CSAM news
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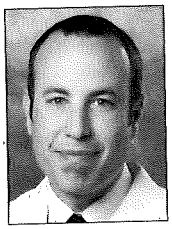
## CSAM's Forum for Dialogues in Addiction Medicine

# Behavioral Addictions

ADDICTION MEDICINE FORUM

By Itai Danovitch, MD, CSAM Newsletter Editor



This issue of the newsletter features three articles offering insightful perspectives on "behavioral addictions." Why the quotation marks around this subject? Because having emerged from the treatment and study of substance use disorders, the addiction field has not quite figured out where behaviors fit in. Uncertainty about how to categorize disorders of gambling, shopping, sex, and gaming, is reflected both in the range of terms that is used to characterize them ("pathological," "compulsive," "impulsive," "addictive") as well as their frequent movement within our diagnostic manuals. One recurring question is: Do compulsive, maladaptive behaviors belong alongside, or apart from, substance use disorders?

*"Do compulsive, maladaptive behaviors belong alongside, or apart from, substance use disorders? It is tough to answer this question without asking another one: Do substance use disorders have more to do with the addictiveness of the person or the drug?"*

It is tough to answer this question without asking another one: Do substance use disorders have more to do with the addictiveness of the person or the drug? Unfortunately, the answer is not as black and white as the question. Substance use disorders result from a gene-environment interaction, whereby intrinsic biological vulnerability interacts with environment to produce a phenotype. While a number of addiction endophenotypes have been proposed, our most reliable definitions are based on phenotypic consequences—physical, psychological, social, legal. Further, we have tended to attribute the characteristic of addictiveness to the drug, which we call "addictive." Though most drugs of abuse have a characteristic ability to potentiate dopamine release in the mesolimbic system, we recognize this is not sufficient to generate "addiction." What makes a drug addictive has to do with its interaction with a vulnerable host.

**Enter behavioral addictions.** Imaging studies show that behavioral addictions are associated with alterations in many of the same brain areas as substance use disorders. But, compared to substance use disorders, behavioral addictions are not confounded by drug-induced neuroadaptation. Perhaps behavioral addictions are relatively untarnished manifestations of intrinsic compulsivity, reward dependence, impulsivity, and low self-directedness, all traits that we tend to see as underpinnings for substance use disorders.

The articles in this issue by **Tim Fong, MD, Reef Karim, MD, Rob Weiss, LCSW,** and **Allen Frances, MD** offer compelling insights into the phenomenology, assessment and treatment of behavioral addictions. They reveal how much the syndrome of behavioral addiction has in common with the syndrome of substance use disorders. They also thoughtfully raise the persisting question: What, exactly, is addiction anyway? ■

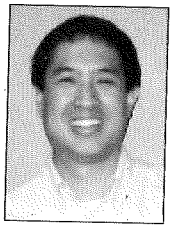
*Itai Danovitch, MD, is an assistant professor of psychiatry and behavioral neurosciences at Cedars-Sinai Medical Center. He is a member of CSAM's Committee on Public Policy.*

*Behavioral Addictions continued on page 2*

# Conceptualizing Pathological Gambling: What Is It?

ADDICTION MEDICINE FORUM

By Timothy W. Fong, MD



Pathological gambling is currently classified in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-4) under the section entitled, Impulse Control Disorder Not Elsewhere Classified.[1] The essential feature of Impulse-Control Disorders is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. Individuals report an increasing sense of tension or arousal before committing the act and then experiences pleasure, gratification, or relief at the time of committing the act. Following the act there may or may not be regret, self-reproach, or guilt. Impulse Control Disorders have been thought as separate, but related disorders to a wide variety of conditions including substance-related disorders, obsessive-compulsive disorders and personality disorders.

*"Emerging research from the field of neuroscience has begun to differentiate and distinguish the varying conceptualizations of pathological gambling. Most notably, recent neuroimaging studies have shown brain regions involved substance-related disorders are also involved in pathological gambling."*

Further clouding the issue is that fact that there have been numerous names used to describe pathological gambling including, problem gambling, gambling addiction, compulsive gambling, disordered gambling and gambling-related disorders. The term compulsive gambling arose from its roots in psychoanalysis and focuses on themes of self-sabotage in the face of seemingly irrational and repetitive behavior. Compulsive behaviors are thought of as ego-dystonic, yet most pathological gamblers talk about high levels of enjoyment and pleasure from gambling. When gambling did get accepted into the official diagnostic handbook, it was not as compulsive gambling but as pathological gambling.

The criteria of pathological gambling, has marked similarities to substance-related disorders (e.g. tolerance, withdrawal) while there are other unique criteria such as chasing losses. As a result of this overlap in symptomatology, there has been considerable debate and confusion on how to conceptualize pathological gambling. Clinically, it resembles substance-related disorders due to the loss of control over engaging in immediately rewarding experiences. On the other hand, because no drugs are ingested, questions have arisen about whether or not one can become addicted to a behavior. Finally, there is the issue of impulsivity. Pathological gamblers have been shown to be more impulsive on personality testing, behavioral testing and in clinical presentation.[2] Yet, impulsivity and compulsivity would be appear to be on opposite ends of the spectrum in terms of conceptualization – impulsivity is acting without thinking about the consequences while compulsivity is having to act due to an irresistible urge.

Emerging research from the field of neuroscience has begun to differentiate and distinguish the varying conceptualizations of pathological gambling. Most notably, recent neuroimaging studies have shown brain regions involved in substance-related disorders are also involved in pathological gambling.[3] Neurocognitive and neuropsychological profiles of pathological gamblers show similar deficits in executive functioning, planning and memory that are also seen in substance-related disorders.[4] These data have been instrumental in demonstrating that pathological gambling, like substance-related disorders, is in fact a brain disease that has a unique and reproducible pathophysiology.

In addition to research, treatment settings for pathological gambling have remained primarily within substance abuse settings, furthering the notion that this condition is related to addictive disorders. Nationally, many state funded treatment programs for pathological gambling are housed within divisions and agencies focused on delivering addiction treatment and not mental health.

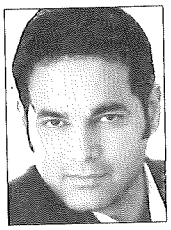
In preparation for the creation of the DSM-5 manual (due out in 2012) the issue of where to place pathological gambling continues to be investigated but it would appear that it will land within the area of addictions. As it currently stands, it is being reviewed with the substance-related disorders workgroup and it has been proposed that pathological gambling be reclassified from Impulse-Control Disorders Not Elsewhere Classified to the substance-related disorders

*continued on page 10*

# "Out of Control Behaviors: Sex, Gambling, Shopping, Food, Videogames... Should Behavioral Addictions Be Classified As Real Disorders?"

