

Clinical Features of Heroin Dependence Onset in Young Women

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Summary

Important clinical mechanisms leading to opiate (heroin) addiction in young female patients have been investigated using a clinical-psychopathological method. The aim of this study is a better understanding of how integration takes place between the main factors involved in the onset and initial dynamics of general syndromes involving chemical dependence: pattern of intoxication, withdrawal syndrome, craving, personality degradation. Our clinical definitions have focused on describing the symptomatology and analysing which factors count the most in determining dependence. Distinctions have been drawn between the main onset mechanisms of heroin dependence in young females. They have been divided into: inductive, hedonistic, neurotic and mixed inductive-neurotic. Each mechanism is characterized by intrinsic clinical traits and symptoms, which comprise both premorbid personality and environmental factors. Comments are provided on the clinical dynamics of opioid dependence in its early stages, as these emerge in young female patients.

Key Words: Heroin Dependence - Sex differences - Clinical Mechanisms

The need for studies on the clinical features of heroin dependence springs directly from the great importance of the problem. This importance is particularly evident in the case of young patients. It must be admitted that this assertion cannot be proved, because chemical dependence usually begins when these patients are still very young [4,5,6,7,10,20]. It is especially interesting for clinicians to understand the main mechanisms that determine the onset and clinical development of opioid (heroin) dependence in young women. Previous investigations of this type have mostly been carried out in

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young men^[5, 15, 16, 19]. The comparison of details (to be found in the two groups) makes it possible to see some differences which are important not only in gaining an understanding of clinical features that are regularly displayed, but in formulating treatment strategies^[9, 13, 18].

The early stages of chemical dependence are characterized by closely related factors of premorbid personality — those dependent on environments and those due to the pathogenicity of mental illness^[6, 8, 11, 12, 15, 17, 22]. We consider opioid dependence to be an expression of psychiatric pathology^[1]. However, different forms of heroin dependence expression correspond to different intensities of illness symptomatology displayed^[3, 7, 9, 11]. This affects both the psychiatric quality of symptoms and the rapidity of their clinical dynamics. In order to understand the main clinical pathogenic mechanisms of chemical dependence, it is important to describe inherent clinical symptoms as precisely as possible. This symptomatology develops into general syndromes of dependence. There are patterns of intoxication (in our case, heroin intoxication) which can be identified by specifying the daily doses of opiate taken, the intake route, and any manifestations of a withdrawal syndrome (the post-intoxication phase and its psychopathological aspects). Another very important component of drug addiction expression is known as craving. This phenomenon is clearly psychopathological. In the last analysis, it can be viewed as a form of personality degradation that arises from the evolution of this disease.

The psychopathological component appears as a specific disorder of general spheres of psychic function. There spheres are those of consciousness, thinking, affective values, intellectual-cognition and memory, volition, behavioural aspects. Every aspect of psychic function finds expression in the symptoms and syndromes which appear as psychopathological signs of opioid (heroin) dependence. The evolution of this symptomatic picture begins in the formation stage of dependence and is only complete once the disease is totally developed. The peculiar properties of clinical displays of this kind of symptomatology in young females can be said of great interest.

The methodology used in studying this phenomenology is based on the traditional criteria to be found in the clinical-psychopathological investigations reported in classic psychiatry^[1]. The advantages of clinical-psychopathological investigation are that it makes possible the identification of complex formations, together with the integrative character of this kind of study, which includes, besides its proper function of psychopathological assessment, a patient's psychic status, along with the somatic toxicological aspects and psychological testing as an auxiliary kind of diagnosis. So, psychopathological disorders can be effectively investigated only by drawing on a complex clinical diagnostic pool. Here the main role belongs to the methodology of classical clinical-psychopathological analysis, which allows for static forms of diagnosis (symptoms and syndromes) to become dynamic in response to changes in symptomatology. This procedure makes diagnosis possible not only on the level of syndromes, but also in assigning a nosologically specific description of heroin dependence appropriate to young patients. Psychological testing with the most useful diagnostic testing methods is helpful in investigating the dynamics of the intellectual and emotional sides of mental activity

as personality traits. The clinical diagnosis of the somatic sphere makes it possible to reveal somatic and neurology disorders as being the result of chronic intoxication, and to assess their clinical significance. When viewed in terms of a complex, all this allows opioid (heroin) dependence to be considered as a holistic psychosomatic disease and authorizes the evaluation of its dynamic characteristics, along with the formulation of an individual prognosis. However, this main function can be fully realized only as the result of further complex studies.

