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‘Addiction Syndrome’ Called Key to Recovery: For better treatment of the problem, a different way of assessing and treating it is needed

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.

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.”