

What Collaborative Care Looks Like: A Commentary on Comprehensive Collaborative Care for People with Behavioral Addictions and Co-Occurring Disorders

Mary McCloskey¹, Carrie VanMeter²

¹University of the Cumberlands, Williamsburg, KY, USA

²Capella University, Minneapolis, MN, USA

*Correspondence should be addressed to Mary McCloskey, mary.mccloskey@ucumberlands.edu

Received date: January 19, 2026, **Accepted date:** August 22, 2026

Citation: McCloskey M, VanMeter C. What Collaborative Care Looks Like: A Commentary on Comprehensive Collaborative Care for People with Behavioral Addictions and Co-Occurring Disorders. J Ment Health Disord. 2026;6(1):127–134.

Copyright: © 2026 McCloskey M, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

The following commentary expands on previous work on treating individuals diagnosed with behavioral addictions (BA) and co-occurring disorders (COD), suggesting a comprehensive-collaborative care model to enhance individual treatment protocols. It examines definitions and the challenges of aligning them with substance use disorders (SUD) in classification systems, noting dissonance among scholars and lack of research hindering acceptance by the American Psychiatric Association and World Health Organization. Exclusion of many BA from the DSM-5-TR and ICD-11 hinders professional education, patient care at all levels, and future research. An overview of BA is discussed with support for inclusion based on previous work and research. Accepted frameworks including the biopsychosocial (BPS) are recommended to support culturally sensitive, comprehensive-collaborative care and are included in a case presentation and analysis applying the proposed model. This commentary underscores the proposal for a pedagogical shift to educate providers to treat those with BA and COD from an interdisciplinary and philosophically similar method to advance prevention and treatment protocols aligned with comprehensive-collaborative care.

Keywords: Behavioral addiction, Comprehensive collaborative care, Co-occurring disorders

Introduction

This commentary expands on McCloskey et al.'s [1] chapter, "Comprehensive Care for People with Behavioral Addictions and Co-Occurring Disorders," by describing the proposed comprehensive-collaborative care model (CCCM) and distinguishing it from current collaborative and integrated care approaches. Comprehensive-collaborative care is defined here as an interdisciplinary, patient-inclusive model in which medical, behavioral health, and psychosocial providers actively share assessment, treatment planning, and outcome monitoring responsibility for a unified clinical presentation, in this case, as applied to behavioral addictions (BAs) and co-occurring disorders (CODs). We strongly emphasize that the CCCM currently is a conceptual framework requiring empirical validation along with significant multi-stakeholder advocacy and accreditation advocacy. The proposed CCCM may appear as a composite of current addiction treatment

models, particularly integrated and coordinated care. While the CCCM model integrates these models, it shifts the focus of development to begin in the education of all healthcare professionals to see one another as parts of the whole, not separate parts. In this commentary, we clarify nomenclature and definition of BAs, present a case example applying the CCCM, and propose a pedagogical shift where education is not simply focused on one discipline but is geared toward recognizing and utilizing multidisciplinary approaches by all providers to assist clients in achieving their identified outcomes.

Diagnostic Exclusion and Its Consequences

Addiction treatments have historically focused on chemical dependency as the primary marker of addictive pathology [2–4]. Chemical dependency or SUD is defined as excessive use of any substance(s) that result in tolerance, withdrawal;

psychological and/or physical, significant problems in core life areas, difficulty stopping/staying stopped, multiple unsuccessful attempts to cut down or stop, and ongoing use despite negative consequences [5–7]. Some examples of well-known SUD include alcohol use disorder (AUD), opiate use disorder (OUD), and cannabis use disorder (CUD) [5].

While the literature varies in its use of BAs and behavioral process addictions (BPAs), this commentary uses the terms interchangeably to reflect shared core addiction criteria. Behavioral addiction is defined as compulsive engagement in and excessive attachment to a person, object, or behavior [2,7,8]. This pattern is characterized by (a) a persistent inability to stop the behavior, even when it leads to negative consequences, (b) an increasing need for the behavior-tolerance, with psychological and/or physical discomfort without the behavior, (c) a termed withdrawal, and (d) a progressive loss of control over the behavior itself, particularly when there are other psychiatric comorbidities [2,7,8]. However, these BA are not as readily found as formal diagnoses due to the ongoing lack of consensus in solidifying a formal set of criteria for all BPA; therefore, impacting the recognition of multiple BA as addictions.