ADDICTION MEDICINE FORUM

By Reef Karim, DO



"Show me the data" "Show me the data"... cried out the CSAM physician in his best 'Jerry Maguire' impersonation."

It was at the CSAM State of the Art Conference 2009 and the controversial topic: "Are behavioral/process addictions real disorders?" was being heavily debated in the closing minutes of the "Out of Control Behaviors" workshop. It was a split room; half the attendees were convinced that the constellation of symptoms and impairment in functioning were enough to warrant the "disorder" status. The other half were not so convinced. They felt these behaviors were just symptoms of other disorders and there wasn't enough in common for these "behaviors" to have their own category, let alone individual disorder status like "sex addiction", "shopping addiction" and "pathological gambling". The discussion led to other relevant questions including: When do you stop diagnosing? Can any behavior become an addiction? Can watching television become an addiction? Eating chocolate? Identifying with the Lakers?

*"There are people out there suffering from these symptoms who may seek help if properly screened but the question many clinicians ask is "what do you do with them?" Do you treat these behavioral addictions like chemical addictions?"*

The word "addiction" can be defined in many ways. Traditionally, the dependence on drugs of abuse causing neuroadaptation has worked as a primary definition. Is it time that we open up this definition to include abnormal repetitive behavioral patterns as "non substance" forms of addiction? It's obviously a controversial topic. The inclusion of behavioral addictions may "medicalize" bad behaviors or bad habits and where do we draw the line between an excessive bad behavior and a true addiction? There is a distinct possibility that adding many more "disorders" to the diagnostic and statistical manual of mental disorders may effectively dilute pathological behavior and pathologize variants of normative behavior. Further, adding more diagnostic disorders may increase the general public's suspicion of the validity of psychiatric disorders in general.

Is the term "addiction" limited to substances?

Currently, online gambling, online shopping and online porn are causing major impairment in many families. State funding problems are accelerating the proliferation of legalized gambling. Food portion, food content (salt, sugar and fat) and predisposition to diminished dopamine tone can facilitate binge eating. As such, these disorders may be growing in numbers and there have been many debates in our field as to what to do with these behaviors specifically in regards to the upcoming DSM-5 revision.

Behavioral conditions can cause significant emotional distress, quality of life impairment, executive function difficulties and increased health care utilization. The condition is predicated on the irresistible impulse, excessive thoughts and poorly controlled behaviors that are at least initially pleasurable. The difficulty in categorization is that they all involve different target behaviors and there is no consistent approach to define them or even name them for that matter (impulse control disorders, behavioral addictions, compulsive disorders, process addictions, etc.)

Legitimacy in the field is determined by research. And there just isn't enough research on this topic. Researchers in the field of impulse control disorders, behavioral addictions and process addictions will tell you that funding is hard to come by and these behavioral disorders have largely been excluded from major psychiatric epidemiological surveys.[1] There are people out there suffering from these symptoms who may seek help if properly screened but the question many clinicians ask is "what do you do with them?" Do you treat these behavioral addictions like chemical addictions?

I treat many of these conditions. And whether you are a skeptic or a believer, you can't deny the fact that there are people out there struggling with impulsive or compulsive behaviors associated with gambling, sex, food, shopping, videogames, etc. So, as the CSAM member asked, let's look at a little data.

The study of food addiction and binge eating has gained popularity as our obese population has grown significantly. Brain imaging studies in humans implicate the involvement of dopamine modulated circuits in pathological eating behavior. And similar to drug addicted subjects, striatal dopamine D2 receptor availability is reduced in obese subjects which could explain how food could temporarily

*continued on page 13*

# When Sex is the Drug

By Robert Weiss, LCSW, CSAT

Often fodder for daytime talk shows and grocery-line literature, today the diagnostic concept of "sexual addiction" is rapidly gaining credibility as a legitimate clinical condition. First listed in the DSM-3-R in 1987 as non-paraphilic sexual addiction and later deleted from the DSM-4 and DSM-4-tr, the diagnosis of Hypersexual Behavior Disorder is now under consideration by The APA Sexual and Gender Identity Disorders Work Group for possible inclusion in the DSM-5. A cursory review of the criteria (shown below) reveals a number of similarities with substance use disorders, and raises the question of whether "hypersexual behavior" is actually a form of "addiction." This review will not address the phenomenology of addiction, but rather will attempt to provide a clinical perspective on why some individuals pursue sex as if it were a drug (we'll call them "sex addicts"), and what can be done to help them.

### Hypersexual Disorder Proposed Diagnostic Criteria

A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:

(1) Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.
(2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
(3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events.
(4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.
(5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.

C. These sexual fantasies, urges, and behavior are not due to direct physiological effects of exogenous substances (e.g., drugs of abuse or medications) or to Manic Episodes.

D. The person is at least 18 years of age.

### Why They Act Out

While most healthy adults experience sexuality as an integrated life affirming experience, for some individuals sexuality is better-described using words such as driven, compulsive, shameful, and secretive. These people compulsively pursue various forms of intense emotional and sexual arousal in an attempt to cope with and ward off unmanageable emotional states and life stressors. As the Internet has provided easy access to both explicit pornography and anonymous sexual contact, more clients and their spouses are seeking clinical solutions for the problems generated by porn use and casual sexual "hook-ups."

Sex addicts describe experiencing overwhelming emotional intensity and emotional arousal even when simply fantasizing about their sexual activity of interest and describe this emotional state as like "being in the bubble" or "being in a trance." When "acting out" sex addicts describe "losing" hours, even days to scanning online pornography and prostitute sites, cruising for prostitutes and sensual massage and searching steam rooms and adult bookstores for potential sexual encounters, often without actually experiencing genital arousal or even engaging in the sex act itself. In fact it could be argued that, like the compulsive gambler, who is at least as invested in staying in the game for as long as possible as in actually winning or losing, for sex addicts, maintaining the 'high' of intense sexual cruising and fantasy is at least as important, if not more so, than the actually having sex or achieving orgasm. Some sexual addicts present as more compulsive — repeatedly engaging in specific sex acts over and over, like compulsive masturbation to online porn, while others act out in more of a binge pattern, based on emotional stressors, opportunity and sexual triggers. While some sexual offenders — exhibitionists and child-porn users for example — also demonstrate similar repetitive and compulsive behavior patterns when sexually acting out, most sex addicts are not sexual offenders as they do not initiate or engage in non-consensual sexual activity.

