ARE OPIOID ADDICTS DEPRESSED

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SUMMARY
The Study was undertaken to explore the extent and nature of depressive illness, if any, in fifty known opioid addicts before undergoing detoxification. The extent and nature of the addicts were compared to those of non-addict population made up of students from Ghana University, Legon. The Beck Depression Inventory (BDI) was used to obtain the scores in both groups.

Statistical analysis of the scores in both groups showed with the exception of three subgroup symptoms (disappointment, appearance and ability to work are not the core of or primary symptoms of depressive illness, the present study does not confirm the association between opioid addiction and depressive illness before detoxification.

There are few drawbacks in using the BDI to eficit depressive symptoms in Ghanaian culture. Subgroup symptoms like tiredness, loss of appetite and lack of effort of the BDI may be falsely scored, by Ghanaians respondents suffering from physical illnesses. The low subgroup symptom scores on guilt and suicidal thoughts on the BDI in both populations have also been discussed.

Key Words: Opioid Addiction, Depressive Illness

INTRODUCTION
There is an increasing concern in most countries on the rising incidence of drug abuse and addiction because of its negative effects on the youth and society at large. In Ghana, barely a week passes without a comment on some aspect of this anti-social behaviour in the news media.

For instance, during the recent launching of an Anti-Drug Fund in Ghana\(^1\), it was estimated that between January 1990 and October 1995, a total of 817 people were arrested for dealing in narcotic drugs, and drugs seized within the same period included 59.3kg. of cocaine valued at 168, 198.71 U.S. dollars, 26.05kgs of heroin worth 447,577.60 U.S. dollars and 68kgs of India hemp valued at 14,469,426.61 U.S. dollars.

The effect of drug addiction on the family, community and the nation is devastating, yet little or nothing is being done to curb the rising incidence of drug use and abuse. This may, among other factors, be due to inconsistencies in research findings on the subject, and the non-availability, therefore, of a firm scientific basis to support primary prevention initiatives or programmes.

In recent years, more and more investigative works carried out on substance abuse have pointed to the fact that basic problem of addicts is psychological or psychiatric. However, the part played by genes, early social interactions and personality traits should not be underestimated. There are those who believe that drug addiction is due to deep seated psychopathic disorder while others blame society for its present values.

Others tend to believe that drug addiction is the result of prolonged emotional disorder and lack of discipline in the families of the victims. For instance, Wieland and Sola (1970)\(^2\) found that users of heroin
tended to have also been obtained by Lehmamn and De Angelis (1970) using a check list symptom. Fejer and Smart (1972), in another study, found that most heroin users gave depression as the major reason which prompted them to seek for treatment. Noble and Barmes (1971) found users of narcotics more depressed and suicidal than users of soft drugs. On the contrary, Gritz et al (1975) and Ling et al (1973) have not been able to substantiate these findings. Hill et al (1960) noted that most addicts seem to be suffering from basic personality disorders associated possibly with psychoneurotic or psychotic states. Wurmsner (1974) also observed that majority of drug abusers as defined by the low and public opinion are emotionally healthy and stable when compared with the total population. It appears, therefore, that there are different research findings and further work is needed to throw more light on the personality trait and concomitant psychiatric morbidity associated with drug addiction. The present investigation was designed to further explore the extent and nature of depression, if any, in drug addicts before detoxification and to compare the degree of their depression to that of non addicts.

METHOD

The study was undertaken at the Valley View Clinic at Dzorwulu, Accra. The clinic offers private and primary medical care with facilities for outpatients and twenty-four in patient psychiatric beds.

Data Collection

The study covered a period of four years (1991 to 1995). During this period, all patients admitted with a history of Heroin addiction were screened for the study. Patients excluded were those with previous history of major psychiatric illness e.g., Schizophrenic illness, Affective illness or severe organic brain syndrome. The ages of the patients ranged from 21 - 40 years (mean 25 years). The total number of heroin addicts who were selected was 50. A similar number of randomly selected males was obtained from Commonwealth Hall and Legon Hall at the University of Ghana, Legon. Their ages ranged from 22 years - 32 years (mean 22 years).

None of the female patients screened was included.