Currently, the only accepted and classified BA include gambling use disorder (GUD), and IGD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) [5]; the former in the substance-related and addictive disorders section, and the latter in the section identified as “considered for further study” [5]. The International Classification of Diseases (ICD-11) of the World Health Organization (WHO) [9], categorizes both GUD and IGD as behavioral addictions. However, lack of agreement continues to exist on what differentiates a behavior from being a hyper focused activity versus an addiction [2,4,7]. For example, there are internet and social-media related behaviors, like IGD, in that they are concerning online activities, and display similar criteria proposed by researchers matching that of GUD, but are not labeled as addictions [2,7,10]. Obsessive scrolling, impulsive and compulsive posting and/or focus on perfecting one’s appearance through filtering excessive pictures, compulsive checking for feedback, displaying criteria for social media addiction [11], internet addiction, internet-based pornography addiction and online shopping, represent predominant internet-related behaviors [3,8]. These BPAs are supported by neurobiological research suggesting activation of similar brain sections [12,13]. There is additional support for the inclusion of these proposed BAs based on other research with comparable results to IGD, GUD, and SUD [14,15].

Research has also prompted some experts to re-evaluate the potential to reclassify additional behaviors, including binge eating disorder (BED) and non-suicidal self-injury (NSSI). Currently, BED is categorized in the Feeding and Eating Disorders section of the DSM-5-TR [5]. In the ICD [9],

BED is categorized in Chapter 06, “Mental, behavioral, or neurodevelopmental disorders; Feeding or Eating disorders.” NSSI is classified as a condition, not a formal diagnosis in both the DSM-5-TR and the ICD and focuses on the compulsive act without suicide intent [5,9]. There is growing evidence supporting the addictive nature of these behaviors, drawing on Griffiths’ [2] components model of BAs, and SUD criteria outlined in the DSM-5-TR [5,16,17]. For example, Mestre-Bach and Potenza [15] highlight multiple biogenetic studies linking specific brain reward system processes involved in SUD, and non-substance-related addictive processes including GUD, that co-exist with those with BED. If similar physiological, psychological, and behavioral criteria are used to include GUD and are also being observed in those with BED, then this provides an avenue for inclusion of BED in classification systems as a BA and has positive implications for BED treatment protocols as a BA [15,17].

The WHO [9] and DSM-5-TR [5] provide the gold standard as to what constitutes a mental health disorder for the world and the United States, respectively. Therefore, the limited inclusion of BPAs from these diagnostic manuals prevents focus on education to medical and behavioral health providers. In addition, this limited inclusion results in a lack of evidence-based and standardized treatment protocols, and inadequate support for rigorous research and reimbursement from third party payers [8,18,19]. This leads to BAs more often than not being explored by most healthcare professionals during patient evaluation, as available and reliable assessments, which are not often included in standard assessment protocols, despite the existence of such assessments [8,18,19]. All these implications hinder individuals from receiving treatment for BPA as most are not covered by insurance. Therefore, optimal care by all healthcare providers regarding BAs and other COD is most likely being limited as when BAs are not covered by insurance to the same degree as SUD, there lacks training focus for health care providers to treat BAs, resulting in patients not being fully assessed in these areas [6,18,20].

Current research estimates a global prevalence of 11.1% for BA, or 913 million people who meet criteria, based on the work of Griffiths [2], for at least one behavioral addiction [21]. This number may be much higher as it does not account for people’s understanding of what a BA is, lack of inquiring about a BA by providers, and patients’ openness during assessments [22–24]. One may suggest, as with SUD and other COD statistics, factors impacting reporting accuracy include providers assuming SUD are primarily what are thought of regarding addictive behaviors, low use of BA assessments by front line workers, individual shame to self-report, and many not seeking treatment [21–23,25]. Despite a lack of agreement on the criteria for all BPAs, Griffiths’ [2] work had ignited many scholars’ focus on achieving his goal with the aim of providing people with optimal care for BA and COD [18,26].

