'Addiction Syndrome' Called Key to Recovery

For better treatment of the problem, a different way of assessing and treating it is needed.

BY KATE JOHNSON
Montreal Bureau

COLORADO SPRINGS — All addictions, whether chemical or behavioral, should be viewed as different manifestations of an underlying addiction syndrome—and addiction recovery programs will fail to achieve optimal outcomes until their protocols reflect this view, Howard J. Shaffer, Ph.D., said at a symposium on addictive disorders sponsored by Psychotherapy Associates.

"We need this different way of viewing and assessing the nature of addiction so that we can do better in treating it," he said in an interview.

In an ongoing study of 508 subjects with multiple drunk-driving offenses, investigators found high rates of coexisting addictions and mental disorders.

Between 80% and 90% of individuals recovering from addiction will relapse within the first year, possibly because their treatment is too narrowly focused on a single substance or behavior, rather than on their general susceptibility to addiction, said Dr. Shaffer of Harvard Medical School and director of the division on addictions at the Cambridge (Massachusetts) Health Alliance.

"The existing focus on addictive substances does not adequately capture the origin, nature and processes of addiction," he wrote in his initial description of the syndrome model of addiction (Harv. Rev. Psychiatry 2004;12:367-74).

Dr. Shaffer outlined the way in which psychoactive drugs and addictive behaviors such as gambling or shopping are neurobiologically similar in that they stimulate the brain's reward system.

Individuals with a genetic predisposition to addiction might find themselves susceptible to one or another psychoactive substance or behavior, depending on which ones they have been exposed to, have access to, and what their psychosocial risk factors are, he suggested.

"Genetic predisposition to addiction is not drug specific," he said, pointing to the phenomenon of addiction "hopping" as an example.

This phenomenon is commonly seen in addiction recovery programs, when the addiction that is being treated—alcoholism, for example—is replaced by another previously unrecognized addiction, such as exercise or disordered eating, said Dr. Shaffer, who has published extensively on gambling treatment programs and addiction.

In an ongoing study of 508 subjects with multiple drunk-driving offenses, Dr. Shaffer has found a high rate of coexisting addictions. These include alcohol abuse/dependence in 98%, substance abuse/dependence in 42%, nicotine dependence in 17%, and pathological gambling in 2%.

In addition, he found comorbid mental disorders in the group, including alcohol/substance abuse/gambling disorder in 99%, generalized anxiety disorder/depression or dysthymia in 20%, conduct disorder in 22%, posttraumatic stress disorder in 14%, and mania in 9%.

His study has not yet explored treatment strategies for these patients, Dr. Shaffer said. But effective treatment for such individuals must address their comorbidities rather than simply focus on their offense.

"Believe me, they know they are not supposed to drink and drive," he said.

Adapting current treatment strategies to reflect the syndromic nature of addiction will require clinicians to take a broader view of the problem, Dr. Shaffer said.

"When you discover your substance abuse patient has a gambling problem, don't farm them out to another provider," he said.

"Now there's a tendency to move people out of one program and into another—to take care of these problems separately rather than together in an integrated treatment plan."

But just identifying comorbid addictions and psychiatric disorders will prove challenging to many clinicians, he suggested.

"Most [comorbidities] are being missed, and so that's the next issue. We have to do a really rigorous evaluation," Dr. Shaffer said. He noted that his study represents the first time multiple offenders have been evaluated in this way anywhere.

Dr. Shaffer said his findings will be used to form the foundation of a computerized evaluation tool that his group is developing.

The computerized tool is aimed at guiding clinicians through a detailed interview with patients.

"The computer will yield a diagnostic evaluation across the DSM categories, mental health as well as the substance use disorders, and this will also cover ICD-10—the International Classification of Diseases," Dr. Shaffer said.

"Then better treatment matching can begin." ■

Meth Epidemic Drains Resources, Pushes Up Costs at Public EDs

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

A survey from the National Association of Counties paints a bleak picture of the toll that methamphetamine abuse is taking on the nation's emergency departments, at least in public and regional hospitals.

