Counselors' Understanding of Process Addiction: A Blind Spot in the Counseling Field

Angie D. Wilson
Pennie Johnson

The Professional Counselor
Volume 3, Issue 1 | Pages 16–22
http://tpcjournal.nbcc.org

www.nbcc.org
doi:10.15241/adw.3.1.16

The addictions field continues to grow and is expanding beyond the area of substance abuse and substance dependence. Process addictions are now an integral aspect of addictions treatment, diagnosis, and assessment. There is a gap in the literature related to process addictions which impacts counselors and clients due to lack of literature and knowledge on this new area. It also is hypothesized that there is a gap in continued education for incorporating treatment and assessment measure into clinical practice. This initial study was conducted to initiate an understanding of levels of knowledge counselors have in diagnosing, assessing and treating clients suffering with process addictions, indicators of where and how they learned about process addictions, and how they integrate their level of the treatment of process addictions into clinical practice. The authors provide a brief overview of process addictions, a summary of original research, implications of this study, discussion, and recommendations for future research.

Keywords: **process addictions, counseling, addiction disorders, compulsive behaviors, behavioral addictions**

It is important for counselors and mental health professionals to stay current with information impacting their profession. Staying abreast of new ideas and new information can assist in providing successful and holistic treatment for clients (ACA, 2005). Specifically, the field of addictions has had many transformations over the last few decades. One of the most recent issues impacting the addictions area in counseling is process addictions (PAs) (Grant, Potenza, Weinstein, & Gorelick, 2010; Holden, 2001; Martin & Petry, 2005). For many years, mental health professionals have treated clients with systematic behaviors mimicking the disease of addiction, but many find they haven't received adequate training in this area to be competent. The terminology of PA sweeps a wide variety of behavioral addictions or compulsive behaviors. PA is defined as any compulsive-like behavior that interferes with normal living and causes significant negative consequences in the person's family, work and social life. Gambling, Internet addiction, sex addiction, exercise addiction and eating addictions are among those identified as PA (Sussman, Lisha, & Griffiths, 2011).

The neurological changes in the brains of people who engaged in gambling, binge eating, and compulsive sex were similar to those brains of persons who abused substances such as alcohol and marijuana. Treatment observations and prevalence data, coupled with a growing body of literature, suggest the existence of PAs (Smith & Seymour, 2004), also called compulsive behaviors (Inaba & Cohen, 2011) and behavioral addictions (Grant et al., 2010). PAs may be new to some; however, PAs represent neither a new phenomenon nor new disorders. In actuality, PAs have been an area of concern in the addictions field for many years (Grant et al., 2010; Holden, 2001; Martin & Petry, 2005).

There is little evidence that this evolving research on PAs is being translated to those providing services to clients. Due to the gap in the literature related to PAs and the knowledge of counselors, students, and counselor educators related to PA, the International Association for Addictions and Offender Counseling (IAAOC) Process Addictions Committee (a division and committee of the American Counseling Association) conducted a survey of students, post-graduate counselors, and counselor

Angie D. Wilson is an Assistant Professor at Texas A&M University-Commerce. Pennie Johnson is the Vice President for Project Management at the International Institute for Trauma and Addiction Professionals (IITAP) and a doctoral student at Walden University in the Department of Counselor Education and Supervision. Correspondence can be addressed to Angie D. Wilson, 1700 Hwy 24, Department of Psychology, Counseling, and Special Education (Binnion Hall), Texas A&M University-Commerce, Commerce, TX 75429, angie.wilson@tamuc.edu.

educators with the purpose of understanding the deficiencies clinicians are struggling with in understanding process addiction. The purpose of this article is to provide the results of a survey, which indicated the percentage of post-graduate counselors/clinicians in the study and their understanding of PAs. The information in this manuscript will specifically address the knowledge of counselors who are actively engaged in providing treatment services in community settings.

Review of Relevant Literature

The most recent definition of addiction was the product of research studies, which took place over four years and included over 80 experts from across the country. These research studies were spearheaded by The American Society of Addiction Medicine (ASAM). According to ASAM (2012) an addiction is not merely a behavioral problem involving the consumption or intake of substances, gambling, or sex; an addiction is a chronic brain disorder. Another definition of addiction is the behavior that occurs with continued substance use or involvement in a PA regardless of the negative impact it has on the participant's life (Shallcross, 2011). What follows is a brief overview of several PAs that have been researched and are referenced in the *Diagnostic and Statistical Manual* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association [APA], 2000), and the new *DSM-5* (APA, 2012a).