Griffiths Criteria

To provide a general recap, Griffiths' original work (2005) identified six components of addictive behavior to highlight similar pathology to SUD and to differentiate an addiction from a hobby, stating "the difference between an excessive healthy enthusiasm and an addiction is that healthy enthusiasms add to life whereas addictions take away from it" [2]. These six components are: (a) Salience: physical, cognitive and psychological obsession with an activity; (b) Mood modification: purposeful behavior to change a mood; (c) Tolerance: the need for increased engagement in a behavior to obtain desired outcomes; (d) Withdrawal: discomfort when not engaged in the behavior; (e) Conflict: problems in core life areas; and (f) Relapse: the potential to return to the addictive behavior after a period of cessation [2]. Much of the scholarly debate centers on the premise that BA's do not have physical withdrawal symptoms compared to SUD [4,12]. Additional research exhibits established biological similarities between BA and SUD [12,13]. For instance, functional neuroimaging and molecular studies indicate that similar dopaminergic surges occur in the midbrain's ventral tegmental area (VTA) and substantia nigra, which lead to the mesolimbic reward area. In addition, such activators cause neuroplastic changes in the prefrontal cortex, resulting in diminished executive control and heightened impulsivity, both in SUD and BA [12,13]. As there are chemical and biological-based processes occurring, we propose that they are therefore physical, as in SUD.

Behavioral Addiction and Co-Occurring Disorders

Substance-related and addictive disorders, including BAs, are further complicated by the high rate of co-occurring disorders COD [4,14]. Kotyuk et al.'s [27] research estimated that between one-third and one-half of individuals presenting with an addictive disorder also have a COD. Research indicates that individuals with BPAs are significantly more likely to present with concurrent SUD, mood, anxiety, or personality disorders [14,27,28]. This brings to the forefront the importance of collaboration among providers to treat BAs and all COD, both within a biopsychosocial framework and in accordance with the proposed CCCM [29]. Research suggests providers are still struggling with collaboration aspects due to multiple limitations, including treatment philosophies, time constraints, lack of third-party reimbursements, and a general siloed approach to care [1,3,20,28–30].

Comprehensive-Collaborative Care Model Applied

The following is a recap of the example of the case utilized in the original chapter to highlight what the proposed CCCM would look like. Jim, the identified patient referenced in the book, represents a plethora of individuals who require healthcare from a system, as it currently is. These individuals

often present with multiple healthcare issues, requiring multiple providers and resulting in confusing and often suboptimal care [31,32]. The following emphasizes the current system, which has multiple negative implications for a client seeking care for a BA and other COD, whether SUD, medical, or a combination thereof. The case then turns into a demonstration of the highlights of CCCM.

Jim was receiving care from multiple providers for an array of healthcare issues. Jim, a veteran, saw his primary care provider (PCP) and a psychiatrist at his local VA clinic. In addition, he attended a weekly PTSD group at the VA of his own volition, led by a group counselor who was also a retired veteran. Having PTSD from his time in active combat, Jim was hesitant to share his problems with the VA staff and therefore engaged in outpatient (OP) therapy with a licensed professional counselor. During his initial assessment with his OP counselor, Jim said he could not stop drinking and was using alcohol and going to the casino at night to avoid sleep due to severe flashbacks. He also said he attended Alcoholics Anonymous, though infrequently, and continued to drink due to an additional COD, chronic knee pain. The counselor asked Jim if he would be willing to answer additional questions and complete additional forms to help the counselor understand how to help him better, and Jim agreed. Jim completed the Alcohol Disorders Identification Test (ADUIT) [33], the Behavioral Addiction Questionnaire (BAQ) [34].

The counselor went over the results in depth with Jim, so he understood them and asked if he had discussed any of his addiction or mental health concerns with his PCP or psychiatrist at the VA or in his VA PTSD group. Jim stated, "my PCP never asked me about my gambling, and I wasn't completely honest about my drinking," sharing he feared judgment and would not receive treatment he may need for his knee injury. Jim stated that the psychiatrist suggested counseling for his flashbacks, and Jim followed up with an outside clinician. Jim also thought the PCP's main job was to address his knee but did acknowledge that both the PCP and psychiatrist suggested attending the PTSD group and AA might help cut down his drinking.