### Assessment and Treatment of the Sex Addict

Working with sexual addicts requires a skill set that emphasizes client accountability, limit setting, confrontation of denial, 12-step orientation and cognitive-behavioral strategies, all within an empathic, relational framework. Detailed assessment, boundary setting, properly aligned treatment planning and accurate referral are key. The treating professional must consider and rule out other mental health diagnoses that also might cause hyperactive sexual behavior like bipolar disorder or amphetamine abuse/dependency. Extensive, sometimes explicit, but always detailed information about

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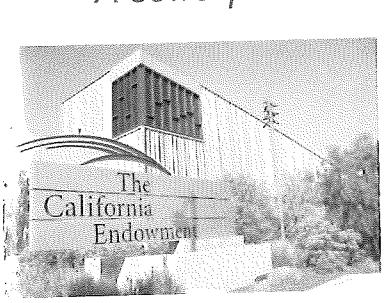
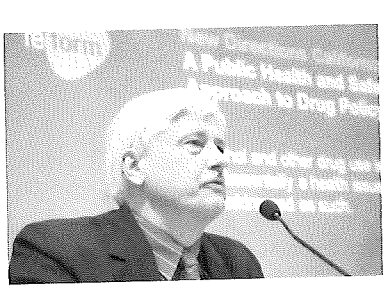
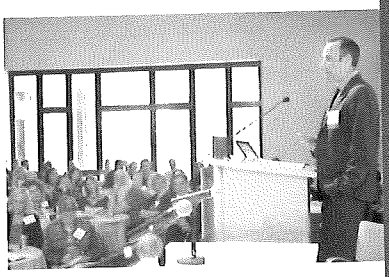
# New Directions California:
# A Public Health and Safety Approach to Drug Policy

*A colloquium convened by CSAM and the Drug Policy Alliance*







It was a broad cross section of people that came together on July 8, 2010 to review a common purpose and build a common effort for achieving drug policy reform by bringing a public health approach to California. The meeting center in the California Endowment's Center for Healthy Communities in downtown Los Angeles was standing room only, crowded with over 400 physicians, public health workers, change advocates, community organizers, scholars, researchers, and civic leaders. Speakers included spokespersons from cities, states and countries with long standing drug policies based on decriminalization of drug use and possession—real world examples of what can be done to bring about changes in U.S. drug policy and how current policies are being implemented in our communities.

The purpose of the day's activity, initiated by CSAM's Committee on Public Policy chaired by **Christy Waters, MD**, was to bring interested organizations and people together into a committed and coordinated course of action. The sponsors were CSAM and the Drug Policy Alliance. The two organizations brought in presenters from different fields to provide the background, the experience, and the vision. Portions of the day were devoted to prevention, harm reduction, treatment, law enforcement and criminal justice. Speakers from as nearby as South Central Los Angeles or Children's Hospital of Los Angeles, to as far away as Portugal and Canada brought first hand experience, and data, to the audience and answered questions about "how it really works."

## Where Are We Now: Drug Policy around the World and Here at Home

Moderated by **Peter Banys, MD**

**PANEL:**

**Donald MacPherson**, former Drug Policy Coordinator for the City of Vancouver

**Robert Garner**, Santa Clara County Alcohol and Drug Program Administrator

**Pete White**, Founder and Co-Director of the Los Angeles Community Action Network

**Ruth Finkelstein**, Vice President for Health Policy at The New York Academy of Medicine

**Fatima Trigueiros**, Senior Advisor to the Executive Board of the Institute on Drugs and Drug Addiction, Portugal described Portugal's policies and procedures for decriminalization of illicit drugs. Trigueiros listed the objectives of Portugal's Model as:

- To dissuade consumption;
- To prevent and reduce drug use and abuse;
- To ensure the sanitary protection of consumers and the community;
- To liberate resources for the fight against drug trafficking as well as petty crime related to drug acquisition for one's own consumption.

Portugal uses the "Dissuasion Model" and it is based on the agreement that consumption of illegal drugs is not merely private choice, because of its social effects. Portugal's public policy holds that the drug addict is a diseased person in need of health care and the dissuasion model provides an opportunity for an early, specific and integrated interface with drug consumers. Dr. Trigueiros said that an important aspect in the development and implementation of this policy is that it liberates resources for the fight against drug trafficking as well as petty crime related to drug acquisition for one's own consumption.

## Prevention: In More Places Than You May Think

Moderated by **Jeffery Wilkins, MD**

**PANEL:**

**Marsha Rosenbaum**, President of the JK Irwin Foundation in San Francisco – prevention carried out in homes where we talk with our sons and daughters about what drug use means to them and to us, and what they can do to protect themselves and their friends.

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# New Directions California

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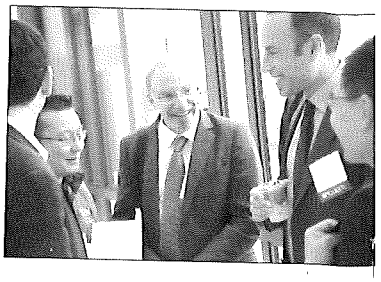

**Froggy Vasquez**, Organizer, Youth Justice Coalition – prevention carried out in schools, replacing zero tolerance with restorative practices that bring young people closer to the mentors and role models rather than expelling them from the school community

**Bruce Livingston**, Executive Director of Marin Institute – in policy research centers and advocacy organizations that track the industry actions such as the monitoring of the influence of the two largest beer companies in the world.

**Allen Hopper**, Litigation Director of the National ACLU's Drug Law Reform Project – in court rooms where case law emerges

**Bamby Salcedo**, Transgender Services Project Coordinator with Childrens Hospital Los Angeles – prevention in getting access to HIV treatment resources

## Public Health Interventions, Integrated Approaches, and Harm Reduction: Doing the Most Good

Moderated by **Barry Zevin, MD**

**PANEL:**

**Patt Denning**, Director of Clinical Services and Training at the Harm Reduction Therapy Center

**Fred Brason**, President/CEO of Project Lazarus

**Becky Kanis**, Director of Innovations for Common Ground, the New York City nonprofit creating and managing affordable, supportive housing and employment programs for homeless, disabled, elderly and low income people, described the project that is aimed at 100,000 Homes for 100,000 Homeless Americans by July 2013.

**Rod Shaner**, Medical Director of the Los Angeles County Department of Mental Health, described Project 50, modeled after the project of Common Ground to dramatically reduce the number of people living on the streets in New York City's Times Square. Dr. Shaner gave a current status report and outcome information about Los Angeles' a highly integrated experimental project to house the most vulnerable chronically homeless people on Skid Row.