The aim of the present investigation is that of studying features currently found in the early stages of heroin dependence in young women. It means describing and identifying the basic clinical phenomena accompanying the formation of heroin dependence in a specific set of circumstances. These phenomena reflect psychological premorbid personality features, as well as the external factors that promote the onset of opiate abuse. They also reflect features belonging to a pattern of intoxication and to the opiate withdrawal syndrome.

Using the classical clinical-psychopathological research method, 53 women aged between 15 and 26 years were studied after they had applied for help to a specialized narcological hospital because they wished to overcome withdrawal infringements after a period of heroin abuse. All these patients were surveyed according to standards accepted in everyday clinical practice, after they had passed a psychological test (on cognitive functions and levels of emotional reaction). Widely applied psychological methods ^[25] were used during the implementation of the research programme. Within the group being studied, young women in the 20-26 years aged group made up a majority (55 %); 38 % of the group surveyed were aged 18-19 years and 6% were minors.

As experienced in these cases, the initial stage of heroin dependence begins with the appearance and progressive build-up of an intoxication continuum. This continuum may be uninterrupted or intermittent ^[1]. In some cases the onset phase appears accompanied by an increase in symptoms of craving. These symptoms reflect the status of conscience, of thought and the cognitive sphere, as well as the emotional, volitional and behavioural spheres of psychic functioning. Thinking disorders prove to be most important and informative signs of mental illness. This is particularly true in the case of opioid (heroin) dependence ^[1]. Mental dysfunctions of this kind appear as the formation of a super-valuable idea. It implies an idea of narcotism as a totalizing function of thinking which is able to subordinate all other motivations and thoughts. It also involves a disappearance of critical capabilities. Other psychic functions largely depend on the thinking process. The destruction of volition appears some time later, when dependence has become stable. During our study on this sample of young female the following factors emerged.

At the moment of initial appraisal, the duration of the heroin use in 53 % of these cases was 18-24 months, in 38 % it was 3 years or more, and in 9 % it was one year or less. A majority of patients had applied to the specialized institution for the first time in their life (85 %). Patients used heroin intravenously and by the inhalation of heroin powder through a nostril. As much as 18 % of the surveyed group of women,

besides abusing heroin, reported episodes of cocaine powder inhalation . This kind of cocaine inhalation is not a distinctive feature of the set of clinical signs that mark heroin dependence, especially the signs that specifically mark withdrawal. In this sense, an additional form of intoxication does not essentially change the symptomatology of an emerging heroin dependence.

The educational level of the patients studied was quite high: 7.5% (4 patients) had received higher education, 68% (36 patients) had had a secondary education, and 7.5% (4 patients) had had a special (professional) secondary education, in the form of vocational training.

Results

Among the women surveyed, the age of first familiarizing with a drug ranged between 14 and 25 years.

Unlike men, whose first experience of a drug in their life turns out, in most cases, to be an experience of cannabis ^[3, 5], for most of the women investigated by us (68%) heroin was their first drug. As many as 45% of the women surveyed (24 patients) began the regular use of drugs as teenagers.