The survey of 200 emergency department officials in 39 states found that 73% of emergency departments saw increases in ED visits involving methamphetamine in the last five years, including 94% of hospitals in counties with a population ranging from 50,000 to 100,000. In Nebraska alone, 94% of EDs reported that up to 10% of their visits involve methamphetamine abuse.

Methamphetamine was also the top illicit drug seen in presentations of emergency department patients, according to 47% of respondents. Marijuana came in a distant second, at 16%, followed closely by cocaine at 15%. On the issue of what EDs recommended for these patients upon discharge, 58% of respondents said they referred them to private treatment programs, 53% referred to hospital treatment programs, and 39% said they referred to county treatment programs. Four percent said they made no referrals.

The survey also asked about the insurance status of methamphetamine abusers. Overall, 83% of respondents reported that during the last 3 years, patients presenting to the ED with meth-related conditions were often uninsured, and 81% said if they had insurance, they were often underinsured. As a result, the survey said, 56% of hospitals report that costs have increased at their facilities because of meth abuse.

A second survey released the same day involved substance abuse treatment facilities. Researchers interviewed 200 behavioral health directors in 26 states and the District of Columbia and found that 69% of respondents said the need for treatment programs has been increasing due to methamphetamine, including 90% of respondents in Texas and 86% of respondents in Maryland.

Some providers note, however, that although the methamphetamine problem clearly is widespread, the statistics in the hospital ED survey may not be representative of the nation as a whole. "My town is a heroin town," said Dr. Jon Mark Hirshon, of the division of emergency medicine at the University of Maryland, in Baltimore, and chair of the American College of Emergency Physicians' public health committee. "That's what I see."

But the National Association of Counties wasn't trying to be representative of all hospital EDs nationwide, according to Tom Goodman, public affairs director for the association. "We believe it's representative, but we're trying to show the effect of methamphetamine abuse on public hospitals, so it's representative of that," he said. "The bigger factor people have to consider is that 83% of those [ED] officials said the people coming in needing treatment related to meth were uninsured. If that's the case, [public hospitals are] where they go, because private hospitals will probably turn them away."

Mr. Goodman agreed that methamphetamine abuse is not a big problem on the East Coast. "It's possible it could grow, but it's not necessarily an urban problem at this point, although it is in the West and the Midwest."

Whatever its shortcomings, the study does point up that the substance abuse problem is contributing to the continued overcrowding of emergency departments, Dr. Hirshon said.

Methamphetamine abuse is an emergency visit that is preventable, "and we need to address these problems in a better fashion. We need to give people resources, so they can get off of drugs and stay off. There needs to be increased public investment to deal with these problems," he said. ■

Black Women More Likely to Smoke to Reduce Tension Rather Than Weight

Black female smokers are less likely to smoke to control their weight than white female smokers, according to a survey conducted to explore differences between the groups.

Because previous studies on the reasons why people smoke have involved almost entirely subjects enrolled in a smoking cessation program, this survey purposely queried individuals not trying to quit in addition to those who were.

The main hypothesis of the research was that white women would be more likely to cite weight control as a primary reason for smoking, and black women would be more likely to cite tension reduction.

The survey found that although the first premise was true, the second was not. White and black women cited tension reduction as a reason for smoking equally, and, in fact, it was the most frequently cited reason for both groups, reported Lisa Sánchez-Johnsen, Ph.D., of the University of Hawaii-Manoa, Honolulu, and her colleagues (Addict. Behav. 2006;31:544-8).

The survey queried 100 smokers attempting to quit and 100 not attempting to quit. Half of each group was white and half was black. A slightly lower percentage of black females smoke (20.8% vs. 23.1% of white females), and they tend to smoke fewer cigarettes per day (an average of 15 cigarettes vs. 20 cigarettes), the researchers noted.

Black smokers are more likely to report a desire to quit smoking and are less likely to be successful, they also said.

Black females have a higher prevalence of obesity than white females, and they tend to gain more weight when they quit smoking, Dr. Sánchez-Johnsen wrote in another recent paper.

—Timothy F. Kirn