**Sergeant Richard Schnell**, Homeless Outreach Team, San Diego Police Department

## Where Does Marijuana Policy Fit In?

**Itai Danovitch, MD**, Director of Addiction Psychiatry Services and Associate Director of the Addiction Psychiatry Fellowship Program in the Department of Psychiatry and Behavioral Neurosciences at Cedars-Sinai, reviewed the core principle of the CSAM Position on the Medical Aspects of Cannabis Legalization: while the public should decide the issue of marijuana legalization through the legislative process, CSAM strongly recommends that any legislation legalizing the use of marijuana should contain the following essential components:

I. Effective restrictions to minimize access to marijuana for anyone under 21 years old.

II. Universally available treatment, not punishment, for adolescent marijuana abusers

III. Revenue stream for treatment funded by fees and taxes from marijuana sales

IV. Warning labels on smokeable products

V. Regulation of Marketing (Advertising), Distribution, and Sales

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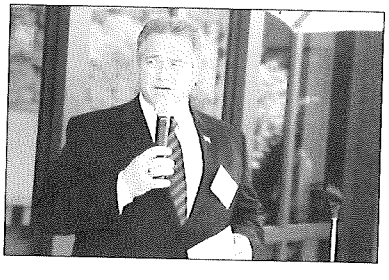
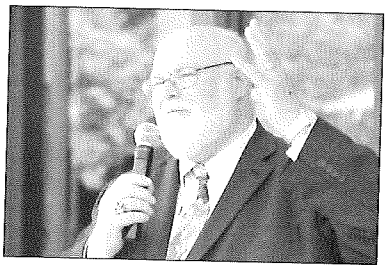
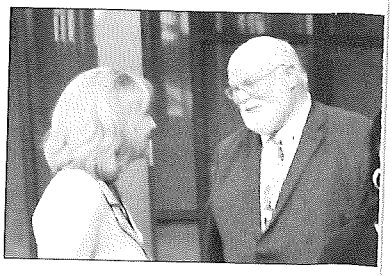

## New Directions California

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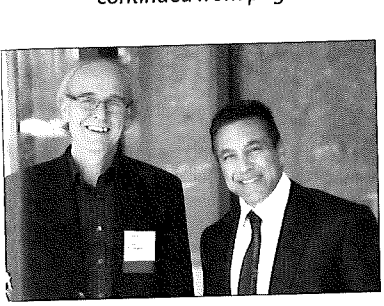
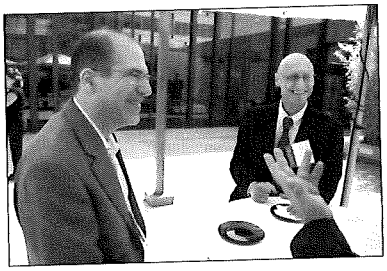

VI. Evaluation to document impact of legalization

VII. Provision for the technical difficulties documenting driving under the influence

**Martin Iguchi, PhD**, Martin Iguchi, PhD, Professor and Chair, Department of Community Health Sciences, UCLA School of Public Health; formerly Rand Drug Policy Research Center, lead the group through a brief analysis of decriminalization models showing how to weigh the harms of use of the drug itself against the harms of all the different elements of enforcement and incarceration. Legalization would be expected to result in an increase in consumption and the associated harms to the individual as well as a decrease in the burden for the community, such as the burdens of law enforcement and incarceration. Moreover, current restrictions on the person's ability to sustain themselves in society (can't get housing assistance, can't get food stamps) would evaporate, further reducing the stress on the community.

As we study and weigh the variables, we conclude that there are these competing realities: when a drug is illegal, it is less available but potentially more damaging to those who use it and to the larger community.

### Treatment: It's About Evidence, Access and Economics

Moderated by **Judith Martin, MD**

**PANEL:**

**Robert Garner**, Santa Clara County Administrator of Alcohol and Drug Services

**Eugenia Oviedo-Joekes**, PhD, North American Opiate Medication Initiative (NAOMI), described the evidence from studies conducted in Vancouver and Montreal that indicates that prescribed heroin for injection is effective, feasible and safe.

**Richard Rawson**, Associate Director of UCLA Integrated Substance Abuse Programs, described how health care reform can change the delivery of treatment for addition.

- A wide range of substance use disorders will be addressed in treatment, not just the most severe.
- Patients will be viewed as respected healthcare consumers and will have choice about treatment types and goals.
- There will be an increasing focus on consumer satisfaction and consumer perception of care
- Treatment for substance use disorders will become more integrated into the healthcare delivery system and become less associated with the criminal justice system.
- Treatments will be have to "attract" patients because of their effectiveness, convenience and acceptability, rather than relying on patient coerced into treatment
- Treatments will need evidence of effectiveness and will be accountable.

### Public Safety: Striking the Right Balance

Moderated by **Thomas J. Brady, MD**

**PANEL:**

**Kash Heed**, Member of the British Columbia Legislative Assembly

**Kyle Kazan**, retired Officer, Torrance Police Department

**Shoshanna Scholar**, Executive Director of Clean Needles Now in Los Angeles

**Fatima Trigueiros**, Senior Advisor to the Executive Board of the Institute on Drugs and Drug Addiction, Portugal

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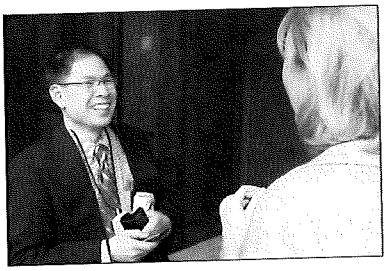


# The Unmaking of Addiction

By Peter Banys, MD, MSc

Neither laws nor public initiatives can make or unmake drugs addictive. Addiction is an interactive property of the chemical meeting a receptive host. Only about 10% of American men are addicted to alcohol. In that case, the majority of risk (of being a receptive host) is genetically inherited. The percentage risk for addictivity to marijuana is not definitively known, but is likely to be somewhere under 9%, and most problematic for youth.

Denying insurance coverage is a well-developed art among insurance companies. They have long ago mastered methods of denying coverage for pre-existing conditions, for expensive chronic conditions, for unusually expensive or new (experimental) medications, and for exceeding yearly or lifetime caps. Who really knows what new and creative methods they will find to reduce their fiscal obligations to medical care? For example, clinicians and researchers not long ago developed a gold-standard medication (buprenorphine) for maintenance treatment of opioid addiction and California Blue Cross simply and against all data declared it a short-term detox treatment.