With additional discussions in therapy, Jim agreed to sign releases so all treating providers could speak with one another. In addition, the counselor included Jim in a phone call to the PCP to discuss Jim's test results and concerns, and the PCP set up an appointment. Both the counselor and the PCP explained to Jim that there were options, including providing medication for his BA, AUD, and flashbacks. After Jim was prescribed medication, he thanked the counselor, who took the opportunity to suggest to him the importance of comprehensive collaborative care between him and all his providers on a regular basis. Jim, originally hesitant and fearful, agreed to this addition to his treatment. The counselor

educated Jim about how the proposed approach could catch potentially missed implications that could impact his care. In conclusion, a monthly online meeting was set up bringing together the client, the OP counselor, the psychiatrist, PCP, PTSD group counselor from the VA, and a member of Jim's personal support group to discuss what was working, what was not, and to allow the client to ask questions, share concerns and to hear options from multiple providers working as an interdisciplinary team to increase the client's desired outcomes.

The case study highlights the benefits of comprehensive-collaborative care in the following ways: the inclusion of the client and all members of the treatment team provides increased accountability for seeking the best outcomes for the patient [30,32]. Perhaps most important is that many clients struggling with BAs and COD who may experience longer waiting times to receive care can result in not feeling important, increased irritability with having to repeat their stories and symptomology repeatedly to multiple providers, and eventually making the decision to stop seeking help, resulting in decreased treatment engagement [22,35,36]. If the healthcare system can decrease the time a client waits to obtain effective care, it might pave the way to increased positive outcomes, including decreased symptomatology and increased patient commitment, as they will more likely feel important and heard, and overall positive outcomes.

We propose that the CCCM may also help reduce the likelihood of relapses, as the client has a stronger support team, all of whom know what the others are doing [20]. The sharing of information between providers helps avoid conflicts and overlaps in treatments, particularly adverse medication effects [31,37]. Having a collaborative team in place makes each service provider aware of the broader range of resources available to the client, and what services may be necessary, which are neither systematically nor consistently provided [36–38]. Having a communication plan in place avoids the hassles often associated with communication between service providers, which hinder timely client care. Most importantly, the CCCM offers the client a safety net, allowing for client empowerment and motivation for desired outcomes as they are always linked to one or more of their treatment teams.

Implications

Primary care providers have a unique advantage in identifying early markers of BAs during routine screenings [19,34]. The presentation of unexplained symptoms: social withdrawal, sleep deprivation, elevated mood symptoms, problems with school, work, and financial concerns, while often attributed to general stress, may represent emerging symptoms of a behavioral addiction, which could be screened by the primary care provider [19,28,31,34]. Utilizing these clinical encounters

with primary care providers could be useful for early detection, prevention, and the initiation of comprehensive collaborative care.

Often, healthcare providers do not use BPA screening tools during assessments with both adults and children, which can delay the identification of potential BAs and further complicate treatment due to extended time without recommended practices [28,31,34]. Typical addiction-related assessments used in PCP offices are disproportionately geared toward chemical substances and frequently omit potential BA, except GUD, as it is both a classified and known addiction [19,28,34]. Currently, multiple screening tools are available for most BAs [18,28]. For specific tools, please review our chapter in *Equipping the interdisciplinary workforce to treat Substance Use Disorders and Behavioral Health* [40]. In addition, the development of more reliable and inclusive screening tools may allow for the identification of multiple BA and COD [18,28,39].

Implicit bias continues to affect the medical perception of non-substance addictions. Research by Rundle et al. [32] identified that, after alcohol and opiate use disorders, disease and moral addiction models stigmatize behavioral addictions more than socially based models, such as the biopsychosocial (BPS) model [29]. Stigma often acts as an impediment to honest patient disclosure [23,25,41,42]. The use of a non-judgmental, evidence-based approach, informed by collaboration amongst all providers with an emphasis on the patient as the most vital component, can help increase trust [23,25,32,41]. Ricciutti's [42] research supported addressing curricula development in counseling programs related to BPAs and SUD as they discussed findings that clinicians used "negative and derogatory" towards clients with BPAs. Again, research supports and encourages additional education on BPAs and SUD where topics on biases are incorporated [42,43]. The CCCM, combined with the BPS, framework [29], provides an approach aimed at strengthening the therapeutic alliance which can improve diagnostic accuracy.

When a provider fails to screen for BPAs, they can lean towards practicing non-optimal health care [5,18,23,25] potentially ignoring a substantial portion of the patient's behavior that may be undermining the efficacy of other psychiatric treatments, such as multiple BA, SUD, and other COD [8]. This lends support to the CCCM, as collaborating with multiple providers can decrease missed care opportunities [8,19]. For example, the stress and cortisol elevation resulting from a compulsive shopping, or gambling debt can completely negate the stabilization efforts of pharmacological treatments for generalized anxiety disorder, major depressive disorder, and other co-morbid disorders [13,14,19]. Therefore, while attempting to stabilize a client/patient, ignoring the potential BA could decrease the likelihood of desired outcomes [13,19].

