

Psychometric Properties and Factor Structure of 2 Chinese Opiate Withdrawal Rating Scales

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Abstract

Objective: This study aimed to examine the psychometric properties and factor structure of the Chinese versions of 2 rating scales: the revised Subjective Opiate Withdrawal Scale and the Objective Opiate Withdrawal Scale.

Patients and Methods: The study comprised 2 parts. In study 1, fifty one patients with a diagnosis of opioid dependence (76.6% male, 23.4% female; mean age, 35.60 ± 11.15 years) were assessed with the revised Subjective Opiate Withdrawal Scale and Objective Opiate Withdrawal Scale after admission to Kwai Chung Hospital for detoxification. In study 2, sixteen patients with a diagnosis of opioid dependence (50.0% male, 50.0% female; mean age, 34.40 ± 10.84 years) admitted to Kwai Chung Hospital for detoxification, were recruited. The revised Subjective Opiate Withdrawal Scale and Objective Opiate Withdrawal Scale were administered on days 1, 2, 7, and 14 of a methadone detoxification programme.

Results: The reliabilities of the 2 scales were shown to be satisfactory. Four meaningful factors emerged in the results of factor analyses for the revised Subjective Opiate Withdrawal Scale, whereas a single-factor solution was found to adequately account for the data-set of the Objective Opiate Withdrawal Scale. Consistent with expectations, a steady reduction profile of opiate withdrawal features was present in the measures of the revised Subjective Opiate Withdrawal Scale, whereas the Objective Opiate Withdrawal Scale was less sensitive in measuring the changes.

Conclusion: The revised Subjective Opiate Withdrawal Scale and Objective Opiate Withdrawal Scale were found to have satisfactory psychometric properties and different factor structures. Salient findings and recommendations for future investigation were discussed.

Key words: Factor structure, Opiate dependence, Psychometrics

Introduction

Opiate addiction remains a major problem among users of illicit drugs in Hong Kong. According to the statistics of the Central Registry of Drug Abuse (CRDA) from 1995 to 2000, opiate misuse accounted for approximately 80% of common drug abuses.¹ In the latest guide for drug addiction treatment, it is emphasised that effective drug interventions should adopt a biopsychosocial approach to address the complex and multiple needs of patients. Detoxification alone is insufficient to achieve long-term abstinence.² However, the principle of operant theory predicts that the undesirable

consequences (the presence of withdrawal symptoms) of discontinuing drug-taking behaviours can serve as a powerful negative reinforcer to maintain drug use.^{3,4} Indeed, local substance abusers have reported that the major reason for current drug use (approximately 55%) was to "avoid discomfort of its absence".¹ Therefore, pharmacological treatment plays a pivotal role in reducing withdrawal symptoms and the associated fear that keep addicted people away from treatment.

In recent decades, new treatment strategies for opiate addiction, such as using opiate receptor antagonists and rapid opiate detoxification under general anaesthesia, have become increasingly common.⁵⁻⁷ Inventing novel pharmacological treatment can minimise withdrawal symptoms and hence facilitate participation in treatment. To document and compare the various treatment approaches for effective detoxification, psychometrically sound measures are necessary.

The Subjective Opiate Withdrawal Scale (SOWS) and Objective Opiate Withdrawal Scale (OOWS) are 2 of the scales developed by Handelsman et al to measure opiate withdrawal signs and symptoms.⁸ The former assesses 16

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Submitted: 7 December 2001; **Accepted:** 7 June 2002

covert withdrawal symptoms reported by individuals, whereas the latter examines 13 overt signs checked by observers. Handelsman et al⁸ showed that these measures had adequate reliability and validity, and Loimer et al⁹ subsequently replicated the satisfactory validity of the scales. However, the latter revealed that the 2 scales did not have a significant correlation.⁹ A few questions or limitations remain to be addressed.