Arguments for marijuana legalization and regulation do not fundamentally turn on its beneficence. More widespread use will increase true addiction to it by some small (<9%) percent of the additional users...although one must certainly note that when 1/3 of HS seniors are regular smokers, then access is pretty widespread already. So, yes, there will be an increased burden in public health costs.

The argument in favor of Proprosition 19 is in a separate domain of public discourse entirely; it is fundamentally about the social and fiscal costs of continuing to provide low-hanging fruit for a massive incarceration industry, the most vigorous per capita in the entire world, helping to bankrupt the state. In California it costs more to go to prison than to Stanford. Criminal records interfere with federal education grants and with employment opportunities. Minorities in California are disproportionately arrested and disproportionately prosecuted for marijuana possession. (Indeed, some years ago two incarceration trend lines crossed—we now incarcerate more individuals for possession than for trafficking.) Finally, it might be noted that a century of history of marijuana demonization in America has always found it closely tied to xenophobia and coarse political agendas, first to Mexican migrants in the Southwest around the time of the Great Depression, then to Blacks in New Orleans during the jazz age, then to hippies/war protesters/students in the 1960's.

The national War on Drugs can be said to have taken off about 1980, roughly coincident with a rapid rise in cocaine use. Three decades later we have increased our incarcerated population in America from about one million to nearly 2.5 million. We have over-filled the prisons, created wicked mandatory sentencing, all without meaningfully diminishing demand for a large variety of drugs, most of which have become relatively purer and cheaper during the interim. I once asked a narcotics officer why with all the high-potency stuff around like heroin, oxycontin, and meth did they continue to arrest folks for mere marijuana possession. He looked about to make sure his colleagues did not hear and said, "Well, Peter, they don't shoot back."

I suppose that the most fundamental meaning of a public initiative is that, depending on its wording, it provides a metric of public opinion. Initiatives don't redefine illnesses or medical realities. If they did, we should sit down to write Prop Panacea — which will outlaw all illness as un-Californian. ■

*Peter Banys, MD, MSc is Health Sciences Clinical Prof of Psychiatry at UCSF, VA Medical Center e-mail: Peter.Banys@ucsf.edu*

## Welcome
## New CSAM Members!

Marilyn Ancel, MD - *Oakland*

Kevin Gohar, MD - *Reseda*

Kevin Gohar, MD - *Woodland Hills*

Onsi Habeeb, MD - *Anaheim*

Jill Kimm, MD - *Porterville*

Nishant Kumar, DO - *Los Angeles*

Tucker Lawrence, MD - *Long Beach*

David Martorano, MD - *Pacific Palisades*

Hakop Oganyan, MD - *Los Angeles*

Shanti Rubenstone, MD - *Redwood City*

Farzin Yaghmaie, MD - *Los Angeles*

# 2010 Father Martin Award Winner Announced at NCAD Conference

## *Kurth is first physician to be so honored*

The Father Joseph Martin Award for Professional Excellence was awarded September 10 at the awards luncheon during the National Conference on Addictive Disorders (NCAD) at the Hyatt Regency Hotel in Washington, DC. **Donald J. Kurth, MD, FASAM** became the seventh recipient of the prestigious award, and the first physician to be so honored. **Fr. Mark Hushen**, President, CEO of the Father Martin's Ashley treatment center in Havre de Grace, Maryland presented the award saying: "Dr. Kurth has devoted his career to helping fellow addicts and their families.

*"Dr. Kurth uses his medical training to help alcoholics and addicts get the care they need, and has channeled his passion for helping others into serving as an elected official."*

Like Father Martin, he has become a vocal advocate of 12 step programs and speaks passionately about the dignity with which every alcoholic and drug addict deserves to be treated. Dr. Kurth uses his medical training to help alcoholics and addicts get the care they need, and has channeled his passion for helping others into serving as an elected official. His work with the American Society of Addiction Medicine (ASAM) has helped others in the medical field better understand the disease of addiction. He is a tremendous role model and is of someone who 'walks the walk and talks the talk' in the true spirit of recovery. I know Father Martin would be very pleased that Dr. Kurth is named the 2010 recipient of the Father Joseph C. Martin Professional Excellence Award."

Dr. Kurth is the president-elect of the ASAM. He has served as President of the California Society of Addiction Medicine (CSAM), is currently the Mayor of Rancho Cucamonga, California and serves on numerous medical boards and committees. He was nominated for the award by CSAM's President **Timmen Cermak, MD.** ■

Fr. Mark Hushen, President, CEO of the Father Martin's Ashley treatment center presented Dr. Don Kurth with the Father Martin Award for Professional Excellence on September 10.

**ABOUT FATHER MARTIN'S ASHLEY:**

Father Martin's Ashley is a nationally-recognized leader in the treatment of alcoholism and chemical dependence. Accredited by The Joint Commission and located on a 147-acre campus in Havre de Grace, Maryland, Father Martin's Ashley has, since being co-founded by Father Joseph C. Martin, S.S. in 1983, worked to heal addicts and help their families with the science of medicine, the art of therapy and the practice of 12-Step spirituality. Father Martin's Ashley is a division of Ashley, Inc., a 501(c)(3) non-profit organization, and has treated more than 32,000 patients, offering inpatient treatment as well as sobriety enrichment, DWI, and family and children's educational programs. Father Martin's Ashley has awarded the Father Joseph C. Martin Award for Professional Excellence since 2003 to an outstanding professional who demonstrates passion and commitment to helping alcoholics and addicts heal.

## Conceptualizing Pathological Gambling

*continued from page 2*

which will be renamed Addiction and Related Disorders.

Sorting out these issues of conceptualization and classification has enormous implications for the patients, providers and advocacy groups. There remains little doubt that pathological gambling brings about harm to individuals, families and society. According to a statewide prevalence survey conducted in 2005, approximately 4% of Californians meet criteria either problem or pathological gambling.[5] This represents nearly a million people who are in need of treatment, with the most vulnerable populations being African-Americans, disabled or unemployed. With a cost to California of nearly $1 billion annually, pathological gambling exerts a profound negative impact on society.