Multidisciplinary Treatment Protocols

Treatment protocols can be addressed among providers from a CCCM. All providers play a part in how clients learn about, identify needs, engage, and be accountable to themselves, their support groups, and their treatment teams [20,39]. The CCCM proposes providers as part of the support group, not simply disconnected, because from most frameworks, patients issues are not disconnected. Current treatment protocols for those with BAs and COD include medication-assisted therapies (MAT), cognitive behavioral therapy (CBT), motivational interviewing (MI), and contingency management (CM) to address treatment concerns and allow patients to develop a variety of coping skills necessary for long-term recovery [1,18]. MAT continues to suggest multiple uses for addictions, classified and not, and other COD.

Despite the use of pharmacological treatments for SUD and the existence of research to support similar MAT for BA [10,18], many primary care providers lack knowledge in this area and/or are unwilling to provide MAT to people with BAs [7,20]. Pharmacological management represents a significant frontier in treatment, as it is constantly changing [10,18]. Opioid antagonists, such as Naltrexone, have demonstrated

efficacy in decreasing cravings and the corresponding reinforcement associated with GUD and other BAs [10]. Unlike SUD, where total abstinence is often the primary endpoint, many BAs involve behaviors which are integral to modern life, such as eating, using the internet, exercising, shopping, and engaging in sexual relations. Abstinence oriented recovery may not be sufficient for treating all BAs [7,18]. There is a need for enhanced professional competency in non-abstinence-based recovery goals and best practices across multiple health care disciplines to better support the CCCM [18,20,44].

Additionally, digital health innovations, including mHealth platforms for real-time monitoring, allow for clinical oversight that was previously impractical in outpatient settings [39]. Neuromodulation and mindfulness, based on dialectical behavior therapy (DBT), are treatments now recommended for BA [7,18]. These advances suggest that the evolution of addiction medicine and treatment also requires all providers to engage in advocacy to support progress across education, patient care, insurance, and government regulations [32,39].

Table 1 outlines the primary structural differences between (a) Coordinated Care, (b) Integrated Care and (c) the Comprehensive Collaborative Care Model, across five domains.

Table 1. Structural comparison of care models.

Care Model	Team Composition & Setting	Communication Mechanism & Frequency	Care Planning Process	Patient Role & Autonomy	Provider Educational Focus
Coordinated Care	Based on Primary Care Provider (PCP) office; mental health, medical, and addiction providers work separately.	As needed between providers, utilizes a semi-shared IT platform without an official communication format.	Separate, individual treatment plans per provider; non-unified Electronic Health Records (EHR).	Included in care choices but carries heavy responsibility for navigating community referrals.	Siloed training within independent specialties; minimal cross-specialty integration.
Integrated Care	Mental health, Substance Use Disorder (SUD), and medical providers co-located under one roof.	In-house data sharing via a single, comprehensive Electronic Medical Record (EMR).	Unified planning under a single EHR, though heavily reliant on inpatient cross-training.	Active partner collaborating with an in-house team; holds high autonomy but lacks final veto power.	In-house cross-training across disciplines and specialized certifications post-graduation.
Comprehensive Collaborative (CCCM)	Licensed, certified, and support staff trained simultaneously across addiction, behavioral, and medical care.	Formal 3-Tier Meeting System: Tier 1: Monthly online meetings with full team. Tier 2: Meetings every 90 days. Tier 3: Bi-annual meetings with formal discharge checklists.	Person-centered, holistic biopsychosocial plans adapted to cultural diversity and evidence-based practices.	Imperatively primary; holds final decision-making power and can designate a navigator/support proxy via legal paperwork.	Training begins during foundational education; features phased staffing (certified vs. licensed) scaled to patient acuity.

Future Directions

The proposed CCCM is currently a theoretical framework and requires additional empirical studies to further develop and support its implementation. Due to ethical concerns, qualitative designs for behavioral and medical healthcare students receiving CCCM-based curricula and activities are one option to identify philosophical differences compared to those receiving education as usual [45]. In addition, ex post facto designs could be used to identify outcomes among patients who received treatment as usual versus interventions based in the CCCM, separately and combined, for both BAs and COD. Lastly, comparative effectiveness research or observational studies could be applied to a variety of types of treatment programs, based on either integrated or collaborative, and the CCCM to compare outcomes on a range of variables. The starting point for the CCCM model must be the educational process across all health care programs, to begin the pedagogical shift from a siloed approach to CCCM in modern health care.