Firstly, because the SOWS and OOWS were built on previous empirical work (the Addiction Research Center Inventory¹⁰ and Himmelsbach Scale¹¹), their conceptualisation of opiate withdrawal symptoms might be different from the current concept. In fact, when compared with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV)¹² and the *International Classification of Mental and Behavioural Disorders* (ICD-10),¹³ 5 subjective opiate withdrawal symptoms are not listed in the scales. Thus, there is a need to re-examine the psychometric properties of the scales (particularly the SOWS) if these items are included.

Secondly, what are the factor structures of the scales? Handelsman et al argued that SOWS and OOWS could measure and reflect symptoms of various domains including motor, autonomic, gastrointestinal, musculoskeletal, and psychiatric.⁸ However, there was no empirical investigation on the factor structures of the scales in previous studies.^{8,9} The findings in another similar scale (the Opiate Withdrawal Scale) showed that the single-factor solution model explained the data in a sample comprising 82 opiate addicts.^{14,15} Empirical examinations of the factor structure may shed light on the future understanding of specific mechanisms or changes of withdrawal symptoms in the process of detoxification. For instance, if both autonomic and psychiatric factors are indeed present, would one sustain longer than the other during the detoxification process, or would they respond differently to different types of drugs or treatment modalities (such as pharmacological versus psychological therapies)? These interesting questions may invite future research to evaluate different treatment programmes for detoxification and motivation enhancement.

Thirdly, could the Chinese versions of the revised SOWS and OOWS yield acceptable reliability and validity? So far, there is no validated Chinese opiate withdrawal scale available in the literature. Although SOWS and OOWS are noted to be clinically applicable in different samples in the West, empirical evaluation is required for local patients.

In sum, the purpose of the present project was to examine the psychometric properties and factor structures of the Chinese versions of the revised SOWS and OOWS in Hong Kong Chinese opiate addicts.

Patients and Methods

Instruments

The following instruments were used in the analysis.

The Chinese version of the revised SOWS is a 21-item scale in which respondents have to give each item a rating

from 0 to 4 (0 = not at all, 1 = a little, 2 = moderately, 3 = quite a bit, 4 = extremely), indicating the severity of the symptoms at the time of the test. The original SOWS consisted of 16 perceived symptoms. However, in the revised version, 5 more symptoms were added based on the description of the DSM IV and ICD-10 for opiate withdrawal symptoms. The new symptoms included are 'dysphoria', 'insomnia', 'craving for an opioid drug', 'diarrhoea', and 'racing heart'. Scores of the revised SOWS range from 0 to 84.

The Chinese version of the OOWS is a 13-item scale in which observers check for the presence or absence of withdrawal signs. Scores for the OOWS could fall into a range from 0 to 13.

To ensure the meanings of the items being correctly translated, the backward translation method was adopted. A clinical psychology trainee and the first author performed the initial and backward translation, respectively. They also subsequently checked the items' meaning before administering the scale to patients.

Study 1

Fifty one Chinese patients, 40 men and 11 women, with a DSM-IV diagnosis of opioid dependence participated in the study. Potential participants were admitted to Kwai Chung Hospital for opiate detoxification. The inclusion criteria for the participants were as follows:

- conforming to the DSM-IV diagnostic criteria for opiate dependency
- deprivation of methadone or heroin for 12 to 18 hours
- Chinese ethnicity
- definitive intention to stop drug use.

As the purpose of the study was to evaluate the initial opiate withdrawal patterns, the participants completed the scales during the first day of hospital admission. The demographic data of this group are presented in Table 1.

Results

As initial *t* tests and correlational analyses indicated no sex and age differences in scores of both the revised SOWS and OOWS, all the data were combined in the subsequent

Table 1. Demographic features of patients in study 1.

Demographic features	Number
Male (%)	76.6
Married (%)	51.7
Currently employed (%)	20.4
Received treatment before (%)	24.5
Having one or more medical condition (%)	17.5
Age (standard deviation) [years]	35.60 (11.15)
Education (standard deviation) [years]	7.40 (2.80)
Duration of drug use (standard deviation) [years]	15.20 (10.40)

Table 2. Means, item-total correlations, and reliability coefficients of the revised Subjective Opiate Withdrawal Scale for study 1.