Longitudinal studies would help address these questions and provide much-needed information about the natural course and progression of pathological gambling. In addition, having shared datasets and treatment programs to compare diagnostic, prognostic and clinical phenomenology will also create significant advances in the field. Lastly, determining accurate, clinical subtypes of pathological gambling will help to clear the air of messy terminology and provide for more a more precise clinical understanding of this disorder. ■

*Timothy W. Fong, M.D. is director of the UCLA Impulse Control Disorders Clinic, an outpatient clinic that treats pathological gamblers with a combination of pharmacotherapy and psychotherapy. His primary research interest is to understand the neurobiological mechanisms that contribute to pathological behaviors. Additionally, he is also focused on developing and translating effective treatments from the laboratory to community settings. E-mail: TFong@mednet.ucla.edu.*

References:

1. American Psychiatric Association (APA) (1980). Diagnostic and statistical manual, 3rd edition. Washington, DC: APA.
2. Blanco, C., et al., A pilot study of impulsivity and compulsivity in pathological gambling. *Psychiatry Res*, 2009. 167(1-2): p. 161-8.
3. Potenza, M.N., et al., An FMRI Stroop task study of ventromedial prefrontal cortical function in pathological gamblers. *Am J Psychiatry*, 2003. 160(11): p. 1990-4.
4. Kalechstein, A.D., et al., Pathological gamblers demonstrate frontal lobe impairment consistent with that of methamphetamine-dependent individuals. *J Neuropsychiatry Clin Neurosci*, 2007. 19(3): p. 298-303.
5. Volberg, R., K. Nysse-Carris, and D.R. Gerstein, *2006 California Problem Gambling Prevalence Survey*. 2006, NORC.

## When Sex is the Drug

*continued from page 4*

the client's sexual history is required to help direct treatment planning and reduce shame.

> *"There are no approved medications for the treatment of "sexual addiction," however a number of agents show promise for alleviating associated compulsivity, emotional reactivity and situational depression."*

From the outset, it is vital to establish that the primary goal of treatment is containing and setting appropriate limits on sexual acting out. This foundation is created through mutually agreed-upon written contracts that clearly define healthy vs. problematic sexual activity. Sex addicts must be held strictly accountable to these and other therapeutic agreements, requiring the outpatient clinician to be ever vigilant in bringing up concerns such as broken commitments, late arrivals, payment issues and missed appointments. As these clients often have a history of trauma and emotional neglect it is not surprising that they may test boundaries in an indirect attempt to determine if they are truly seen and cared for by the treating professional. The clinician must be willing to confront patterns of minimization, seduction and avoidance while regularly setting limits in a directive way. As in most addiction cases, sexually addicted clients often need immediate help to negotiate and prioritize pressing crisis brought on by the sexual behavior itself such as relationship chaos or legal, health and career consequences. Referral to sexual addiction specific group therapy and twelve-step self-help programs will help clients gain the social support and peer relationships essential for shame reduction and ongoing sexual healing.

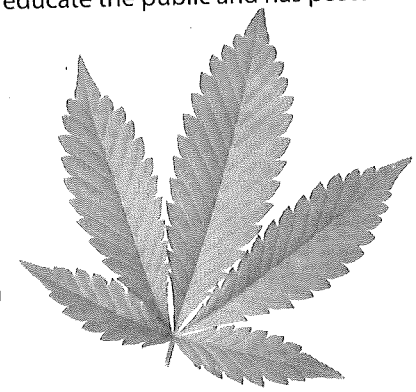
There are no approved medications for the treatment of "sexual addiction," however a number of agents show promise for alleviating associated compulsivity, emotional reactivity and situational depression. For example, the sexual adverse effects of serotonin reuptake inhibitors can actually be harnessed to dampen sexual drive and facilitate behavior

*continued on page 13*

# Cannabis/Marijuana Informational Resources

## *Available at CSAM Website*

Reasonable dialogue regarding marijuana use has historically proven extraordinarily difficult. Fortunately, scientific research has now uncovered a great deal about the effects of marijuana on the basic working of the brain that can form the foundation for a reasonable exchange. The California Society of Addiction Medicine (CSAM) seeks to educate the public and has posted these resources to **csam-asam.org**



Go to CSAM's website to find the items listed below on Cannabis:
http://www.csam-asam.org/CannabisInfo.vp.html

**CSAM's Statement on the Medical Aspects of Marijuana Legalization**
**CSAM's Position on Medical Marijuana**
**Text of the Regulate, Control and Tax Cannabis Act of 2010 (Proposition 19)**

### Marijuana's Addictive Potential
>> For the general public
>> For healthcare professionals

### Adverse Effects of Marijuana
>> For the general public
>> For healthcare professionals

The site also includes these resources:

- Introduction to CSAM's Evidence-Based Information on Cannabis/Marijuana Web Pages by **Timmen Cermak, MD**
- Cover article by **Timmen Cermak, MD** in the August 21, 2010 issue of *Insight Magazine* in the San Francisco Chronicle "Californians Must Look at the Science of Marijuana"
- Editorial article by **Itai Danovitch, MD** in the October 5, 2010 *Los Angles Times*, "Marijuana's health effects - Proposition 19 would legalize marijuana in California, but voters should be aware of the health risks associated with using the drug."
- "Altered State? Assessing How Marijuana Legalization in California Could Influence Marijuana Consumption and Public Budgets" by RAND Drug Policy Research Center | Brief Summary of RAND Report
- Australia's "National Cannabis Prevention and Information Centre"

**Visit the CSAM website: www.csam-asam.org**

***CSAM News*** is published quarterly by the California Society of Addiction Medicine (CSAM), an organization of approximately 400 physicians who specialize in the treatment of substance abuse. The specific purpose of the Society is to advance the treatment of alcoholism and other addictions through education of physicians, physicians-in-training, and other health professionals. Additionally, the Society promotes research, prevention, and implementation of evidence-based treatment. CSAM is a state chapter of the American Society of Addiction Medicine (ASAM).

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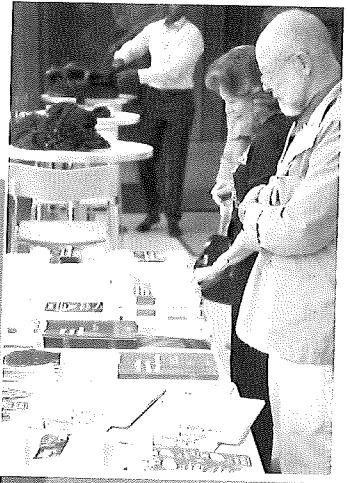

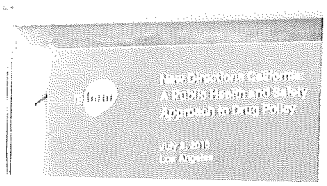


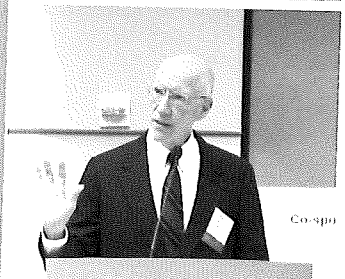

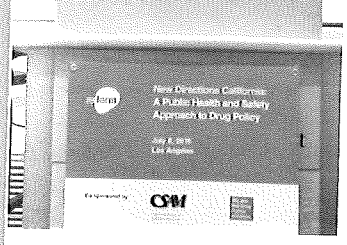


# New Directions California

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## Can this work?