Interview

The Beck Depression Inventory (BDI) (1972) was used to elicit depressive symptoms in both the addicts and non-addicts. The BDI provides a quantitative assessment of the intensity of depression as evaluated by the patient. The scale assesses the mood of the patient and does not take into account fluctuations in the patients condition. BDI was chosen to elicit the depression scores because the scores have been validated using comparisons with previously established methods of diagnosis of depression and it can also discriminate between anxiety and depressive symptoms. Secondly BDI has published impressive reliability and validity. Thirdly the instrument has fairly easy instructions on administration in a group setting. Finally the BDI has been administered to many narcotic users, normal and/or psychiatric population. Because of the low level of education of ten of the addicts the author administered the BDI questionnaire on these addicts. This was done to prevent misinterpretation of the meanings of the subgroup symptoms and scoring procedure. Some words like “pessimistic” and “guilty” had to be explained to them. Two of the ten addicts felt that the information was being collected by the Police, however, after explaining the purpose of the information they agreed only to answer but not the fill the questionnaire themselves. None of the subgroup symptoms needed translation into Ghanian language. The students from the University completed the questionnaire themselves. The addicts were interviewed within twelve hours of admission (i.e. before withdrawal symptoms appeared since these were likely to affect the scores).

RESULTS

Table 1 shows the age distribution of addicts and randomly selected non-addict students from University of Ghana. Table 2 shows the levels of depression using the BDI for the addicts and non-addicts. The scores show that none of the groups was mildly depressed (5-7).
Table 1: Age Distribution

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Addicts</th>
<th>Non-Addicts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>1-24</td>
<td>9 (18)</td>
<td>15 (30)</td>
</tr>
<tr>
<td>25-29</td>
<td>25 (50)</td>
<td>21 (42)</td>
</tr>
<tr>
<td>30-34</td>
<td>13 (26)</td>
<td>10 (20)</td>
</tr>
<tr>
<td>35-39</td>
<td>3 (6)</td>
<td>4 (8)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

Table 2: Beck's Depression Inventory for Addicts and Non-Addicts

<table>
<thead>
<tr>
<th>Scores</th>
<th>Non-Addicts</th>
<th>Addicts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>5-7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>8-15</td>
<td>17 (34%)</td>
</tr>
<tr>
<td>Severe</td>
<td>16-39</td>
<td>33 (66%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50 (100%)</td>
</tr>
</tbody>
</table>

Seventeen (34%) of the non-addicts were moderately depressed and eight (16%) of the addicts were moderately depressed (8 - 15). Thirty three (66%) of the non-addicts were severely depressed against 42 (84%) of the addicts. It is of interest to note that there is a tendency for high scores on the BDI and that none of the cohorts was mildly depressed (5 - 7). Possible reasons for these findings will be discussed later. The objective of the analysis of these scores was to examine the extent of variation between a group of 50 drug addicts and a group of 50 non-addict persons. This was done in respect of their respective scores according to the BDI. The method of analysis was chi-squared ($\chi^2$) was used even though a few cells had total counts of less than 5 responses. Though some categories could have been regrouped, it was deemed important to show the full range of responses obtained on the Beck Scale.

The chi-square test was employed to show how drug addicts varied from the normal population with regard to each phenomenon or characteristic. The analysis showed that with the exception of 3 symptom sub-groupings, drug addict did not vary significantly from the normal population was not statistically significant both at the 90% and 95% confidence levels.

These included test involving differences in pessimism, failure, satisfaction, guilt, suicidal attempts, interest, ability to make decisions, tiredness and appetite on the BDI.

On the other hand, with respect to disappointment, appearance and ability to work, the test indicated that the variation between the two groups was statistically significant both at the 90% and 95% confidence levels with three degrees of freedom except for pessimism and disappointment (two degrees of freedom). Sadness was significant at 90% confidence level although not significant at 95% level.