Individual item	Mean (standard deviation)	Item-total correlation	
1. Anxiety	1.04 (1.30)	0.723*	
2. Yawning	1.55 (1.29)	0.664*	
3. Perspiring	0.61 (1.04)	0.748*	
4. Tearing	1.02 (1.21)	0.777*	
5. Running nose	1.00 (1.25)	0.823*	
6. Goose flesh	0.75 (1.23)	0.887*	
7. Shaking	0.78 (1.15)	0.853*	
8. Hot flashes	0.67 (1.19)	0.751*	
9. Cold flashes	1.00 (1.26)	0.891*	
10. Bone and muscle aches	0.86 (1.15)	0.649*	
11. Restlessness	0.71 (1.20)	0.665*	
12. Nausea	0.35 (0.74)	0.596*	
13. Vomiting	0.33 (0.55)	0.669*	
14. Muscle twitching	0.31 (0.68)	0.630*	
15. Stomach cramps	0.27 (0.72)	0.342 [†]	
16. Shooting up	0.39 (0.75)	0.755*	
17. Dysphoria	0.67 (1.11)	0.689*	
18. Insomnia	1.18 (1.55)	0.688*	
19. Craving for opioid drug	0.35 (0.82)	0.491*	
20. Diarrhoea	0.18 (0.43)	0.538*	
21. Racing heart	0.41 (0.78)	0.730*	
Aggregate scale	Mean (standard deviation)	Internal consistency	Split-half reliability
	14.43 (15.27)	0.944	1st half = 0.936 2nd half = 0.836

* $p < 0.001$.[†] $p < 0.01$.

The minimum possible revised Subjective Opiate Withdrawal Scale score is 0 and the maximum is 84.

statistical analyses. Descriptive data, item-total correlation, and reliability coefficients of the revised SOWS are presented in Table 2. The 3 most distressing symptoms during the initial withdrawal phase in this sample were ‘yawning’, ‘insomnia’, and ‘anxiety’, whereas the relatively less disturbing ones included ‘diarrhoea’, ‘stomach cramps’, and ‘muscle twitching’. The item-total correlation coefficients were all significant, ranging from 0.342 to 0.891, with an average of 0.693. Both the coefficients of internal consistency (alpha) and split-half reliability were excellent.

The descriptive data, item-total correlation, and reliability coefficients of the OOWS are presented in Table 3. The most commonly observed withdrawal signs consisted of

Table 3. Means, item-total correlations, and reliability coefficients of the Objective Opiate Withdrawal Scale for study 1.

Individual item	Mean (standard deviation)	Item-total correlation	
1. Yawning (1 or more)	0.28 (0.45)	0.661*	
2. Rhinorrhoea (3 or more)	0.09 (0.30)	0.647*	
3. Piloerection	0.04 (0.19)	0.363 [†]	
4. Perspiration	0.11 (0.32)	0.479*	
5. Lacrimation	0.17 (0.38)	0.733*	
6. Mydriasis	0.06 (0.24)	0.448*	
7. Tremors (hands)	0.04 (0.19)	0.331 [†]	
8. Hot and cold flashes	0.30 (0.46)	0.763*	
9. Restlessness (frequent shift of position)	0.17 (0.38)	0.807*	
10. Vomiting	0.04 (0.19)	0.237 [‡]	
11. Muscle twitches	0.04 (0.19)	0.284 [‡]	
12. Abdominal cramps	0.04 (0.19)	0.472*	
13. Anxiety (e.g., foot shaking, agitation, breathing difficulty)	0.21 (0.41)	0.594*	
Aggregate scale	Mean (standard deviation)	Internal consistency	Split-half reliability
	1.47 (2.18)	0.802	1st half = 0.696 2nd half = 0.687

* $p < 0.001$.[†] $p < 0.01$.[‡] $p < 0.05$.