The diagnostic criteria of the various PAs are similar to those of substance addictions. Due to these negative consequences, PAs continue to disrupt the lives of significant proportions of the U.S. adult population (Sussman et al., 2011). Based upon a literature review of 83 studies, Sussman et al. (2011) estimated prevalence rates for gambling addiction (2%), Internet addiction (2%), sex addiction (3%), exercise addiction (2%), and eating addiction (2%) among the general American population. The growing concern regarding PAs may be due to the increased co-morbidity with mental health concerns and substance addictions (Sussman et al., 2011). Substance abuse co-morbidity rates for gambling addiction were approximated at 20-30%, Internet addiction 10%, love and sex addictions 40%, exercise addiction 15%, and eating addiction 25% (Sussman et al., 2011). According to Carnes (2009) most addicts have more than one addiction, sustained recovery is more successful when all addictions present are addressed in counseling, and addictions do not merely coexist, but actually interact with each other.

The term *disorder* is often used interchangeably with the term *addiction*. For example, one of the most widely known and recognizable PA is gambling disorder, which is also called gambling addiction and pathological gambling (Ashley & Boehlke, 2012; Jamieson, Mazmanian, Penney, Black, & Nguyen, 2011). It is believed that gambling disorder will be categorized under Addiction and Related Disorders in the *DSM-5* (APA, 2012b), as the diagnosing criteria closely resemble substance use disorder. In order for one to be diagnosed with gambling disorder, the gambling behavior must disrupt the personal or work life of the affected person and cannot be related to a manic episode (APA, 2000). According to Crozier and Sligar (2010), some indicators that one's social gambling is shifting into a PA include lifestyle changes to accommodate gambling-related activities, extreme mood fluctuations related to gambling, justifications for continued gambling, perceptible excitement when discussing gambling, as well as financial indicators such as hiding debt and frequently borrowing money.

Food addiction, eating addiction, and compulsive eating also are referenced as Binge Eating Disorder (BED) and is another of the PAs that may be revised in the *DSM-5*, from the category of Other Conditions (APA, 2000) to Feeding and Eating Disorders (APA, 2012c; Wonderlich, Gordon, Mitchell, Crosby, & Engel, 2009). Frequent episodes of uninhibited food consumption beyond the point of fullness, without being followed by purging behaviors (e.g., vomiting or the use of laxatives), are characteristics of BED. According to Karim and Chaudhri (2012), individuals with BED will typically eat without feeling hungry, spend excessive amounts of time thinking about and obtaining food, and may attempt to hide their eating from others. Although some people with BED may be obese or overweight, BED is distinct from other eating disorders, as individuals with this condition are mentally and emotionally different from individuals who are obese or overweight (Wonderlich et al., 2009).

The term *exercise addiction* was first introduced by Glasser (1976), who studied long-distance runners and found out that most of them had an obsessive-compulsive disorder. Exercise addiction, or sports addiction, is a phenomenon typically found in athletes (McNamara & McCabe, 2012). Exercise addiction has been a growing concern for the counseling field for a number of years (Parastatidou, Doganis, Theodorakis, & Vlachopoulos, 2012). Exercise dependence, obligatory exercise,

compulsive exercise, and excessive exercise are other names for exercise addiction or sports addiction (Parastatidou et al., 2012). Training interferes with daily life and is diagnosed with criteria similar to those of substance abuse disorders as well as other PAs.

Another widely recognized addiction is Internet addiction, also called Internet Use Disorder (APA, 2012d), which is not found in the *DSM-IV*, but is being considered for inclusion in the *DSM-5* (APA, 2012d; Ko, Yen, Yen, Chen, & Chen, 2012). The criteria used to define this addiction closely match the criteria for substance dependence. For example, the use of the Internet becomes a preoccupation or begins to monopolize the individual's time, there is an increased need to obtain positive feelings, social relationships are negatively affected by Internet usage, and a person returns to maladaptive Internet use after a period of abstinence (Smahel, Brown, & Blinka, 2012).

According to Karim and Chaudhri (2012), a disproportionate amount of time spent on planning for and participating in sexual activity, participating in sexual activity to alter one's mood or as a way to handle stress, inability to control sexual compulsions and sexual fantasies, and engaging in unsafe sexual activity can be called hypersexual disorder (APA, 2012e). Hypersexual disorder (APA, 2012e) also is called sex addiction and compulsive sex. Shifts in emotions and values; compulsive masturbation; inappropriate jokes, personal boundaries, and touching; boasting about sexual conquests; and unplanned sexual encounters are indicators of compulsive sex (Crozier & Sligar, 2010).