Educators of all healthcare providers are well-positioned to create both a paradigm and a pedagogical shift in educational programs from a siloed approach to a CCCM approach. Far too often, provider education focuses solely on their general and specialty requirements. However, we propose that under the CCCM, all providers recognize the importance of other providers and how to best collaborate with them within the health care system. This is essential to enabling a paradigm shift that will change how providers see one another and how they develop working relationships during their education. For example, having mental health providers provide training to medical students, and vice versa, would introduce the CCCM early enough in future providers' education that a CCCM approach would become not merely suggested but the norm. The inclusion of post-degree training for and by multidisciplinary healthcare providers would be ideal to reinforce the importance of this approach. This approach would suggest that graduates from all healthcare backgrounds view their work as part of what is necessary to treat the whole person [41].

Additionally, the model proposes that collaboration among providers and patients be imperative. Research reveals those who feel valued and prioritized are more likely to remain in and engage in treatment [23,41]. Placing the patient at the center of the collaborative care team would increase the likelihood of identifying problems which otherwise may have been missed by a siloed approach. Moreover, such collaboration may advance professional understanding of medical and behavioral pathologies. For example, increased collaboration may lead to more consensus upon the nature of appropriate diagnostic classification of, and treatment protocols for behavioral addiction.

Research identifies increasing BPA rates between 30.7% for smartphone addiction, 21% for food addiction, 15.1% for social media addiction, and 10.6% for internet addiction between 2013 and 2022 [14,21,28]. To add to this concern, research suggests approximately 15% of the American population, 50.8 million Americans, reported co-occurring disorders, suggesting a doubling of reported and diagnosed cases since 2019 [4,14,41]. Mental health reporting increased from 11.5% to 14.1% between 2013 and 2022, while 21.2 million adults had a co-occurring mental illness and substance use disorder in 2024 [28].

As cases of BAs and other COD, including SUD, continue to rise, we propose the need to promote increased optimal care. A shift toward the CCCM encourages collaboration among providers and patients to develop treatment plans that enhance care efficiency through a philosophical model while integrating it with an evidence-based framework, the BPS [1,29]. Supporting comprehensive collaborative care will require interdisciplinary advocacy to allow both research and pedagogical changes in academic healthcare settings to encourage interdisciplinary partnerships among providers.

Conclusion

Behavioral addictions are complex conditions requiring the same clinical rigor and therapeutic resources as SUD. Current diagnostic divides are the byproduct of outdated addiction science, and acknowledging this evolution is the first step toward modernizing care. Currently, medical and mental health systems are not well-suited to a collaborative approach. Looking ahead, our proposed comprehensive-collaborative care model would enable interdisciplinary teams to work as a unit, built on pedagogical changes designed to reduce siloed approaches. These teams would have the benefit of viewing presenting behavioral addictions and any additional co-occurring psychiatric comorbidities as unified clinical cases with the individual as the nexus. This proposed philosophical approach aims to enable the healthcare community to provide more comprehensive-collaborative care that could increase the likelihood of positive outcomes.

References

1. McCloskey ML, VanMeter C, Attara CM. Comprehensive care for people with behavioral addictions and co-occurring disorders. In: Colistra AL, Editor. Equipping the interdisciplinary workforce to treat substance use disorders and behavioral health. Reducing the stigma. Cham: Springer Nature; 2025.
2. Griffiths MA. 'Components' model of addiction within a biopsychosocial framework. *Journal of Substance Use.* 2005;10(4):191–7.
3. Kardefelt-Winther D, Heeren A, Schimmenti A, Van Rooij A, Maurage P, Carras M, et al. How can we conceptualize behavioural