The analysis of these scores in both group shows that:
1. Both normal people and drug addicts are not prone to sadness.
2. Normal people and drug addicts are equally not pessimistic.
3. The normal population and drug addicts do not feel that they are a failure.
4. Normal people and drug addicts both feel satisfied.
5. There is no difference in the guilt feelings between the two groups.
6. Drug addicts are more disappointed than normal people.
7. Both groups do not experience any difference in suicidal thoughts.
8. Both groups have interest in life.
9. The propensity to make decisions is still high for both groups.
10. Normal people feel more attractive in their appearance than drug addicts.
11. Normal individuals are more able to work better than drug addicts.
12. There is no difference in the vulnerability to tiredness in both groups.
13. There is no difference in the appetite of both groups.
DISCUSSION
The results of the present study showed that only three symptom subgroups reached statistically significant level when the normal population was compared to the opioid addicts. The symptoms subgroups on the BDI which were statistically significant were disappointment, appearance, ability to work. These symptoms are not primary symptoms of depressive illness which basically involves mood changes. The difference in the scores of sadness, pessimism, guilt, suicidal attempts, tiredness and loss of appetite were not significant.

The present study, therefore, does not confirm association between opioid addiction and depressive illness. Wurmser (1974)\textsuperscript{9} using BDI, found that irritability, loss of appetite, loss of weight, lack of sleep and performance difficulties are the kind of dysphoric mood experienced by the addicts. He further stated that the nature of their dysphoric mood differs qualitatively from that of neurotic and psychotic; in that the opiate user experiences more irritability, performance difficulties and negative outlook as an important constituent factors of their depression whereas the neurotic and the psychotic tend to experience a predominance of deeper mood changes.

The present study administered the BDI to elicit depressive symptoms in addicts and non-addicts. However, there are drawbacks in the BDI which may have affected the scores of the study. The study of depression in different cultures has posed many problems and unanswered questions. There have been reports on the rarity of depression in developing societies (Kiev 1972)\textsuperscript{14}. This has been attributed to the social attitudes towards depressive illness rather than actual rarity. It is now widely accepted that depressive symptoms are almost always somatised in the developing societies. Could these factors affect the present scores of the BDI? No doubt, beliefs and societies, but also tend to furnish channels of expression for the causes of mental disturbance. Depressive illnesses are, therefore, rendered psychodynamically understandable to the extent that they are recognised or may be explained without treatment.

Furthermore, some of the BDI subgroup symptom scores e.g. tiredness, loss of appetite, lack of effort may be falsely scored by a respondent suffering from malaria fever or anaemia. No doubt, these false positives may affect scores. It is, therefore, not surprising that there were high scores for depressive illness to such an extent that none of the scores fell within the mildly depressed (5 - 7) scores and for severe depressive illness (16 - 39), the non-addicts scored 66% and the addicts scored 84%. Guilt and suicidal tendencies have been frequently reported as being rare in developing societies (Kiev 1972)\textsuperscript{13}. Thus, guilt feelings was only found in 2% of the non-addict population. In contrast to these findings, Kosten and Rounsaville (1988)\textsuperscript{14}, Badden (1970)\textsuperscript{15} reported of a high incidence of suicide tendencies among addicts applying for treatment in the United States.

It is of interest to note that students are naturally not an ideal group for comparison because most students are vulnerable to other stresses like academic and financial, hence these factors may be taken into consideration. Another factor which may affect the results of the study is the size of the addict population. Owing to the strict criteria adopted for case selection and the fact that the project was undertaken at a private clinic, it was impossible to obtain a large number for the study. The fifty addicts selected for the study were collected over four years. Another drawback which is relevant is the method of scoring. The students (non-addicts) competed the questionnaire themselves while the author scored the questionnaire for some the addicts. This was inevitable because of the lower-levels of education of few of the addict and other reasons previously discussed.

It is important also to note that the addicts were interviewed and scored within twelve hours of admission. It has been shown that symptoms of opioid withdrawal may coincide with those of depressive
illness and it may be difficult, if not impossible, to make a diagnosis in the context of opioid dependence. (Hundlesmanet et al 1992)\(^{17}\). The interview given to patients within twelve hours of admission seemed to delimitate the symptoms of opioid withdrawal from those of depressive illness. It was further noted by Hundlesmanet et al that the psychiatric diagnosis such as major depressive disorder may in part be an affective (depressive) component of opioid withdrawal syndrome rather than the cause of opioid addiction. The strong association, therefore, between symptoms of opioid withdrawal and depression should be interpreted with caution. The issue of whether depressive illness is the cause or consequence of Opioid abuse or withdrawal can only be resolved by further prospective studies.

REFERENCES

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