Do we have any evidence that the integrated, coordinated approach will be effective in improving the public health? Yes; the examples are the now-required use of bicycle helmets and seat belts and consider the variety of tobacco-related mandates that have changed our lives and our health. For example, the admission rate to hospitals for myocardial infarctions has dropped 20 – 40% in communities that have banned smoking in public places. That was accomplished by taking known science and working together with organizations such as we have here in the room and our elected officials. This is something that could never be done by individual clinicians in our offices urging people to stop smoking, even if we prescribed a nicotine replacement system.

## What does it take to bring about the shift we need?

Change is not silent. **Christy Waters, MD**, described her personal experience this way. "I am a psychiatrist who spends much of the day listening to others, but I have stepped out and begun to speak up. With CSAM's Committee on Public Policy, I write letters that are sent to places where it makes a difference. I have been able to step out of my familiar office and meet with legislators and their staff members chosen because they were interested and some chosen because we saw their lack of knowledge about chemical dependency and drug policy. I have been able to testify before legislative committees and bring medical science to their discussions in a way that I could never do in the isolation of my clinical practice."

Out of this effort has emerged the "New Directions California Coalition", a network of nearly 100 organizations that have endorsed the following principles and want to advocate for health-centered policies:

- The war on drugs has failed and it is time for a new approach to drug policy.
- Effective drug policy balances prevention, harm reduction, treatment and public safety.
- Alcohol and other drug use is fundamentally a health issue and must be addressed as such.
- Drug policies must be based on scientific evidence, compassion, health and human rights.

In closing the day's activities, **David Pating, MD** (above) and **Ethan Nadelman, PhD** agreed that we must do "what ever it takes" to end the culture of incarceration as a mechanism of drug policy enforcement. ■

*Special thanks to **Gail Jara** for summarizing the events of this conference and to **Margaret Dooley-Sammuli** who coordinated the conference with CSAM's executive director **Kerry Parker, CAE**. The event was conducted under the direction of CSAM's Committee on Public Policy.*

## Out of Control Behaviors

*continued from page 3*

compensate for under-stimulated reward circuits (Volkow, 2008). In pathological gambling, neuroimaging studies reveal decreased activation of the vmPFC in pathological gambling subjects during presentation of gambling cues (videos) which resemble cocaine addicts watching a cocaine video (Potenza, 2003). There are many similarities in clinical presentation, cognitive behavioral therapy response and pharmacotherapy treatment response in some behavioral conditions when compared to substance disorders but there is very little data.

> *"Stay Tuned... as our technology continues to advance and our behaviors continue to show addictive properties, we may finally see enough funding to find some answers."*

Despite the fact that these conditions are fairly common and can lead to significant impairment, there are few researchers and little money invested in learning more. Many clinicians aren't aware of these disorders and fail to recognize them when present. At a minimum, we need researchers to better define these conditions with uniform diagnostic criteria and develop valid screening measures.

Although preliminary comparative research reveals similar neurocircuitry to chemical addictions, these behaviors require specialized treatment and a lot more research.

Stay Tuned... as our technology continues to advance and our behaviors continue to show addictive properties, we may finally see enough funding to find some answers. ■

*Reef Karim, DO, is an Assistant Clinical Professor Semel Institute for Neuroscience and Human Behavior; Associate Director, UCLA Addiction Medicine Clinic; Director, Beverly Hills Center for Self Control and Lifestyle Addictions. He is a member of the 2010 planning committee for CSAM's Review Course in Addiction Medicine.*

References:
1. Potenza, 2006
2. Volkow, 2008
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## When Sex is the Drug

*continued from page 10*

change. Serotonin reuptake inhibitors can also assist with frequently co-occurring mood symptoms. Active sex addicts and their spouses can be neglectful of their own physical health, necessitating a referral for necessary medical evaluations (including screening and treating venereal disease), healthy nutrition and exercise. Not surprisingly, some sex addicts have multiple addictions, substance and/or behavioral, requiring further evaluation or additional treatment planning. Treatment of co-occurring substance use disorders should generally be prioritized, as clients who are actively abusing substances are unlikely to be able to stop an addictive behavior problem until they have some period of chemical sobriety.

Following individual therapy, assessment, and shorter-term individualized interventions, addiction-focused group therapy is the preferred long-term method for most addiction work and for sexual addicts in particular, provided clients have the ego strength to tolerate a group experience. Group treatment provides non-sexual peer bonding, motivation toward behavior change and role modeling toward healthy intimacy. Sharing long kept secrets with the group helps to reduce long-held sexual shame. Effective group work group also reduces the cost of longer-term outpatient care for those who cannot afford ongoing individual work. Outpatient sexual addiction treatment generally has an eighteen to twenty-four month timeline supported by ongoing 12-step or faith based support/accountability groups. Those clients who are able to afford both individual and group work can utilize the group to deal with ongoing addiction, recovery and relationship concerns, thereby allowing individual therapy to refocus on family of origin concerns and early trauma. Referral to 12-step programs such as Sex Addicts Anonymous, Sexual Compulsives Anonymous, Sexaholics Anonymous and others, can provide much needed lifelong peer support toward change. ■

# DSM-5 Suggests Opening The Door To Behavioral Addictions

ADDICTION MEDICINE FORUM

By Allen Frances, MD

The recently posted first draft of DSM-5 (www. dsm5.org) has suggested a whole new category of mental disorders called the "Behavioral Addictions." The category would begin life in DSM-5 nested alongside the substance addictions and it would start with just one disorder (gambling). None of the other "behavioral addictions" suggested for DSM-5 would gain official status as a stand alone diagnosis. But if a clinician felt that the patient were "addicted" to sex, or to shopping, or to the Internet, or to working, or to video games, or to credit card spending, or to surfing, or to suntanning, or (my own personal favorite) to blogging on blackberries, or to whatever else (the list is long and could easily expand into every area of popular activity)--this could be diagnosed as "Behavioral Addiction Not Otherwise Specified" and thus receive the dignity of an official DSM code.

The rationale for this category is that compulsive behaviors follow the same clinical pattern and may even derive from the same neural network as compulsive substance use. The criteria set for pathological gambling developed for DSM-4 was modeled in close imitation to the criteria for substance dependence. Similarly, the DSM-5 draft criteria set for "hypersexuality" also uses the same items as define substance dependence and would seem to fit nicely as a "behavioral addiction"-although for some reason it has been proposed instead for the section on sexual disorders (one placement or the other, this is a bad idea for reasons detailed in a previous blog).