- addiction without pathologizing common behaviours?. *Addiction.* 2017 Oct;112(10):1709–15.
4. Petry NM, Zajac K, Ginley MK. Behavioral addictions as mental disorders: to be or not to be?. *Annual Review of Clinical Psychology.* 2018 May 7;14:399–423.
5. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed., text rev.) USA: American Psychiatric Association Publishing; 2022.
6. Brand M, Potenza MN. Behavioral addictions in the ICD-11: An important debate that is anticipated to continue for some time. *J Behav Addict.* 2023 Sep 8;12(3):585–9.
7. Giordano AL. A Clinical guide to treating behavioral addictions. Cham: Springer Nature; 2021.
8. Mann K, Kiefer F, Schellekens A, Dom G. Behavioural addictions: Classification and consequences. *Eur Psychiatry.* 2017 Jul;44:187–8.
9. World Health Organization. International statistical classification of diseases and related health problems (11th ed). Geneva: WHO; 2022. Available from: <https://icd.who.int/>
10. Sherer J, Levounis P. Technological Addictions. *Psychiatr Clin North Am.* 2022 Sep;45(3):577–91.
11. Triberti S, Milani L, Villani D, Grumi S, Peracchia S, Curcio G, et al. What matters is when you play: Investigating the relationship between online video games addiction and time spent playing over specific day phases. *Addict Behav Rep.* 2018 Jun 22;8:185–8.
12. Dossi N, Pesce RC. Neural Mechanisms of the Reward System and the Cognitive Control System in Internet Addicts. *Science Insights;* 2023 Mar 30;42(3):867–75.
13. İzci F, Sağlam NG, Ergelen M. Neurobiology and genetics of behavioral addictions: A brief review. *Bağımlılık Dergisi.* 2022 Jun 1;23(2):233–41.
14. Konkoly TB, Hodgins DC, Wild TC. Co-occurring substance-related and behavioral addiction problems: A person-centered, lay epidemiology approach. *J Behav Addict.* 2016 Dec;5(4):614–22.
15. Mestre-Bach G, Potenza MN. Potential biological markers and treatment implications for binge eating disorder and behavioral addictions. *Nutrients.* 2023 Feb 6;15(4):827.
16. Carenys AZ, Adan A. Non-suicidal self-injury as a behavioural addiction: A systematic review. *Current Addiction Reports.* 2025 Jul 30;12(1):67.
17. Fernández-Aranda F, Granero R, Jiménez-Murcia S. Eating Disorders and Addictive Behaviors: Implications for Human Health. *Nutrients.* 2023 Aug 25;15(17):3718.
18. Brand M, Antons S, Bóthe B, Demetrovics Z, Fineberg NA, Jimenez-Murcia S, et al. Current Advances in Behavioral Addictions: From Fundamental Research to Clinical Practice. *Am J Psychiatry.* 2025 Feb 1;182(2):155–63.
19. Pautrat M, Pierre Lebeau J, Laporte C. Identifying available addictive disorder screening tests validated in primary care: A systematic review. *Addict Behav.* 2022 Mar;126:107180.
20. Kaur V, Maleckas O. Integrated healthcare and interdisciplinary collaboration for substance use disorder treatment. *Alcoholism Treatment Quarterly.* 2025 Jul 3;43(3):447–59.
21. Alimoradi Z, Lotfi A, Lin CY, Griffiths MD, Pakpour AH. Estimation of Behavioral Addiction Prevalence During COVID-19 Pandemic: A Systematic Review and Meta-analysis. *Curr Addict Rep.* 2022;9(4):486–517.
22. Brown M, Moore CA, MacGregor J, Lucey JR. Primary care and mental health: overview of integrated care models. *The Journal for Nurse Practitioners.* 2021 Jan 1;17(1):10–4.
23. Cazalis A, Lambert L, Auriacombe M. Stigmatization of people with addiction by health professionals: Current knowledge. A scoping review. *Drug Alcohol Depend Rep.* 2023 Oct 24;9:100196.
24. Rawlinson C, Carron T, Cohidon C, Arditi C, Hong QN, Pluye P, et al. An Overview of Reviews on Interprofessional Collaboration in Primary Care: Barriers and Facilitators. *Int J Integr Care.* 2021 Jun 22;21(2):32.
25. Chagas C, Galduróz JCF. Stigma: can we still do more to reduce it? *Lancet Psychiatry.* 2024 Apr;11(4):250.
26. Gullo MJ, Wood AP, Saunders JB. Criteria for the establishment of a new behavioural addiction. *Journal of Behavioral Addictions.* 2022;11(2):191–8.
27. Kotyuk E, Magi A, Eisinger A, Király O, Vereczeki A, Barta C, et al. Co-occurrences of substance use and other potentially addictive behaviors: Epidemiological results from the Psychological and Genetic Factors of the Addictive Behaviors (PGA) Study. *J Behav Addict.* 2020 Jun 26;9(2):272–88.
28. Substance Abuse and Mental Health Services Administration. Medical professionals: Screen youth and young adults for substance use at every healthcare exam. Rockville. SAMHSA; 2025. <https://www.samhsa.gov/substance-use/prevention/communities-talk/mini-campaigns/medical-professionals>
29. Smith RC. The biopsychosocial revolution: interviewing and provider-patient relationships becoming key issues for primary care. *Journal of General Internal Medicine.* 2002 Apr;17(4):309–10.
30. Ramanuj PP, Pincus HA. Collaborative care: enough of the why; what about the how?. *The British Journal of Psychiatry.* 2019 Oct;215(4):573–6.
31. Matthews KJ. Primary care and behavioral health provider communication: Strategy for improvement. *The Journal for Nurse Practitioners.* 2021 Jul 1;17(7):865–9.
32. Rundle SM, Goldstein AL, Wardell JD, Cunningham JA, Rehm J, Hendershot CS. Examining the relationship between public stigma, models of addiction, and addictive disorders. *Addiction Research & Theory.* 2025 Mar 4;33(2):143–9.

