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Addiction: A Lifestyle Choice or a Disease?

UNDERSTANDING ADDICTION – A LIFESTYLE CHOICE OR DISEASE?

HOST:

Stuart Gitlow, MD, MPH, MBA

GUEST:

Howard C. Wetsman, MD

Dr. GITLOW:

Addiction, is it a lifestyle choice or is it a disease? I am Dr. Stuart Gitlow. You are listening to ReachMD XM157, the channel for medical professionals. Welcome to the Clinician's Roundtable.

With me today is Dr. Howard Wetsman, author of QAA: Questions and Answers on Addiction. Dr. Wetsman, a board member of the American Society of Addiction Medicine is joining us today from New Orleans.

Thanks very much for being with us, Dr. Wetsman.

Dr. WETSMAN:

Thanks for having me, Stu.

Dr. GITLOW:

Absolutely. Let's start right off with your understanding of addiction, does it start simply as a lifestyle choice?

Dr. WETSMAN:

No, not for most people. I think that it is possible the stereotype of choosing, abusing, then becoming addicted actually does happen, but that is actually the vast minority of patients. Most seem to have been sick before their first use.

Dr. GITLOW:

What is that about? What do you mean by sick before the first use?

Dr. WETSMAN:

Well, for instance, let's take opiates, commonly called narcotics. They are called narcotics because the normal response is to put one to sleep and for about 90%-95% of the population, if they take an opiate pain medicine, they get tired, they may get a little nauseated, and their pain is relieved, but there are a minority of people who when they take an opiate, they do not get a narcotic effect. They get energized and many of them say that they feel like they were always supposed to feel that in retrospect they were never right and only when they were taking an opiate did they seem to be able to act and feel like other people around them.

Dr. GITLOW:

So let's look at that a little bit more. If we have an opiate addict and the first time they use, they recognize that it makes them feel right. How would we know that there was something wrong prior to the time that they picked up that opiate?

Dr. WETSMAN:

Well, it's really a supposition, I mean we could do the genetic test to see if there was may be something single nucleotide polymorphism or there is mu receptor, but I think the supposition is there that if you have a non-normal response to something, the reason for that non-normal response is not the thing, but difference in you.

Dr. GITLOW:

Fair enough. Now, are all the addictions really the same with alcoholism, cocaine dependence, opiate dependence, would all those be based upon the same abnormality.

Dr. WETSMAN:

In my experience, yes, and in my reading of the literature that the final common pathway seems to be the tone and reaction of dopamine and the brain's reward system in the midbrain and regardless of what drug or behavior people have worked at, they see the same final common pathway, whether that's not going well because you don't make enough dopamine or dopamine receptors don't work right or your opiate receptors don't work right that are on the cells that make the dopamine, there are many different ways to have that final common pathology, but vast majority of people I have treated seem to have that final common pathway.

Dr. GITLOW:

What about gambling, that's in DSM-IV as well, is that the same disease?

Dr. WETSMAN:

It's funny that you mentioned DSM-IV, because in DSM-IV, it's nowhere near substance dependence and the word addiction isn't used in association with it, but <_____> used to say if the diagnosis doesn't change the treatment, don't change the diagnosis. I treat gambling dependence or pathological gambling per DSM-IV with the same medications I treat cocaine dependence and I get the same results, so to me there seems to be no reason to add a diagnosis, it's just addiction.

Dr. GITLOW:

Okay, we will come back to the medication issue in a little bit. Let’s go further down this path. DSM-IV does not list a number of other issues that are commonly referred to as being addiction. Some have spoken of internet addiction. More recently there has been an outcry that video game overuse might be related to addiction. Are these all the same as well?

Dr. WETSMAN:

Yeah, I think so. In fact, in the new Journal of Addiction Medicine, a couple of months ago there was a very good study from China showing that a group of people who were usually overusers of video game had a single nucleotide polymorphism in the dopamine receptor at far higher prevalence than a group of normal video game players did.

Dr. GITLOW:

So taking your supposition as being true that individuals with addictive disease have something biologically wrong with them to begin with that continues to be wrong with them as their use of a substance or an activity persists. Can one use the terms acute and chronic to refer to addictive disease?

Dr. WETSMAN:

You know it's been standard wisdom in the field that you really can't, that addiction is addiction and it never goes away and all addiction is chronic, and as much I or you are comfortable with that old saw that I learned in training, I have to say that, now that we know more about the neurobiology, we have to consider even the possibility of temporary addiction. If we looked at someone, for instance, who was put into a social role where they felt shamed and less than other people that may cause a decrease in dopamine receptor density in their midbrain resulting with a decreased dopamine tone which would be reversible with a change in environment. So that person who may be would have used the drug and not had an abnormal addiction effect in that particular environment, a good example might be the 95% of heroin using GIs in Vietnam who came back, went through withdrawal and didn't pick up heroin again. They really didn't have the genetic disease of addiction, but had a temporary form that was brought on by some change and I guess another analogy would be diabetes brought on by cortisol.

Dr. GITLOW:

For pregnancy-induced diabetes. So healthcare professionals should basically not use the terms acute and chronic. What about the term in-remission? Is an addictive disease ever in-remission, and if it is, what would that mean?