The minimum possible Objective Opiate Withdrawal Scale score is 0 and the maximum is 13.

‘hot and cold flashes’, ‘yawning’, and ‘anxiety’, while the infrequently observed ones were ‘piloerection’, ‘tremors’, ‘vomiting’, ‘muscle twitches’, and ‘abdominal cramps’. These objective signs were highly consistent with the subjectively reported symptoms. The item-total correlation coefficients were again all significant, ranging from 0.237 to 0.807, with an average of 0.525. The coefficients of internal consistency (alpha) and split-half reliability were acceptable.

To examine the structural validity of the scales, factor analyses were conducted in the following procedure. Firstly, in the revised SOWS, the principal component method was employed and 5 factors with eigenvalues greater than unity emerged. Secondly, direct oblimin rotation analyses were applied to improve the interpretability of all 5 factor

structures. Thirdly, an optimal factor structure was selected and decided by comparing the relative structural stabilities or the size of factor loadings.¹⁶ This method is superior to other methods such as the scree test¹⁷ where the sample size for factor analyses is small. We used a conservative cut-off, factor loading of 0.53, to eliminate unstable items in each factorial structure.¹⁶ The results indicated that the 4-factor solution, in which all the items were retained, appeared to adequately represent the data.

Lastly, following the suggestion of Pedhazur and Schmelkin,¹⁸ we examined the 4-factor solution and confirmed the meaningful interpretation for these factors. The 4 factors, which accounted for 70.45% of the total variance, were named as 'autonomic symptoms', 'craving', 'gastro-intestinal symptoms' and 'negative affect'. The symptoms were generally consistent with the nominal labels of respective factors. The corresponding items, loadings, eigenvalue, percent of variance, and descriptive data are presented in Table 4.

For the OOWS, factor analyses with the above similar stringent procedure for SOWS were conducted. Four factors initially emerged with eigenvalues greater than one. Results of the structural stability analyses indicated that the single-factor solution had 12 items with factor

loadings greater than 0.53, whereas all the other factor solutions contained 9 items only. Also, the results of the interpretability analyses showed that other factorial structures were relatively less well defined and interpretable. Finally, we decided that the sole-factor solution should be optimal for OOWS. The single factor, which was labelled as 'perceived symptoms', accounted for 32.24% of the total variance. The results of the factor loadings are reported in Table 5.

The results indicated that correlation between the revised SOWS and OOWS in our sample was non-significant (0.169, $p > 0.05$).

Study 2

Sixteen Chinese patients with DSM-IV diagnoses of opioid dependence admitted to Kwai Chung Hospital for detoxification treatment were recruited into the study. Their mean age was 34.40 (standard deviation [SD], 10.84); there were 8 men and 8 women. Approximately 37.5% of the patients were working, 43.8% unemployed, 12.5% receiving public assistance, and 6.3% were missing these data. Their average duration of opiate use was 15.31 years (SD, 8.86).

Table 4. Factor solution of the revised Subjective Opiate Withdrawal Scale for study 1.

Item	Autonomic symptoms	Craving	Gastrointestinal symptoms	Negative affect
5. Running nose	0.882			
21. Racing heart	0.851			
6. Goose flesh	0.829			
7. Shaking	0.821			
4. Tearing	0.821			
10. Bone and muscle aches	0.769			
9. Cold flashes	0.741			
8. Hot flashes	0.602			
3. Perspiring	0.581			
2. Yawning	0.565			
18. Insomnia	0.538			
19. Craving for opioid drug		0.715		
20. Diarrhoea		0.611		
15. Stomach cramps			0.823	
14. Muscle twitching			0.648	
12. Nausea			0.600	
13. Vomiting			0.543	
16. Shooting up			0.533	
11. Restlessness				0.915
1. Anxiety				0.774
17. Dysphoria				0.752
Percent of variance	49.91	8.09	6.05	6.40
Eigenvalue	10.48	1.70	1.27	1.34

Table 5. Factor solution of the Objective Opiate Withdrawal Scale for study 1.