The notion that underlies the "addiction" concept is that the substance use (or behavior) originally intended for pleasurable recreation is now compulsively driven. Although the act is no longer the source of much pleasure, it has become so deeply ingrained that the person continues to perform it in a repetitive fashion despite great and mounting negative consequences. The evidence supporting the idea that someone is "addicted" would consist of the continuation (or even increase) of seemingly autonomous and driven behaviors despite the ever diminishing gain and the ever increasing cost. Subjectively, the person feels an escalating loss of control over the act and instead comes to feel increasingly controlled by it.

The rationale for a "behavioral addictions" category is that the subjective experience, clinical presentation, neurobiological substrate, and treatment indications for it are equivalent tothose for substance addiction. But the proposal has one fundamental problem and an assortment of negative unintended consequences that should be more than sufficient to disqualify it from further consideration.

The fundamental problem is that repetitive (even if costly) pleasure seeking is a ubiquitous part of human nature-while compulsive behavior that is not rewarding is relatively rare. But on the surface it is extremely difficult to tell the two apart. The "behavioral addictions" would quickly expand from their narrowly intended,(perhaps) appropriate usage to become a popular and much misused label for anything that people do for fun but causes them trouble. Potentially millions of new "patients" would be created by fiat, medicalizing all manner of impulsive, pleasure seeking behaviors and giving people a "sick role" excuse for impulsive irresponsibility.

We, all of us, do short term pleasurable things that can be quite foolish in the long run. It is the nature of the beast. The evolution of our brains was strongly infuenced by the fact that, until recently, most people did not get to live very long. Our hard brain wiring was built for short term survival and propagating DNA- not for the longer term planning that would be desirable now that we have much lengthened lifespans. Salience was given to the short term pleasure centers that encouraged us to do things that give an immediate reward. This is why it is so difficult for people to control impulses toward food and sex, especially when the modern world provides such tempting opportunities.

> *"If a person shops till she drops because this is fun, it should not be called 'addiction' no matter how much trouble it causes."*

Thus our massive collective societal weight gain comes from an enduring sense of facing famine that makes it hard to say no to the attractions offered by refrigerators and supermarkets. Pleasure at the mall satisfies survival motivations based on gathering and nesting. And so on (I will leave sex to your own individual imaginations).This type of hard wiring was clearly a winner in the evolutionary struggle when life was "nasty, brutish, and short." But it gets us into constant trouble in a world where pleasure temptations are everywhere and their long term negative consequences should count for more than our brains are wired to appreciate. The late blooming insight of the new discipline of

*continued on page 15*

## DSM-5 Suggests Opening The Door To Behavioral Addictions

*continued from page 14*

behavioral economics is that we are not rational animals (they would figure this out sooner had they read Darwin or Freud). We all make bad short term decisions because it is hard to resist the immediate fun at the time. Then we suffer the long term consequences.

In a better world, our forebrains would do a more efficient job controlling impulses and long term planning and would anticipate and/or avoid those pleasures not worth the price. But we live in this world and exist within an inherently imperfect human condition - the stuff of tragedy, comedy, and melodrama. In a statistical sense, it is completely "normal" for people to repeat doing fun things that are dumb and cause them trouble. This is who we are. It is not mental disorder or "addiction" - however loosely these much freighted terms are used.

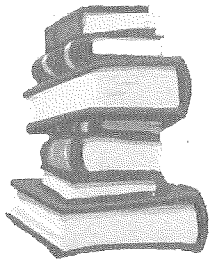
Instead "addiction" would imply that there has been an override of our average expectable impulsive, pleasure system. The individual does the behavior over and over and over and over again-despite a lack of reward and much negative reinforcement in a way that does not now (and never could have had) any survival value.

Previously, I have written about the difference between the commonplace fun loving philanderer and the rare, tortured "sexual addict." The philanderer enjoys his sexual activity so much that he keeps doing it despite the external trouble he gets into or any internal moral qualms he may have. The immediate pleasure it brings has more salience than the eventual pain. This would be in sharp contrast to that rare person who compulsively repeats the sexual act without experiencing much or any pleasure, even in the face of great risks or punishments.

The parallel would apply to all of the possible "behavioral addictions." If a person shops till she drops because this is fun, it should not be called "addiction" no matter how much trouble it causes. People who prefer the internet or video games to other life pleasures are not addicted so long as the activity remains pleasurable. ■

*Reprinted from Psychiatric Times, April 23, 2010.*

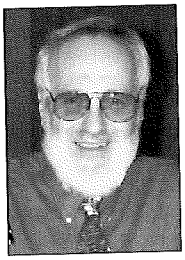
## Book Review Corner



# A New Prescription for Addiction

*The Gracer Comprehensive Method for Treating Addiction to Alcohol, Cocaine, Meth, Prescription Drugs*

WRITTEN BY RICHARD I. GRACER, MD

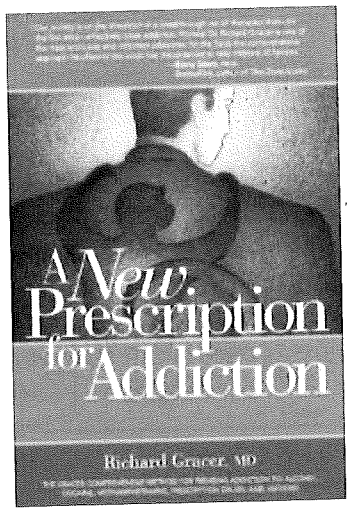


BOOK REVIEWED BY
JOHN HARSANY, MD
HEMIT, CA

In my view, Dr. Gracer's book offers a simple and realistic explanation of the clinician's need for a "blended" approach to the treatment of the "Addicted-Brain-Syndrome." He explains the need for pharmacotherapy and psychotherapy to be blended in each patient in their intake assessment to ensure that treatment will be successful.

The strategic blending of the physiological and psychological aspects of each patient is thoroughly addressed in an excellent, readable, and comprehensive fashion. This allows the book to be used by patients and significant others. Addiction professionals, as well as primary care physicians who are new to the field of Addiction Medicine, will each find this book to be helpful and informative.

In summary, this book is an excellent resource for any and all in the field of Addiction Medicine. It is an easy, informative read that is comprehensive without being technically overwhelming. Enjoy!




*CSAM members are invited to submit books and film reviews for consideration. Send email to: csam@compuserve.com*

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CALIFORNIA SOCIETY OF ADDICTION MEDICINE

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