The earliest experiences of drug use in this subgroup were caused by curiosity, by an aspiration "to try everything", and by the psychological reaction to group thought, with an attitude of passive submission to the existing norms of the social environment closest to these patients (environment of pathological type). Quite often the earliest occasions on which heroin was tried took place quite a considerable time (from 2 months to about one year) before the period in which the patients first belonged to a group of drug users — members of the immediate family, school friends, people living in the same building, other neighbours and distant relatives. These data allow us to recognize the dominant role of environmental factors in the period when heroin dependence emerges. Even before there is any direct involvement with heroin, the previous behaviour of these addicts goes to show that drug use is not thought to be "so terrible". The sharing the experiences and moments spent hearing the description of sensations experienced by others made these women first feel interest in, and then a desire to try, a drug. Because they knew about the consequences, these girls felt sure they "had enough will-power" and would not become dependent on heroin. This finding is very important for our subgroup, because in it we did not encounter any significant factor arising from post-traumatic stress disorder (connected, in particular, with sexual violence), in contradiction with the views of some investigators ^[23]. This first model of familiarization with narcotism — its most common pattern — is named by us as *inductive*. The dominance of mechanisms determining the development of addictive behaviour through the formation of early psychological dependence on a drug (e.g. a positive perception of the primary idea of narcotism) emerges here. This is where the influence of environmental circumstances is decisive. This phenomenon is based on adolescent infantilism, which is a trait that is characteristic of this whole age-group.

We have no predisposition to exaggerate this kind of element in this age bracket, so we will only say that we view environmental factor as being of general importance.

32% (17 patients) of those in the 18-20 year age-group used more than one drug.

Less than half of those in this subgroup (6 patients, or 35%) accepted heroin for the first time in a circle of congenial people (“for company”), on at a party, or from a wish to stay abreast of others by being “like everyone”, or to show a certain primary, independent interest in a drug. 24% (4 women) took that decision together with a girlfriend or from a desire to feel unusual sensations. 41% (7 women) started drug use “to understand” the experiences of their husband (or boyfriend), who was suffering from drug addiction. We can now go on to consider induction as a component. Further familiarizing with a drug was favoured by such qualities in these women as unreasonably high demands, or an aspiration “to make life easier”. The impossibility of immediately satisfying usual needs resulted in daily disappointment. This is the real component that brings about frustration! In this case, too, the main inductive mechanisms that lead to familiarization with drug use are expressed in connection with personality factors. 35% (6 patients) of this subgroup, prior to the onset of regular drug abuse, retrospectively recognized anxiety and neurotic depression, when the frustration of these particular patients and their reactions to negative life circumstances were revealed by them. According to one patient, “the impossibility of living in any way that would be desirable” led to the beginning of her drug-taking. A diagnosis of post-traumatic stress disorder in the premorbid period was absolutely real in this case. Evidence has also been reported of a certain erosion of emotional attachments and in will-power in the premorbid phase^[14,22]. This second variant of familiarization with heroin abuse is referred by us as being mixed *inductive-neurotic*.

Heroin use began at a more mature age (21-25 years) in 23% of the women surveyed (12 patients) in our group. 67% (8 patients) of the women in this subgroup with onset age of 21-25 years — women displaying infantile thought-patterns — have been deeply influenced by ideas of a “beautiful life” imagined in the form of visits to night clubs bars, and the enjoyment of “high quality leisure” and permissiveness. This special variant has been named by us as *hedonistic*. Here we feel fully justified in speaking about infantilism as a symptom of the retardation of psychic functions (without any need to go into further details).

In the other 33% of the women in this subgroup, anxiety and neurotic traits were expressed in the initial phase of dependence. The symptomatology here was univocal, because signs of formatted neurosis before the formation of a heroin toxic continuum were implicitly dominant. Nevertheless, post-traumatic stress disorder was a mark of premorbid characteristics and factors favouring early experiments with heroin through a real ability to accept neurotic mechanisms capable of determining drug dependence. This variant of familiarization with heroin abuse has been defined by us as *neurotic*. Further interaction between the symptomatology of preliminary neurosis, neurotic mechanisms of drug dependence formation and the proper psychopathology of chemical dependence raises clinical questions which involve additional issues. Here any decision

to consider such interaction only as a simple co-morbidity would mean committing various methodological mistakes ^[2].