33. Paulus DJ, Rogers AH, Capron DW, Zvolensky MJ. Maximizing the use of the Alcohol Use Disorders Identification Test (AUDIT) as a two-step screening tool. *Addict Behav.* 2023 Feb;137:107521.
34. Mastropietro S, Favieri F, Forte G, Locuratolo N, Mannarelli D, Pauletti C, et al. Behavioral Addictions Questionnaire (BAQ): Validation of a new tool for the screening of multiple addictive behaviors in the Italian population. *International Journal of Mental Health and Addiction.* 2024 Jun;22(3):965–78.
35. Hempel S, Ganz D, Saluja S, Bolshakova M, Kim T, Turvey C, et al. Care coordination across healthcare systems: development of a research agenda, implications for practice, and recommendations for policy based on a modified Delphi panel. *BMJ Open.* 2023 May 17;13(5):e060232.
36. Minkoff K, Covell NH. Recommendations for integrated systems and services for people with co-occurring mental health and substance use conditions. *Psychiatric Services.* 2022 Jun 1;73(6):686–9.
37. Möckli N, Simon M, Denhaerynck K, Martins T, Meyer-Masseti C, Fischer R, et al. Care coordination in homecare and its relationship with quality of care: A national multicenter cross-sectional study. *Int J Nurs Stud.* 2023 Sep;145:104544.
38. Corbin L, Schmoyer N, McCormick S, Peters M. Integrated Behavioral Health Education for Counselors in an Osteopathic Medical School: Lessons Learned and Future Directions. *Teaching and Supervision in Counseling.* 2025;7(2):4.
39. Substance Abuse and Mental Health Services Administration. *Digital Therapeutics for Management and Treatment in Behavioral Health.* Rockville (MD): SAMHSA; 2023. Available from: <https://library.samhsa.gov/sites/default/files/pep23-06-00-001.pdf>
40. Colistra AL, Randolph A, Ward A. Reducing the stigma. In: Colistra AL, Editor. *Equipping the interdisciplinary workforce to treat substance use disorders and behavioral health: Reducing the stigma.* Cham: Springer Nature; 2023.
41. Kempner S, Brackmann M, Kobernik E, Skinner B, Bollinger M, Hammoud M, et al. The decline in attitudes toward physician-nurse collaboration from medical school to residency. *J Interprof Care.* 2020 May-Jun;34(3):373–9.
42. Ricciutti NM. Counselors' stigma toward addictions: Increasing awareness and decreasing stigma. *Journal of Counselor Preparation and Supervision.* 2023;17(3):6.
43. Carlisle K, McCloskey M. Didactic Recommendations for Teaching About Integrated Care in Human Services Addiction Education. *Journal of Human Services.* 2023;42(1):53–65.
44. Ungar-Sargon J. Evidence-based addiction treatment comparison: a comprehensive analysis of substance use and process addictions. *Addict Res.* 2025;9(3):1–3.
45. American Counseling Association. *ACA code of ethics.* USA: American Counseling Association; 2014. Available from: <https://www.counseling.org/resources/ethics>