Training of Counselors on Process Addictions

The US Department of Health and Human Services, TAP 21 (HHS, 2006) recommends that all counselors should be competent in "understanding of addiction, treatment knowledge, application to practice, and professional readiness" (p. 5). Although this is recommended, it is often difficult for counselors to locate educational training and research related to PAs due to the limited available information. Although licensed counselors graduate from master's- and doctorate-level universities in counseling programs, researchers (Crozier & Agius, 2012) indicate many counselor educators are not adequately equipped with recent knowledge regarding PAs and, therefore, academic organizations are not properly educating future counselors in this area. Of course, some information regarding addictions is infused into the coursework in most graduate programs, but counselors with specific interest in addictions must seek additional training and education through outside sources such as continuing education and specified certification programs. Ultimately, it is the responsibility of licensed counselors to stay abreast with clinical training and new areas related to treatment, assessment and diagnosis of maladaptive disorders. However, there are concerns regarding the accessibility of training and professional growth seminars on PAs, as many counselor educators who are the primary researchers in the counseling field are not aware of this growing area of PAs (Crozier & Agius, 2012), and many counseling students are not being taught about PAs in their counselor training programs (Nelson, Wilson, & Holman, n.d.). This creates a problem for the counseling profession in that there is continued need for training and research in this area. "The development of effective practice in addiction counseling depends on the presence of attitudes reflecting openness to alternative approaches, appreciation of diversity, and willingness to change" (HHS, 2005, p.5).

Methodology

This pilot study has helped provide structure for a national study being conducted by the IAAOC. An online survey was constructed by members of the IAAOC Committee on PAs who are all active professionals in the field. They followed methodological research guidelines (Dillman, Smyth, & Christian, 2009) to design a valid, mixed-methods design (Onwuegbuzie & Johnson, 2006) comprised of open-ended and closed-ended research questions. Upon approval from the Institutional Review Boards, counselors in NC and TX received an email requesting their participation in this initial study. The survey, statement of anonymity and confidentiality, as well as the informed consent was posted in Zip Survey and participants were prompted to review this information before proceeding with the study. The data also was collected and analyzed within the Zip Survey program. Potential participants later received two separate reminder emails prior to the survey's closing date asking them to participate in the study.

Participants

The participants were solicited by the investigators through professional listservs, websites of professional organizations, personal communication with counseling professionals and word of mouth. Participants were asked to address the online survey, read the informed consent and begin the survey. Calculating the response rate for the survey was not possible because it was not possible to determine how many counselors actually received the survey. It also is important to note that counselors may have chosen to describe themselves as counselor educators, if they were both counselors and counselor educators. In this case, those counselors' responses would have been included in the data for counselor educators and not counselors.

The total sample for our study included 37 counselors who were post-graduate clinicians/counselors. The counselors who participated in the study included the following: 59% with a master's degree in community counseling/mental health counseling, 8 % with a master's degree in a counseling-related field with a certificate in addiction, 3% with an educational specialist degree in a counseling-related field, and 22% with a doctorate in a counseling-related field. Fifty-eight percent graduated from CACREP-accredited programs with 2009 standards and 3% from CACREP-accredited programs with 2013 standards. Thirty percent graduated from a regionally accredited program that was not CACREP-accredited, and 9% graduated from an academic setting that was not regionally accredited or CACREP-accredited. It must be noted that five participants omitted the question regarding accreditation of their most recent counselor education program.

Instrument

A survey was developed to obtain counselors' opinions and experiences with assessing, diagnosing and treating PAs. The survey questions were based on a thorough review of the literature and were relevant to the participants' knowledge of PAs and their experiences as clinicians. The survey questions were developed in accordance to current survey methodological research guidelines (Dillman et al., 2009), and then the questions were sent to all members of the IAAOC Process Addictions Committee to asses for content validity. Finally, they were revised based on the members' feedback. The survey included both closed- and open-ended questions and was designed to be completed in 10–15 minutes.

A grand tour question is a type of descriptive inquiry that provides information on an experience or phenomenon. According to Spradley (1979), using grand tour questions constitutes an emergent quality of the interview process that results in subsequent questions. One grand tour question was used: "What are your thoughts or feelings about working with clients who present with PA?" In addition to the grand tour question, descriptive survey questions and open-ended text boxes were provided for participants to elaborate on their responses.