A distinctive feature of one type of patient studied by us is a high tolerance of deviant behaviour in the social environments closest to these subjects: the consequences include the inaccessibility of information from them about how they earn money, and the lack of discrimination in their choice of a partner. This hypothesis has been supported by other studies ^[16, 17, 21, 22, 24]. With women in this group one finds emotional dullness, with erosion of the supreme emotions and of moral and ethical categories; typical outcomes include situations of indebtedness, unfulfilled responsibilities and compulsiveness. In these cases the process of familiarizing with a drug was facilitated by the fact that at the initial stage the majority took heroin powder by inhaling it through a nostril, not by resorting to injections.

In 55% of the women in our group (29 patients), the condition of intoxication initially received a positive subjective assessment. In these cases, right from the beginning, drug abuse had a regular character (2-4 doses a week). Psychic dependence was formed through 4-5 drug-taking events, and in 2-3 months from its initial use, the consumption of heroin became a daily occurrence. Tolerance grew, reaching 1g of a heroin powder per day, comprising 2-4 doses. According to addicts skilled in the amplification of euphoria over 4-6 months, patients moved on to an intravenous route of heroin intake, so that their daily doses fell to 0.2-0.3g of heroin powder. Quite active narcotic intoxication lasted 2-3 years in these cases. The withdrawal syndrome here became full-dress during a period as little as 3 or 4 months. It had sufficient manifestation, but the components characterizing the post-intoxication phase included no excessively expressed somatic or vegetative features. Furthermore, patients in this group aspired only to the achievement of a subjectively comfortable condition, without any wish to experience an expressed euphoria. What can be noted here, therefore, could be called a rather malignant current of narcotism, with the fast formation of syndromes of dependence. At the same time, the observed features of female narcotism comprises a rather fast stabilization of the clinical picture and an outcome of illness at a stage when a drug is constantly consumed, but with rather low toxic parameters. These tendencies allow us to speak about the original current of illness as being accelerated — a feature that distinguishes female narcotism. After the initial phase, the illness functions like a continuous current. As shown by the cases examined under our supervision, in men the similar script of development of a malignant clinical picture takes considerably longer; it is accompanied by the characteristic of a high degree of intoxication both during the initial phase, and during stabilization of the pathological process, which can at that point be called opioid (heroin) dependence.

Another subgroup of patients (36%: 19 patients) was characterized by a long period — lasting between half a year and 2 years — of irregular frequencies, with long breaks, in the use of heroin. Heroin intakes were carried out at a frequency of 1 to 4 times a month, usually on days off, when visiting a disco, or at a party, or when on vacation. Further psychological traumas (“an unfortunate love-affair” is the commonest exam-

ple), or a love-affair with an addict favoured the formation of psychic dependence, and the consumption of heroin became regular (2-4 times a week). Later, after 4-6 weeks of regular consumption, the features of physical dependence appeared, and patients moved on to daily intravenous intakes of a drug, 2-3 times a day, with a dose of up to 0.3g. As can be noted, in this particular variant the formation of the clinical features of dependence takes place quite slowly. Even so, in this case, too, narcotism ends up by taking a constant form, though with rather less malignant clinical characteristics than those found in other subgroups.

One focus of special interest is the small group of women — 5 patients (9% of the whole group investigated) — who used a drug cyclically, with long intervals between periods of use. In this subgroup, the rhythm of drug taking roughly followed the pattern of consuming the drug 2-4 days a week for a period of 1-3 months, uninterruptedly, followed by a break of 1.5-2 years. After a psychological trauma or an abortion, drug taking was renewed; regular drug use became a marked feature over the next 2-3 months. Once a really stressful situation ended, spontaneous remission became increasingly likely. Women in this subgroup preferred not to go beyond the inhalation route to drug intake. In these cases, tolerance increased considerably — reaching as much as 1.5g of heroin powder; the features of withdrawal were not, however, expressed harshly. The painful component was feebly marked, which allowed patients to avoid resorting to medical aid. Nevertheless, 2.5 years after the onset of drug abuse, these patients proceeded to make use of the intravenous heroin intake route, too. In this case it is the initial picture of the illness that displays the lowest degree of malignancy. Here the onset of narcotism is characterized by a long-standing, casual use of a drug. Cases like these reveal with the utmost clarity the importance of environmental factors in the development of considerably deferred constant forms of intoxication that end up by becoming constant.