Dr. WETSMAN:

Well, that's a good way to look it at. I think you have to look at what do we use of that word for in the rest of medicine. Commonly, we have said relapse when people start using drugs again, when I guess the coincident remission would be when people aren't using drugs, but I think that's not really the best use of the term. We wouldn't say that someone with diabetes has relapsed because now they are not doing a diet and exercise or taking the medicine right. We would say they were nonadherent to care plan and if they were in relapse what that means is their sugar is high in spite of treatment. So I think that what relapse should mean in addiction is that they are without the original symptoms of addiction which are those low dopamine symptoms in the midbrain and that's the way I talk about it with my patients, that they are in remission as long as they are feeling well and when they stop feeling well, it's time to look at their medical situation before they ever use another drug.

Dr. GITLOW:

So, let's talk about how to help the patient to feel better. Should patients with addictive illness ever be placed on addictive substances? For e.g., should an alcoholic in recovery ever have his or her anxiety treated with benzodiazepines?

Dr. WETSMAN:

That's an interesting and very controversial subject. I look at it more in terms of Russian Roulette. I am sure that nature has presented us with some people with alcohol dependence who could safely take, for instance, a long-acting benzodiazepine like Klonopin and may be even something a little bit shorter acting like Valium, but I have no way of telling which are the patients who can safely take it and which are the patients who can't safely take it and until science gives me that test, I think it's better not to be used in anybody because the risk, the catastrophic risk of restarting the person on drug use is just not worth the benefit of treating with that class of medicine, especially when we have alternatives.

Dr. GITLOW:

You are listening to the Clinician's Roundtable on ReachMD XM157, the channel for medical professionals. I am Dr. Stuart Gitlow. We are speaking today with Dr. Howard Wetsman, author of QAA: Questions and Answers on Addiction. We just spoke about using cross tolerant drugs for individuals with addictive disease, what about drugs that are not cross tolerant. If an alcoholic in recovery is in pain, should that individual be prescribed opioids? It's a different substance, does that matter?

Dr. WETSMAN:

It probably goes in some of the cases. I know alcoholics who have an abnormal response to the opioids and I know alcoholics who have

a normal response to opioids and I can imagine though I can't prove that some people are drinking because they have a problem at the opioid receptor and some people are drinking even though their opioid receptor works well because they have a problem with the dopamine receptor or with dopamine tone directly. Alcohol is a terrible way to tell what somebody's biology is because it's like a pharmacy in a bottle and you get kephalin response, dopamine response, serotonin response, and so I kind of think of it as, I hope I can of it this way, when I ask my patients how is cocaine and they tell me "Well, cocaine is not so hot" and how do opioids do, "Oh! I like those," well that's really someone who shouldn't take an opiate in their alcoholism treatment and if somebody says "Oh yes, I have had opiates before and they make me a little nauseated and I go to sleep", that may be someone who could safely take the opiates for pain control.

Dr. GITLOW:

So a series of questions would be necessary to make that determination?

Dr. WETSMAN:

Right, and right now there aren't in the field easy to do tests. It's really very, shouldn't say complicated, but specific history to take.

Dr. GITLOW:

You have spoken about how addiction is a biologic illness, do you still consider 12-step treatment to be important?

Dr. WETSMAN:

Yeah, because I think 12-step treatment is a biological treatment. It's actually the best cognitive behavioral system I have ever seen and it's the only one we have that's been actively working for 70 years.

Dr. GITLOW:

It represents medical treatment.

Dr. WETSMAN:

Well, no, not really because there is no medical professional involved, but it is a useful adjunct and it must change people through changing the brain. I may get to go to some people in AA who would like to believe it is a spiritual change, but as a neuroscientist I have to see the personality change and behavioral change and symptoms change as having worked to the brain and I have an idea, but no proof that actually how AA works neurobiologically.

Dr. GITLOW:

Are there specific medications that you have found useful in the treatment of addictive illness.

Dr. WETSMAN:

Yes and what's even more important is that they are pretty much all the same that it has more to do with the picture you have in your head of what the neurobiology of addiction is and what the patient's symptoms are and then you can pick from that rather than the way these drugs are marketed like this drug is for alcoholism and this drug is for cocaine dependence. I actually find those labels very unhelpful so that Wellbutrin for instance has been useful in treating addicts of all strives, not just cocaine dependence and the same goes for the antiepileptic drugs; they are touted as the treatment for alcoholism, equally good for other addictions.

Dr. GITLOW:

Wonderful. My thanks to Dr. Howard Wetsman, our guest, as we discussed his new text QAA: Questions and Answers on Addiction. I have one last question for him. Where can our listeners obtain a copy of your new book?

Dr. WETSMAN:

Well, it's on Amazon. It was written not quite as a text, but hopefully as an accessible book to answer commonly asked questions of both clinicians and the patients and their families.

Dr. GITLOW:

So see you are finding it to be useful by both physicians and by their patients?

Dr. WETSMAN:

Very, yes.

Dr. GITLOW:

I am Dr. Stuart Gitlow. You have been listening to the Clinician's Roundtable on ReachMD XM157, the channel for medical professionals. We welcome your comments and questions to our website at www.reachmd.com, which now features our entire medical show library in on-demand podcast. Thank you again for listening.