willenbring (2001) suggested a closer examination of the definition and goal of abstinence. Although many of the 12-step fellowships call for total abstinence from all mood-altering drugs, the reality is that many individuals with an addiction routinely ingest substances for either pleasure (e.g., caffeine and nicotine) or mental health purposes (e.g., Zoloft for depression and/or anxiety). These authors recommended that abstinence be redefined as the avoidance of any drug that would result in dependence. According to this view, many persons who are chemically dependent would still choose to abstain from all mood-altering chemicals.

When defined in this manner, abstinence from process addictions would involve avoiding or eliminating those behaviors in which the individual loses control or experiences negative consequences. Instead, healthy behaviors would be emphasized. When abstinence from addictive behavior is defined in this context, healthy eating, sexuality, spending, exercising, and Internet use is possible, and lifetime abstinence from process addictions is more realistically attainable.

**Impulse Control, Obsessive-Compulsive, and Other Established Disorders**

The final argument against the creation of the addictive disorders diagnosis is that the behaviors could be contained in syndromes covered by the *DSM-IV-TR* (APA, 2000)—specifically, impulse control disorders (ICDs), obsessive-compulsive disorders (OCDs), and other addiction-like disorders that already have designated diagnoses. Each is briefly addressed in the following sections.

*Addictive disorders versus ICDs.* Some authors note that an addictive disorder might be better defined as an ICD (e.g., Brewer & Potenza, 2008; Shapira, Goldsmith, Keck Jr., Khosla, & McElroy, 2000; Treuer, Fabian, & Furedi, 2001). In reviewing the *DSM-IV-TR* (APA, 2000, pp. 663–677) criteria for an ICD not otherwise specified (NOS), one might be able to see how some view these as encapsulating addictive disorders. The four key criteria found in ICDs are as follows: (a) individuals feel an increasing sense of tension or arousal before committing the impulsive act; (b) individuals experience pleasure, gratification, or relief at the time of committing the impulsive act; (c) following the impulsive act, there may or may not be regret, self-reproach, or guilt; and (d) individuals will fail to resist an...
impulse, drive, or temptation to perform an impulsive act that is harmful to the person or to others.

Whereas the first three criteria may be common among addictive disorders, the last criterion, namely, that the impulsive act is one that is harmful to the person engaging in the behavior or to others (APA, 2000), is not necessarily the case in addictive disorders. For example, many sexually addictive behaviors identified by Carnes (2001), including compulsive masturbation, multiple sexual partners (heterosexual and/or homosexual), and addictive use of pornography, are not necessarily always harmful to the individual or to others. A similar lack of harm can be found in Internet addiction, as well as the early stages of addictive gambling, eating, and spending. Clearly, ICDs do not sufficiently cover the range of maladaptive behaviors found in addictive disorders.

**Addictive disorders versus OCDs.** In addition to the ICD argument, other authors state that the behaviors seen in persons with addictive disorders are simply manifestations of OCDs (Schwartz & Abramowitz, 2005). It is interesting that these two disorders do share some important similarities. For example, both addictive disorders and OCDs can include intrusive thoughts and compulsive behavior patterns. Although addictive behaviors are often used to reduce anxiety and other painful affects (a hallmark diagnostic criterion of compulsive behaviors), they also produce pleasure and gratification, which rules out the diagnosis of compulsion (in which no pleasure is experienced). Similarly, many addictive behaviors in and of themselves do not cause severe distress (another trait of an OCD). In fact, according to the *DSM-IV-TR* (APA, 2000), given that the person usually derives pleasure from many addictive activities, he or she may wish to resist them only because of their negative consequences.

**Addictive disorders versus disorders with established criteria.** Ruling out ICDs and OCDs still leaves those disorders that already have established *DSM-IV-TR* (APA, 2000) criteria. These include paraphilias (i.e., addictive sexual behaviors), eating disorders (i.e., addictive eating), and pathological gambling (i.e., addictive gambling). Although the full examination of the differences among these disorders is beyond the scope of this article, a brief mention is warranted here.

