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## The Shorter PROMIS Questionnaire Further validation of a tool for simultaneous assessment of multiple addictive behaviours

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### Abstract

There is both a theoretical and clinical need to develop a questionnaire that assesses a range of addictive behaviours. The Shorter PROMIS Questionnaire (SPQ) is a 16-scale self-report instrument assessing the use of nicotine, recreational drugs, prescription drugs, gambling, sex, caffeine, food bingeing, food starving, exercise, shopping, work, relationships dominant and submissive, and compulsive helping dominant and submissive. Clinical cut-off scores using the 90th percentile were derived from a normative group of 508 individuals. These cut-offs correctly identified 78–100% of cases within clinical criterion groups of specific disorders. The clinical sample also completed other validated scales assessing gambling, eating, alcohol, and drug use. Correlations were typically .7 with relevant SPQ scales. The SPQ food, drug, and alcohol scales were at least equivalent to validated comparison scales in the strength of their relationship to relevant clinical criterion groups. Internal consistency was high for all scales, and test-retest reliability was generally good. This clinically useful instrument provides a broad assessment of addictive problems, thereby benefiting both the treatment provider and the client.

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## 1. Introduction

Functional similarities between substance-related and other addictive behaviours have been observed at the biological, psychological, and social levels of analysis (Donovan, 1988; Orford, 1985). It is also the case that different addictions tend to co-occur in predictable ways (Stephenson, Maggi, Lefever, & Morojele, 1995). Moreover, as McKay and McLellan's (1998) recent review would suggest, there is a clinical, not to say financial, imperative to deal simultaneously with the related difficulties of "polyproblem individuals." These various considerations provide a compelling incentive to develop an instrument that assesses a broad range of excessive behaviours that could be deemed as being addictive.

It has been observed that behaviours not involving the use of psychoactive substances can still produce physiological arousal. The heart rates of pathological gamblers increase during a gambling session (Coventry & Constable, 1999; Coventry & Norman, 1998), and altered dopaminergic and serotonergic functions have also been observed (Bergh, Sodersten, & Nordin, 1997; De-Caria, Begaz, & Hollander, 1998). Similarly, cortical arousal is a discriminating factor in the identification of individuals with a dependency on exercise (Beh, Mathers, & Holden, 1996). Other processes usually associated with addictive psychoactive substance use have been observed in excessive use of sex (Roth, 1992), work, and gambling (Orford, 1985); food (Cummings, Gordon, & Marlatt, 1980); tobacco and caffeine (Aubin, Laureaux, Tilikete, & Barrucand, 1999); shopping (Christensen, Farber, & DeZwaan, 1994); exercise (Furst & Germone, 1993); and the playing of video games (Phillips, Rolls, Rouse, & Griffiths, 1995).

Other evidence suggests that addictive behaviours consistently covary. It is common for a high proportion of alcoholics in treatment to report previous drug use (Sokolow, Welte, Hynes, & Lyons, 1981). Conversely, alcohol use is considered a complicating factor in the treatment of drug users (Miller, Belkin, & Gold, 1990). Wiederman and Pryor (1996) reported that a third of adolescents with bulimia also drank alcohol, used nicotine, and smoked marijuana. A study of high school students classified as problem drinkers found that 35% also had eating problems (Peluso, Ricciardelli, & Williams, 1999). There have been similar rates of comorbidity reported in inpatient populations. For example, approximately 40% of individuals with a diagnosis of anorexia or bulimia also abused drugs and alcohol (Zerbe, Marsh, & Coyne, 1990). In addition, 22% of those with an eating disorder reported using cocaine in an attempt to alleviate their symptoms (Gold, Gold, Sweeney, & Potash, 1987).

High levels of comorbidity have been found in a survey of gamblers in treatment, with 47% also abusing drugs and alcohol (Ramirez, McCormick, Russo, & Taber, 1984). Conversely, 14% of substance abusers in treatment also met the criteria for pathological gambling, with a further 14% identified as experiencing problems with gambling behaviour (Lesieur & Heineman, 1988). These relationships also exist in nonclinical populations. Griffiths and Sutherland (1998) discovered that among adolescents, self-reported gamblers were also significantly more likely than nongamblers to report that they drank alcohol, took drugs, and smoked tobacco. In a study investigating 'overlap-

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