One consequence of chronic heroin intoxication in women is the increasing damage done to their gonads, leading to amenorrhea and infertility. Although they all belong to a fertile age-group, only 8 patients (15% of those surveyed) have children. Displays of a falling away in personality levels in young women with heroin dependence are not so obvious at the initial stages of illness. At the same time, as narcotism progresses, together with complications in the form of polynarcotocomania or dramatic alcoholism (which are sometimes found together, mainly in a final phase of this illness), what is especially prominent — when the malignant current prevails — is an expressed deterioration of all the parameters of the personality, even at the initial stage of heroin dependence. What first becomes apparent is a specific hysteroid personality dynamics. Then hypobulia and parabolia are found, with a falling away in emotional involvements specific autism, impairment of creative personality functions, psycho-organic dysfunction. When these forms of personality changes are combined in a uniform complex we call this a *defect*. The breakdown of all a patient's ongoing developments causes an upheaval in that patient's socialization, which can be observed in her refusal to work or carry out any form of creative activity; at the moment of testing, as many

as 77% (41 patients) in the whole group were idle and had to depend on husbands or relatives. We call this type of behaviour “*rental*”; it is a feature that can be considered one of the most important clinical characteristics of a specific drug addiction defect. These patients have lost all other interests apart from drugs, and show a very low level of social adaptability.

Points of interest

Study of the onset stage of heroin dependence in young women has shown four main clinical variants whose description allows a clearer understanding of the pattern taken by this dependence. The inductive mechanism is a features intrinsic to the teenager subgroup. Here the main role belongs to environmental factors. The mixed inductive-neurotic mechanism is typical of women whose use of heroin begins at a later stage. In this case the role of premorbid personality and environmental factors shows its strength. Hedonistic and neurotic mechanisms surrounding the onset of heroin dependence reflect peculiar properties of the premorbid personality connected with infantilism and post-traumatic stress disorder.

The next characteristic of the initial period of heroin dependence in young women is their rapid evolution through the stages of illness, leading to a quick defect attack. The specific features of an opiate defect include: hysteroid personality dynamics, hypobulia and parabulia, a fall in emotional involvement, specific autism, and the impairment of creative personality functions. Psycho-organic dysfunctions, together with a polynarcotomicomanic pattern of intoxication (including alcoholism), complete this defect. In general, this kind of development of the clinical picture can be observed in the evolution of the illness.

As a result of research it has been found that, in women, mental infantilism, when combined with deformed authentication and incorrectly understood femininity showing as passive subjection, are able to determine heroin dependence at the initial stage of its formation. At the same time, as rather softer clinical displays of drug dependence go to show, the main impulse to take drugs comes through social factors which, because they are pathogenic, favour the pathological dynamics of illness already discernible in its initial displays. In the group studied, despite its rather low tolerance, the use of a drug with breaks between periods of consumption, and a rather low level of prescription writing for the disease, a clear clinical picture of dependence proved to be specific to this form of narcotism. Even when, as in these cases, the level of intoxication is rather low, the functional features of a woman’ social role does much to determine the importance of the personal and social consequences of drug abuse. The importance of the social side can be traced in the falling Russian birth rate, the deterioration of health levels nationwide, and the fall in the percentage of the population that is working. On rates of social degradation, a dependence on heroin in women comes nearer to a teenager type of narcotism. Heroin dependence in women, despite a moderate display of toxic patterns, follows a more rapid course, compared with narcotism in men. This is shown

to be true by the earlier advent of defect in women, along with the earlier evolution of their social problems and their loss of adaptability at an earlier age.

The present study is the first step that has been taken within the framework of a research project dedicated to the main problem in clinical narcology — the psychopathological aspect of drug dependence.

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Received September 28, 2006 - Accepted January 12, 2007