Data Collection and Analysis

Zip Survey was used to post the surveys and collect responses as well as to analyze the demographic and quantitative data. Participants received an email with a link to the survey requesting their participation. Upon opening the link, participants read the informed consent and agreed that they understood the nature of the study by continuing with the survey questions. Participants were assured in the informed consent that their responses were anonymous and confidential.

The survey program collected the responses and aggregated them into charts and Excel files. The quantitative results are descriptive data and are reported as such in the results section. Participants also had the opportunity to utilize text boxes within the survey in order to give a rich description of their experiences. The qualitative data obtained from participants who shared their ideas and experiences through the text boxes embedded in the survey also were utilized as data in this study. According to Moustakas (1994), data must be in written form in order to organize qualitative research; the qualitative data was in written form for this study as the Zip Survey collected the written words of participants via typed text. Organizing the text responses and following Moustakas's (1994) seven steps adapted from Van Kaam's (1959, 1966) interview analysis process were key steps during the data organization phase of the study. Additionally, both quantitative and qualitative data were compared with one another to achieve triangulation (Onwuegbuzie & Johnson, 2006).

Results

The total sample for this study included 37 counselors. They provided information on their training and clinical experiences related directly to the assessment, diagnosis and treatment of clients with PAs. Specifically, the participants responded to

questions regarding their comfort levels working with PAs and assessing, diagnosing, and treating nine different forms of PAs. Approximately 89% of the respondents indicated that learning about PA was very important for clinicians, while 6% noted that it was important and 6% indicated learning about PA was a neutral issue. Less than 13% of the participants understood that PA included compulsive behaviors such as eating disorders, exercise, Internet, gaming, gambling, relationships, sex, work addiction and compulsive spending. Sixty-four percent of the counselors surveyed acknowledged they treated clients with PAs, but where lacking the training to assess and screen for addictions.

Regarding comfort level in assessing, diagnosing and treating PAs, 25% of respondents reported feeling very comfortable, 42% reported feeling comfortable, 22% reported feeling ambivalent, 6% reported not feeling comfortable, and 6% selected not applicable. Counselors reported being trained to assess, diagnose and treat eating disorders more than the other PAs listed on the survey. Eating disorders, relationships and sex were the three PAs that counselors reported having the most learning experiences. Approximately 24% of the respondents had been trained to assess and screen for eating disorders. However, 36% of the participants were trained to diagnose eating disorders and only 19% had been trained to treat eating disorders. From the responses of the participants in this pilot study, it can be gathered that counselors are treating PAs without adequate training and continued education.

On average, a third of the participants had been trained to diagnose eating disorders, but most had little to no training in diagnosing the various other forms of PA. Yet, they knowingly are treating clients with addictions. With this admittance, the 89% of counselors who participated in the survey identified the importance of training counselors to assess, screen, diagnose and treat PAs, and 94% expressed interest in taking a process addictions seminar or course. Regarding theoretical orientation, 69% of the participants identified as cognitive behavioral, 8 % as humanistic, and 6% as psychodynamic.

Participants also were given the opportunity to provide qualitative responses to some questions. Overall, participants shared that they believed learning about PAs was important. Many were not prepared to provide treatment for clients with PAs, and many were not trained to adequately provide therapeutic services for clients with PAs. One participant stated, "I have never considered the term *process addiction*, and I could easily see myself changing that answer upon further thought and education. I find the ignorance in the counseling world regarding process addictions terrifying." Another wrote, "I think graduate programs are very deficient in chemical and behavioral education/training. I was never taught anything in graduate school about addictions." Overall, the majority of participants expressed their opinions about the importance of continued education and knowledge of PAs, shared that they had not been educated on PAs, or shared that their education on addictions was mainly focused on substance abuse treatment.

Discussion

"Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (ACA, 2005, p. 9) is an integral aspect of the counseling profession. By adhering to this section of the ACA Code of Ethics (ACA, 2005), all licensed professionals vow to accept responsibility to 'do no harm' to the physical, mental and emotional well-being of self, clients, and associates. Although most counselors intend to do no harm and strictly follow ethical guidelines, it is important to understand that by not providing comprehensive treatment for all addictive or problematic behaviors, some counselors may be unintentionally harming clients. Moreover, when the counselors' only focus for treatment is the first behavior presented by the client, there is a danger of overlooking co-addictions. "Once the initial neural pathway is laid down, other addictions become overlays using some of the same circuitry" (Carnes, 2009, p.13). These co-addictions are often referred to as addiction interactions. Unfortunately, many factors of co-addictions can be found in PAs, which are often compounded by nature such as eating, sex and exercise, making the need or craving acceptable in society.