Sexual addiction is just one of the addictive disorders that warrants its own legitimate diagnosis. It is also one of the most prevalent addictions (Carnes, 2001; Cooper et al., 2000; Mahorney, 2002; Wolfe, 2000). Whereas several of the behaviors referred to in the *DSM-IV-TR* (APA, 2000) as paraphilias (e.g., exhibitionism, fetishism, and voyeurism) may be exhibited by individuals addicted to sex, these do not sufficiently cover the entire range of sexual behaviors manifested in sexual addiction. This is especially true with addictions to pornography, masturbation, and multiple sexual partners, each of which is not covered in the paraphilias. Even sexual disorder NOS (which has some applicability to a client who is sexually addicted) does not sufficiently cover the variety of problematic behaviors found in this subtype of addictive disorders.
A large amount of clinical and research debate has focused on the distinction between eating disorders and food addiction/addictive eating. Some authors have called for a strict adherence to the DSM-IV-TR (APA, 2000) designations (e.g., Wilson, 1999) because an addictive model may not account for some of the personality correlates found with disordered eating, such as emotional instability, difficulties in emotional flexibility, impulsivity, perfectionism, low self-esteem, control issues, and distrust of others (Ram, Stein, Sofer, & Kreitler, 2008).

On the other hand, there has been a proliferation of noted similarities between recognized addictive features and eating problems, including loss of control, cravings, mood alteration, preoccupation, secrecy, denial of a problem, relapse, cross-addiction, and continuation of maladaptive behaviors despite negative consequences (Garner & Gerborg, 2004; Gold, Frost-Pineda, & Jacobs, 2003; Power, 2005). Other studies have (a) validated the similarities between chemical dependency and disordered eating (Cassin & von Ranson, 2007), (b) highlighted the similarities in the brain characteristics of individuals with chemical and food addictions (Gold et al., 2003; Pelchat, 2002), and (c) noted the prevalence and success of using an addiction model in the treatment of disordered eating (Trotzky, 2002; von Ranson & Cassin, 2007). It is not the intent of this article to present all the data that support an addictive view of eating; rather, the notion that an addictive relationship with food exists has been demonstrated and should be recognized as another manifestation of the addictive disorders classification.

The DSM-IV-TR (APA, 2000, pp. 671–674) criteria for pathological gambling most closely embody the behaviors found in gambling addiction. In fact, the DSM-IV-TR established gambling criteria have often been used as the basic diagnostic features for process addictions (Goodman, 1993; Levin, 1999; Young, 1998). Unfortunately, pathological gambling is found in the ICDs and, as noted earlier, the ICD qualifier of harmful does not always apply (there are times that people who gamble succeed). Also, given the range of addictive behaviors, renaming and regrouping addictive gambling into the larger diagnosis of addictive disorders would seem prudent.

Having explored the rationale for the creation of the new diagnosis, as well as making attempts at addressing the concerns found in the literature, the chair of the IAAOC Committee on Process Addictions conducted a preliminary needs assessment. The data that resulted from this brief assessment supported the basic position that a new diagnosis is indicated. Following the needs assessment, the article concludes with an outline for the proposed definition, diagnostic criteria, and subtypes of the proposed addictive disorders classification.

A Needs Assessment for the New Diagnosis

Procedure

After securing permission from the university’s institutional review board, I gathered information from attendees at a recent national conference of the
American Counseling Association. This convenience sample was gathered by interviewing individuals who attended a poster session that I gave titled *Is It an Addiction? Counseling Professionals Share Their Experiences and Opinions on the Efficacy of the Addictive Disorder Diagnosis* (Hagedorn, 2006).

The purpose of the interview was explained to participants as a time to collect their professional opinions regarding the efficacy of the addition of a new diagnosis, the addictive disorders, to the next edition of the DSM. The disorder was described verbally, and participants were provided a handout further explaining the disorder. After having a chance to review the material and agreeing to provide consent, participants were allotted time to voice their professional opinions regarding whether the new diagnosis was warranted. Participants responded to three questions and then completed a demographic form. All comments were audiotaped for reporting accuracy.

