

Commentary

## Recovery and research: A better paradigm

For decades, physicians have spent countless hours treating patients with addictive disease in the hope that each such patient will enter recovery. A variety of treatment approaches have been used. Traditional medical models in which physicians talk with their patients, therapeutic communities, and medically supervised therapies provided by nonphysician clinicians each has a goal of seeing a patient return to “normal” function with morbidity and mortality rates returning to those that would be expected for the patient’s age.

Over the recent years, despite significant literature indicating excellent outcomes when patients are treated by physicians well versed in addictive diseases, our society has concluded that treatment for addiction is unsuccessful more often than not. In part as a result of this incorrect determination, our medical, political, and legal systems have sought a variety of interventions designed to “improve” outcomes. One method of improving efficacy is to change the desired goal to something easier to achieve, whether or not that goal has actual value.

As we look at the recent literature in which alcoholics are treated with a variety of proposed interventions, pharmacological and otherwise, we are astounded by the range of efficacy improvement efforts:

1. Do not study alcoholic individuals, but rather study a subgroup of subjects with alcoholism, perhaps those who drink a great deal or who already have an abnormal blood chemistry. This way, it is easier to achieve significant alterations of use that might be labeled with success.
2. Do not look at long-term outcomes, despite addiction being a lifelong illness, but rather study results over only a few months.
3. Do not compare results against those achieved using a traditional medical model, but rather compare the study entity against results obtained using a more commonly available technique because addiction specialist physicians are difficult to find.
4. Do not use recovery as an outcome measure, but rather pick an outcome measure that will be easier to achieve during the limited duration of the study, thus

resulting in a more easily established success rate. The percentage of days on which a subject drinks heavily, for example, or the percentage of days on which a subject drinks at all might be compared in pre- and poststudy periods.

5. When picking an outcome measure, pay no attention to whether that outcome actually provides enhanced morbidity and mortality rates in the group under study.
6. Alter the meaning of certain terms to better suit the chances that the hypothesis will be met or that the reader will be confused into thinking that success is meaningful. For example, abstinence rate, rather than referring to the percentage of study subjects who become abstinent, could refer to the percentage of days on which a specific subject was abstinent.
7. Ignore entirely issues that are known to predict eventual relapse, such as use of addictive substances, including those prescribed, other than the one being studied.

By following these rules, studies have demonstrated unfortunately meaningless success in a wide variety of areas. Those not recognizing the rules that have been followed are led astray, only to discover inevitably, and still incorrectly, that those with addiction are difficult to treat.

One major obstacle to more useful studies taking place has been the failure of our specialty to clearly define the desired outcome for those suffering from an addictive disease. If one follows the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* criteria rigorously, a patient can be in full remission from dependence yet might still be using addictive substances, either as prescribed or as desired. Yet those of us working in the field are secure in the knowledge that such individuals are neither in recovery nor likely to lead a long and fruitful life. Although the *DSM-IV* definition might be entirely reasonable, the very nature of the *DSM-IV* diagnostic criteria does not describe treatment goals or targets beyond the simplistic elimination of the original criteria themselves.

A more complete description has been left to others. And perhaps this has been the problem. To those of us in the field, the treatment goals are intuitive and obvious. They are unfortunately neither to those on the outside.

The Betty Ford Institute Consensus Panel's working definition of recovery is the first recent giant step in the right direction toward pushing both research and public policy in the direction they need to travel. For although recovery has always been our goal, the panel has correctly determined a lack of clarity as to what recovery represents. And without such criteria, researchers can hardly be expected to know

what we need them to study. My hope is that this early excellent work developing such criteria will inspire others to build upon it, will inspire researchers to implement studies that seek recovery as a goal, and will inspire politicians to ask not for prevention—somewhat difficult to accomplish in a disease with genetic underpinnings—but for recovery.

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