PA can be defined as any compulsive-like behavior that interferes with normal living and causes significant negative consequences, and the physiological responses in the brain are similar to chemical dependency (Grant, 2008). As aforementioned, the difficulties in recognizing PAs lie within the realm of society. For example, many of the associated behaviors are socially accepted, such as sex, spending, eating and work, all of which are an intricate part of our hierarchy of

basic human needs. When assessing and diagnosing addictions, the focus is typically drug and alcohol dependency behaviors; however, PAs may mimic some of the same characteristics. Such characteristics include loss of control, compulsive behaviors, efforts to stop the compulsive behavior, loss of time, preoccupation, inability to fulfill obligations, continuation of the behavior despite the consequences, withdrawal, escalation and losses (Carnes, 2010). Other potential problems are often experienced by clients who have not been treated for all addictions and problem behaviors. Some of these include personal neglect, compulsive Internet use, isolation and avoidance of people, lost productivity, depression, dissociative states, marital and relationships problems, increased sexual risk behaviors, gambling, and academic failure.

Recommendations and Future Research

The addictions field is emerging with various types of disorders, and counselors are finding themselves to be overwhelmed and incompetent in handling the increasing demands for diagnosis, assessment and treatment of addictions in general and specifically PAs. Although counselors are expected to obtain continuing education to keep abreast of the evolution of counseling in the field, clinicians who participated in this study indicated that they were overall ill-prepared to work with clients who are living with PAs. First, it is recommended that counselor education programs implement courses that include properly assessing, diagnosing and treating PAs.

Second, it is important to reiterate that counselors make a professional vow to practice within their scope and to make referrals for services they are not capable of providing. Based on the information provided by participants in this pilot study, counselors who have no training with treating PAs are not making referrals for their clients, and are making the conscious efforts to continue working with clients who are living with PAs. It is recommended that workshops and continuing education programs specifically focused on PAs be provided for counselors who are active in the field. Staying current with the profession is of utmost importance when working in a field that changes based on available information. Moreover, it is an ethical violation to provide treatment services in an area that is beyond one's scope of competency (ACA, 2005).

Finally, this pilot study will be replicated on a national level, obtaining further information about counselors' knowledge and comfort level with assessing, diagnosing and treating PAs. The IAAOC is interested in further researching the knowledge of counselor educators and graduate students in counselor education programs regarding their knowledge of PAs in order to meet the needs of this population and strengthen the knowledge base of PAs within the counseling profession.

References

American Counseling Association. (2005). ACA code of ethics. Retrieved from http://www.counseling.org/resources/codeofethics/TP/home/ct2.aspx.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). doi:10.1176/appi.books.9780890423349.

American Psychiatric Association. (2012a). *DSM-5 development*. Retrieved from http://www.dsm5.org/Pages/Default.aspx.

American Psychiatric Association. (2012b). *R 37 gambling disorder*. Retrieved from http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=210.

American Psychiatric Association. (2012c). *DSM-5 development: K 05 binge eating disorder*. Retrieved from http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=372#.

American Psychiatric Association. (2012d). *DSM-5 development: Internet use disorder*. Retrieved from http://www.dsm5.org proposedrevision/Pages/proposedrevision.aspx?rid=573.

American Psychiatric Association. (2012e). *Hypersexual disorder*. Retrieved from http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=415

American Society of Addiction Medicine. (2012). *Addiction defined*. Retrieved from http://www.asam.org/for-the-public/definition-of-addiction.

Ashley, L. L., & Boehlke, K. K. (2012). Pathological gambling: A general overview. *Journal of Psychoactive Drugs*, *44*(1), 2737. doi:10.1080/02791072.2012.662078.

Carnes, P. (2010). *Facing the shadow* (2nd ed.). Carefree, AZ: Gentle Path Press.