**Participants**

Seventeen individuals agreed to participate in this brief study. This convenience sample consisted of 6 men and 11 women, ranging in age from 30 to 69 years, the majority of whom identified themselves as Caucasian/White (88%). Additional descriptors included 6 (35%) who identified their professional identity as a clinician, 8 (47%) who identified themselves as an educator, and 3 (18%) who labeled their primary identity as a graduate student. In terms of highest degree earned, the following was reported: 1 (6%) had a bachelor’s degree, 4 (24%) held master’s degrees, 1 (6%) was a specialist, and 11 (65%) had doctorates. (Percentages do not equal 100% because of rounding.) Finally, in sharing their experience levels, 3 (18%) noted that they possessed a graduate degree with an emphasis in addictive disorders, 5 (29%) possessed a certification and/or license in addictions counseling, 13 (76%) reported having treated clients with an addictive disorder, and 4 (24%) reported conducting research related to addictive disorders. Regarding experience level, it should be noted that participants reported belonging to more than one category.

**Materials**

In addition to the demographic form, participants were asked to respond to three questions. The first question asked participants to rate their overall opinion regarding the efficacy of adding a new addictive disorder diagnosis to the *DSM-V*. Individuals were asked to choose which of the following statements most accurately described their opinion: (a) “I am in total support of the addition of the addictive disorders diagnosis,” (b) “I am in support of the addition with some minor reservations,” (c) “I am neutral to the addition of the addictive disorders diagnosis,” (d) “Although I can see some merits of the diagnosis, I am not in support of the addition,” and (e) “I am totally nonsupportive of the addition of the addictive disorders diagnosis.”

Following this process, participants were encouraged to share their experiences and opinions related to two open-ended questions. The first question
asked individuals what they saw, if any, as the main benefit(s) of having a new addictive disorders diagnosis. The second question, similar to the first, was what they saw, if any, as the main deterrent(s) of having a new addictive disorders diagnosis. The data resulting from these interviews are presented in the following section.

### Results

Of those who responded to the first question (i.e., “What is your opinion regarding the efficacy of adding a new addictive disorders diagnosis to the next edition of the DSM?”), 7 (54%) stated that they were in total support of adding the addictive disorders diagnosis, 5 (38%) shared that they were in support of the addition with some minor reservations, and 1 (8%) remained neutral to the need for the new disorder. Two participants chose not to answer this question, and 2 participants’ answers were discarded because I was unable to read and/or understand their answers.

The second question asked participants to share what they believed were some of the main benefits of adding the addictive disorders diagnosis to the DSM-V. Among the participants, various supportive comments were made. Grouping these comments together by common themes resulted in three categories: training/education/research benefits, client benefits, and clinical benefits. Each of these categories is briefly explored in the Discussion section.

The final question posed to participants was for them to list some of the main deterrents to adding the new diagnosis. Eight participants noted that there were no deterrents, whereas 9 shared their varied concerns. Grouping these comments together by common themes resulted in three categories: overlap with established disorders, pathologizing client behaviors, and complications related to insurance. Comments related to each of these categories are noted in the following section.

### Discussion

The results of this brief needs assessment cannot be generalized to the entire population of counseling students, practitioners, and educators. Similarly, participants who were surveyed likely had an interest in the subject matter given that they attended the poster session where data were being collected. Even with these limitations, the intent of this needs assessment was to secure a preliminary professional response to the need for the new diagnosis to see whether it matched the endorsement by IAAOC.

The results indicated that most participants (91%) endorsed the addition of the new diagnosis. The recorded comments pertaining to the benefits of adding the new diagnosis resulted in three categories: training/education/research benefits, client benefits, and clinical benefits. The comments related to the training/education/research benefits included (a) the increased preparedness of future clinicians, (b) the expansion of an understanding of addictions, and (c) the development of empirical research related to the various addictive
disorders. For client benefits, participants noted that clients would (a) have a better understanding of their disorders, (b) be able to use their insurance to help offset the costs of treatment, and (c) be able to find treatment that up to this point had been unaffordable because of the lack of a formal diagnosis. Finally, the various clinical benefits included (a) a shared recognition of these disorders with the medical profession, (b) a more inclusive treatment approach that addresses all addictions simultaneously, (c) the establishment of a standardized assessment and treatment protocol, (d) increased reimbursement by third-party payers, and (e) a better clinical understanding of these disorders that distinguishes them from SUDs and ICDs.

