

Commentaries

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Behavioural health disorders rather than behavioural addictions

Doug Sellman

Department of Psychological Medicine,
National Addiction Centre, Christchurch
School of Medicine & Health Sciences,
University of Otago, Christchurch, New
Zealand

Corresponding author:

Doug Sellman, Department of Psychological
Medicine, National Addiction Centre,
Christchurch School of Medicine & Health
Sciences, University of Otago, PO Box 4345,
Christchurch 8140, New Zealand.
Email: doug.sellman@otago.ac.nz

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Starcevic's (2016) article is a timely caution against using the term 'behavioural addiction' to include all repetitive behaviours involving poor impulse control, particularly in the light of a burgeoning number of new potential disorders for inclusion.

He identifies a wide range of behaviours and disorders as potential 'behavioural addictions' on a continuum from compulsivity to impulsivity, including gambling, spending, buying, sex, Internet use, exercise, food, work, social networking, dancing, fortune-telling and so on 'ad infinitum', and obsessive-compulsive disorder (OCD), kleptomania, pyromania, body dysmorphic disorder, repetitive self-injurious behaviours, personality disorders, autistic disorders, chronic tics, stereotypic movement disorders, trichotillomania, skin-pricking disorder and so on.

Diagnoses are useful simplifications of reality when they are clinically

informative. Utility is likely to be diluted by including every disorder which involves a degree of compulsivity or impulsivity under one umbrella diagnostic category such as 'behavioural addiction'.

'Behavioural addiction' is more likely to be useful clinically when reserved for a set of compulsive disorders which have strong aetiological, treatment and prognostic similarities to the substance addictions. Repetitive problematic behaviours primarily motivated by hedonic desire to consume or interact with something compelling may be a useful starting point for delineation. This set of disorders could then potentially cover a range of modern products that can induce a compelling pleasure in certain vulnerable people, and which over time with repetitive, heavy, use lead to a similar de-humanized state of compulsive consumption and craving for the product as in substance addiction.

It makes sense to include OCD alongside alcoholism, pathological gambling and sex addiction in a broad grouping of disorders from the point of view of similarities in the unconsciously learned nature of the compulsive habit (Lewis, 2015) and the known neural pathways associated with this learning, such as the involvement of dopaminergic pathways and neuroplastic changes in the striatum (Everitt et al., 2008). However, phenomenologically, this is mixing compulsive disorders primarily motivated by the avoidance of anxiety (OCD) with those primarily motivated by hedonic desire (alcoholism and others). There is a world of difference between fear and hunger, between anxiety management and hedonic control. A similar argument could be used for other disorders which include

compulsivity or impulsivity in their phenomenology but do not involve the consumption or interaction with a 'moreish' object.

Starcevic outlines three main problems with validating new candidate behavioural addictions. First, he suggests the specific withdrawal patterns of substance addictions are entirely different from a general negative state of deprivation experienced by people afflicted with, for instance, a buying or pornography compulsion. However, anecdotal reports from people with a combination of a substance and behavioural addiction (narrowly defined as above) suggest the experience of hunger (craving) for the addictive object is very similar for both. It is noteworthy that the status of a specific withdrawal syndrome as a sign of an established addiction has recently been down-graded in *Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* (DSM-5; American Psychiatric Association [APA], 2013).

Second, Starcevic suggests that because many of the new behavioural addictions extend on a continuum into normality, this differentiates them from substance addictions. This is a false distinction. Substances have been used by *Homo sapiens* for over 100,000 years and almost undoubtedly have contributed to the species' success. Drug use is just as much a normal human activity as is sexual activity, gambling and engaging in the Internet (in the modern world). All of these activities are intensely rewarding for some people and can lead to the development of compulsive habits (addictions). Changes in the nature of food and eating over the past half century, away from nutritious whole food and 'eating to live' to a range of hyperpalatable recreational food products

and the marketing of 'living to eat', is emphasized in food addiction (Popkin, 2012).