Carnes, P. (2009). *Recovery zone, volume 1: Making changes that last: The internal tasks.* Carefree, AZ: Gentle Path Press.
Crozier, M., & Agius, M. (2012). Counselor educators & process addictions: How we know what we know. *NC Perspectives, 7*, 32–40.
Crozier, M., & Sligar, S. (2010). Behavioral addictions screening during the vocational evaluation process. *Vocational Evaluation & Work Adjustment Association Journal*, *37*, 45–57.
Dillman, D., Smyth, J., & Christian, L. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method* (3rd ed.). Hoboken, NJ: John Wiley.
Glasser, W. (1976). *Positive addiction*. New York, NY: Harper & Row.
Grant, J. (2008). *Impulse control disorders: A clinician's guide to understanding and treating behavioral addictions.* New York, NY: W.W. Norton.
Grant, J. E., Potenza, M. N., Weinstein, A., & Gorelick, D. A. (2010). Introduction to behavioral addictions. *The American Journal of Drug and Alcohol Abuse*, *36*(5), 233–241. doi:10.3109/00952990.2010.491884
Holden C. (2001). 'Behavioral' addictions: Do they exist? *Science, 294*, 980–982.
Inaba, D., & Cohen, W. (2011). *Uppers, downers, all arounders: Physical and mental effects of psychoactive drugs* (7th ed.). Medford, OR: CNS Productions.
Jamieson, J., Mazmanian, D., Penney, A., Black, N., & Nguyen, A. (2011). When problem gambling is the primary reason for seeking addiction treatment. *International Journal of Mental Health and Addiction*, *9*(2), 180–192. doi:10.1007/s11469-009-9268-3
Karim, R., & Chaudhri, P. (2012). Behavioral addictions: An overview. *Journal of Psychoactive Drugs*, *44*(1), 5–17. doi:10.1080/027910722012.662859
Ko, C., Yen, J., Yen, C., Chen, C., & Chen, C. (2012). The association between Internet addiction and psychiatric disorder: A review of the literature. *European Psychiatry, 27*(1), 1–8. doi:10.1016/j.eurpsy.2010.04.011
Martin, P. R., & Petry, N. M. (2005). Are non-substance-related addictions really addictions? *The American Journal on Addictions*, *14*(1), 1–7. doi: 10.1080/10550490590899808
McNamara, J., & McCabe, M. P. (2012). Striving for success or addiction? Exercise dependence among elite Australian athletes. *Journal of Sports Sciences*, *30*, 755–766. doi:10.1080/02640414.2012.667879
Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
Nelson, J., Wilson, A., & Holman, L. (n.d.). Training students in counselor education programs on process addictions. Unpublished manuscript.
Onwuegbuzie, A. J., & Johnson, B. (2006). The validity issue in mixed research. *Research in Schools, 13*, 48–63.
Parastatidou, I. S., Doganis, G., Theodorakis, Y., & Vlachopoulos, S. P. (2012). Addicted to exercise: Psychometric properties of the Exercise Dependence Scale-Revised in a sample of Greek exercise participants. *European Journal of Psychological Assessment*, *28*(1), 3–10. doi:10.1027/1015-5759/a000084
Shallcross, L. (June, 2011). Don't turn away. *Counseling Today*, *53*(12), 30–38.
Smahel, D., Brown, B., & Blinka, L. (2012). Associations between online friendship and Internet addiction among adolescents and emerging adults. *Developmental Psychology*, *48*(2), 381–388. doi:10.1037/a0027025
Smith, D., & Seymour, R. (2004). The nature of addiction. In R. Coombs (Ed.), *Handbook of addictive disorders: A practical guide to diagnosis and treatment* (pp. 3–30). Hoboken, NJ: Wiley.
Spradley, J. P. (1979). *The Ethnographic Interview.* Belmont, CA: Wadsworth, Cengage Learning.
Sussman, S., Lisha, N., & Griffiths, M. (2011). Prevalence of the addictions: A problem of the majority or the minority? *Evaluation & the Health Professions*, 34(1), 3–56. doi: 10.1177/0163278710380124
US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice, TAP 21, Technical Assistance Publication Series* [DHHS Publication No. SMA 06-4171]. Retrieved from http://www.kap.samhsa.gov/products/manuals/pdfs/tap21_08r.pdf.
Van Kaam, A. (1959). Phenomenal analysis. Exemplified by a study of the experience of "really feeling understood." *Journal of Individual Psychology, 15*, 66-72.
Van Kaam, A. (1966). *Existential foundations of psychology*. Lanham, MD: University Press of America.
Wonderlich, S. A., Gordon, K. H., Mitchell, J. E., Crosby, R. D., & Engel, S. G. (2009). The validity and clinical utility of binge eating disorder. *International Journal of Eating Disorders*, *42*(8), 687–705. doi:10.1002/eat.20719