In addition to the various benefits of adding the new addictive disorders diagnosis, participants shared several statements related to the challenges and deterrents of making this change. These comments were grouped according to categories named overlap with established disorders, pathologizing client behaviors, and complications related to insurance. Regarding the concerns with overlap with established disorders, participants noted that (a) many of the proposed addictive disorders already have DSM-IV-TR (APA, 2000) diagnoses (e.g., How would they be distinguished from such things as eating disorders or pathological gambling?) and (b) the new diagnosis may be too much of a catch-all set of disorders that do not sufficiently encompass specific ICDs. Comments that were grouped under the category pathologizing client behaviors included (a) this diagnosis may overpathologize clients’ symptomology, (b) this diagnosis may add additional (and potentially harmful) labels to client behaviors, and (c) there are currently too many DSM-IV-TR labels without an additional diagnosis. Finally, participants noted several concerns connected to complications related to insurance. These consisted of (a) the likely outcry of insurance companies and the related increase in health care insurance costs; (b) once these diagnoses get onto clients’ records, they will follow clients wherever they use their insurance; and (c) the politics of the insurance and medical professions will likely prevent the development of this diagnosis.

Overall, the results of this preliminary needs assessment supported ongoing exploration of the need for a new addictive disorders diagnosis. A few obstacles or challenges arose, including the need to settle disputes that will likely be initiated by insurance companies that may avoid the coverage of treatment for previously unrecognized disorders (e.g., sexual addiction); the resulting increase in health care costs to cover the number of disorders that will finally be given the clinical attention they deserve; and the importance of not overdiagnosing, mi-diagnosing, or labeling clients’ behaviors as addictive (i.e., not seeing everything as an addiction). Even with these anticipated challenges, the Committee on Process Addictions, as well as the leadership of IAAOC, believes that the increased attention to these disorders, provided in the form of proper clinical training, improved prevention efforts, and standardized treatment protocols, will pave the way for healthier clients, families, and communities.
Definition, Criteria Development, and Subtypes for the Addictive Disorders

The final goal of this position paper is to combine the findings from the literature review with the positions established by professional counseling organizations and the results from the brief needs assessment to describe in some detail a new diagnosis and its subtypes.

Addictive Disorders: The Definition

In working toward a definition of the addictive disorders, one might combine criteria from the definition of chemical dependence (focusing on those elements that are necessary and sufficient for dependence) and then add the similar features that have been noted earlier with ICDs and OCDs. Goodman’s (2001) suggested definition for an addictive disorder has great merit.

A behavior that can function both to produce pleasure and to reduce painful affects is employed in a pattern that is characterized by two key features: (1) recurrent failure to control the behavior, and (2) continuation of the behavior despite substantial harmful consequences. (p. 195)

Addictive Disorders: Diagnostic Criteria

With an appropriate definition for the addictive disorders having been determined, the development of specific and observable criteria needed for diagnosis is necessary. Several authors developed such criteria by adapting those that have already been established for compulsive gambling (Goodman, 1993; Levin, 1999; Young, 1998). Goodman (2001) further adapted these criteria by (a) exchanging behavior for the words substance and substance use in the established criteria for substance dependence and (b) applying a more encompassing definition for withdrawal that would include all addictive behaviors. Therefore, the criteria for the diagnosis of an addictive disorder include common or shared features (see Appendix).

Goodman’s (2000) proposed definition and diagnostic criteria have been substantiated throughout the literature, with some authors even stating that the criteria may be more stringent than they need to be. For example, Cassin and von Ranson (2007) noted that the participants of their study (women with binge-eating disorder) met modified criteria for chemical dependency more readily than they did for the addictive disorder. Additional research may therefore be warranted to determine whether these criteria are both valid and reliable across all client populations. Nonetheless, the applications of the aforementioned criteria have shown repeated efficacy in clinical practice (e.g., Carnes, 2001; Schneider & Irons, 1996) and may be adapted for use with any addictive chemical or behavior.

Addictive Disorders: Subtypes

One way to designate subtypes for the addictive disorders is to return to the literature describing the shared and unique characteristics of particular
process addictions or addictive disorders. The following subtypes are well established in the literature.

1. **Addictive disorder, eating type.** A maladaptive pattern of eating-related behaviors (e.g., binging, restricting, and/or purging), leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Campana, Riglietta, & Tidone, 1998; Garner & Gerborg, 2004; Petrucelli, 2004; Trotzky, 2002).