Finally, Starcevic argues that abstinence is unreasonable when considering new potential behavioural addictions (which extend into normality) such as food and sex. Addiction interruption through abstinence is an effective strategy in drug addiction including alcohol, and is easily applied to, for instance, certain types of food products or certain types of sexual activity, rather than the absurdity of advocating abstinence from all food or all sexual activity.

The most important aspect of Starcevic's paper may be the highlighting of a range of disorders involving impulsivity/compulsivity, which involve the development of deeply embedded habits that become increasingly inaccessible to frontal lobe influence over time. These externalizing disorders have attracted less attention in psychiatry to date than the traditional

internalizing disorders, such as mood, anxiety and psychotic disorders.

Rather than try and herd all externalizing disorders into one diagnostic category such as behavioural addiction, as Starcevic has rightly cautioned against, it might nevertheless be useful and timely to name a new psychiatric domain, such as behavioural health disorders, to sit alongside the mental health disorders within psychiatry. The substance and behavioural addictions would be one of a number of diagnostic categories in this new domain.

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Anorexia nervosa (AN) is a significant mental health issue, yet little is known regarding the underlying factors that contribute to illness onset and maintenance. AN has the highest death rate of any mental illness and a recovery rate of less than 50% in surviving patients. Thus gaining an understanding of the neurobiological underpinnings of this condition is of great importance for tailoring appropriate treatments for this illness. To date, the scientific study of AN is considerably variable with few empirical findings being consistently reported. This has been particularly true in relation to the illness' underlying neurobiology. Unlike many other psychiatric conditions, the brain regions and neurotransmitter systems involved in the illness are unknown. A key review published by our group in ANZJP (Phillipou et al., 2014a) highlighted the lack of consistency of the neurobiological literature in AN, and emphasised the need to utilise tasks known to employ specific brain networks to uncover

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See Viewpoint by Starcevic 50(8): 721–725.

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The eyes have it: Eye movements and anorexia nervosa

Andrea Phillipou^{1,2,3,4},
Susan Lee Russell^{4,5,6},
Caroline Gurvich⁶, David
Jonathan Castle^{2,4,7} and
Larry Allen Abel¹

¹Department of Optometry and Vision Sciences, The University of Melbourne, Melbourne, VIC, Australia

²Department of Psychiatry, The University of Melbourne, Melbourne, VIC, Australia

³Department of Mental Health, The Austin Hospital, Melbourne, VIC, Australia

⁴Department of Psychiatry, St Vincent's Hospital Melbourne, Melbourne, VIC, Australia

⁵Brain and Psychological Sciences Research Centre, Swinburne University of Technology, Melbourne, VIC, Australia

⁶Monash Alfred Psychiatry Research Centre, Monash University and The Alfred Hospital, Melbourne, VIC, Australia

⁷Faculty of Health Sciences, Australian Catholic University, Melbourne, VIC, Australia

Corresponding author:

Andrea Phillipou, Department of Psychiatry, St Vincent's Hospital Melbourne, PO Box 2900, Fitzroy, VIC 3065, Australia.
Email: ap@unimelb.edu.au

the neurobiological underpinnings of this illness. This was the specific aim of our recent research programme in which we compared patients with AN to healthy individuals on a range of saccadic eye movement tasks. Saccadic eye movement tasks are well-characterised research tools frequently utilised in psychiatric populations to understand cognitive deficits while drawing inferences about compromised neural pathways. Our recent research programme was the first detailed analysis of saccadic eye movements in AN.

Eye movements have been thoroughly assessed in aetiological investigations of other psychiatric and neurological conditions, providing valuable information on brain regions and neurotransmitter involvement in these illnesses. The neural circuitry of saccadic eye movements is well understood, and deficits in different saccadic parameters (e.g. error rate, latency, gain and peak velocity) are indicative of specific neurobiological abnormalities. Collectively, our recent research has identified four saccadic eye movement