2. **Addictive disorder, exercise type.** A maladaptive pattern of exercise behaviors (e.g., running, gym activities, and exercise classes), leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Cockerill & Riddington, 1996; Garman, Hayduk, Crider, & Hodel, 2004; Munroe-Chandler, Kim, & Gammage, 2004).

3. **Addictive disorder, gambling type.** A maladaptive pattern of gambling behaviors (e.g., betting on sports events and playing machines or table games), leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Blume, 1995; Buchta, 1995; Chamberlain, 2004; McCown, 2004).

4. **Addictive disorder, Internet type.** A maladaptive pattern of Internet behaviors (e.g., gambling, sex, instant messaging, purchasing, information surfing, role playing, and gaming), leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Armstrong et al., 2000; Barbora & Jan, 2004; Block, 2008; Nalwa & Anand, 2003; Young, 1999).

5. **Addictive disorder, sexual type.** A maladaptive pattern of sexual behaviors (e.g., masturbation, pornography, multiple sexual partners, and exhibitionism), leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Abouesh & Clayton, 1999; Carnes, 2001; Goodman, 2001; Levin, 1999; Mahorney, 2002; Schneider, 2004; Weiss, 2004).

6. **Addictive disorder, spending type.** A maladaptive pattern of spending behaviors (e.g., purchasing gifts or buying unnecessary or multiple items), leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Benson & Gengler, 2004; Dittmar, 2004; Kausch, 2003; Lee, Lennon, & Rudd, 2000; Lejoyeux, Ades, Tassain, & Solomon, 1996).

7. **Addictive disorder, work type.** A maladaptive pattern of work-related behaviors (e.g., spending excessive time or energy on work projects),
leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period (Berglas, 2004; Burke, 2004; Harpaz & Snir, 2003; McMillan & O’Driscoll, 2004; Robinson, 2000; Robinson & Flowers, 2004).

8. *Addictive disorder, NOS.* A maladaptive pattern of addictive behaviors that do not meet the criteria of any specific addictive disorders subtype, leading to clinically significant impairment or distress, as manifested by three (or more) of the criteria for an addictive disorder, occurring at any time in the same 12-month period. Examples of behaviors that may be found in this category include television viewing, video gaming, religious practices, and relationships.

**Conclusion**

The IAAOOC Committee on Process Addictions would like to advocate for the professional recognition of a new diagnosis: the addictive disorders. The proposed diagnosis combines criteria from several disorders in such a manner that it captures the core characteristics. Particular subtypes have been identified in the literature. This is an important first step in bringing researchers, educators, and clinicians together with a common goal of providing competent and comprehensive client care. The new diagnosis could be presented to an APA work group as they move toward consensual validation of disorders for the *DSM-V.*

Clients seldom present with a single addictive disorder (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Delmonico & Griffin, 1997; Hagedorn, 2003; Ledgerwood & Downey, 2002; Merta, 2001; Potenza, 2002; Rowan & Galasso, 2000). As such, multiple addictions should be treated simultaneously so as not to repeat therapeutic interventions for each disorder (Hagedorn & Juhnke, 2005; Juhnke & Hagedorn, 2006). Corresponding diagnostic criteria for the addictive disorders could be effectively used as a clinical framework for treatment. Ultimately, such a diagnosis would have positive and far-reaching implications for clinicians, researchers, and clients with an addiction and their families.

**References**


**APPENDIX**

**Diagnostic Criteria for Addictive Disorders**

A maladaptive pattern of behavior, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following:
   a. a need for markedly increased amount or intensity of the behavior to achieve the desired effect
   b. markedly diminished effect with continued involvement in the behavior at the same level of intensity

2. withdrawal, as manifested by either of the following:
   a. characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the behavior
   b. the same (or a closely related) behavior is engaged in to relieve or avoid withdrawal symptoms

3. the behavior is often engaged in over a longer period, in greater quantity, or at a higher intensity than was intended

4. there is a persistent desire or unsuccessful efforts to cut down or control the behavior

5. a great deal of time spent in activities necessary to prepare for the behavior, to engage in the behavior, or to recover from its effects

6. important social, occupational, or recreational activities are given up or reduced because of the behavior

7. the behavior continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the behavior (Goodman, 2001, pp. 195–196).