Item	Perceived symptoms
3. Piloerection	0.818
2. Rhinorrhoea	0.780
12. Abdominal cramps	0.739
9. Restlessness	0.714
5. Lacrimation	0.704
4. Perspiration	0.703
6. Mydriasis	0.695
11. Muscle twitches	0.662
10. Vomiting	0.657
13. Anxiety	0.644
7. Tremors (hands)	0.612
8. Hot and cold flashes	0.592
1. Yawning	0.510
Percent of variance	32.24
Eigenvalue	4.05

Detoxification Procedure

In the opioid detoxification programme, methadone was used to reduce withdrawal symptoms and achieve abstinence. To measure the withdrawal symptoms in a standardised schedule, the revised SOWS and OOWS were administered at 4 specified time points in a 14-day period. Since some patients entering the programme had already been replacing methadone for opiates, the amount of methadone consumption for detoxification at the first day of the methadone programme differed between the participants. Regardless of the amount of methadone consumption on the day of admission, methadone 20 mg was recorded as the detoxification baseline or day 1 (time 1) — the third day was recorded as day 3 (time 2), the seventh day as day 7 (time 3), the fourteenth day as day 14 (time 4). From days 1 to 7, daily methadone consumption was gradually reduced from 20 mg to 0 mg, and remained at 0 mg in the following week before discharge.

When patients were completing the revised SOWS, a research assistant clarified any questions. The observers were 2 registered psychiatric nurses familiar with opiate withdrawal symptoms. To minimise the observers' bias in checking OOWS, observers would receive standardised instructions for rating before the observation.

As initial *t* tests indicated no sex differences in the scores of both the revised SOWS and OOWS, data for men and women were combined in all subsequent statistical analyses. The purpose of the study was to examine the predictive validity* of the scales by comparing their respective scores

* Predictive validity means the degree to which performance on a test can predict a criterion in the future. If the pattern of scores shows that the scales are responsive to changes in opiate withdrawal symptomatology, it implies adequate criterion or predictive validity.¹⁴

measured over different points of time. Given the nature of gradual diminishing properties of withdrawal signs and symptoms shown in previous similar programmes, it was predicted that the scores of the revised SOWS and OOWS would be gradually decreasing in the initial stage.¹⁵ Due to the absence of methadone for patients from days 8 to 14, withdrawal symptoms were predicted to be stabilised and still present at the last 2 ratings.

Results

Figures 1 and 2 present the means of the 2 rating scales across different time points. The findings could be

Figure 1. Means of the revised Subjective Opiate Withdrawal Scale measured at different time points.

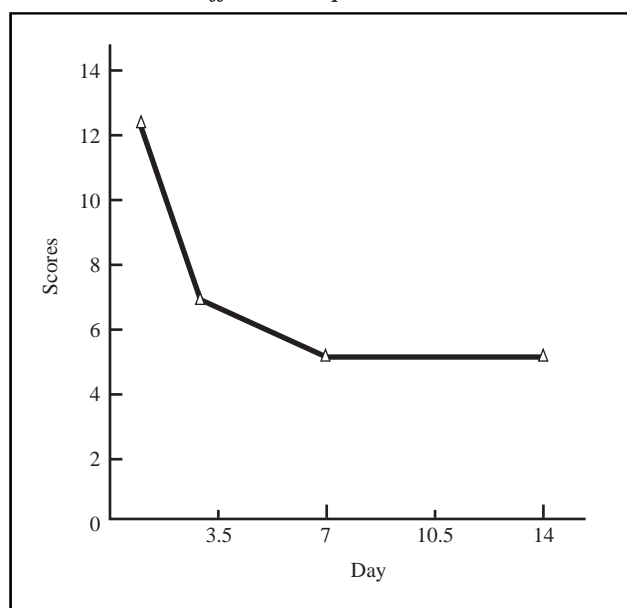


Figure 2. Means of the Objective Opiate Withdrawal Scale measured at different time points.

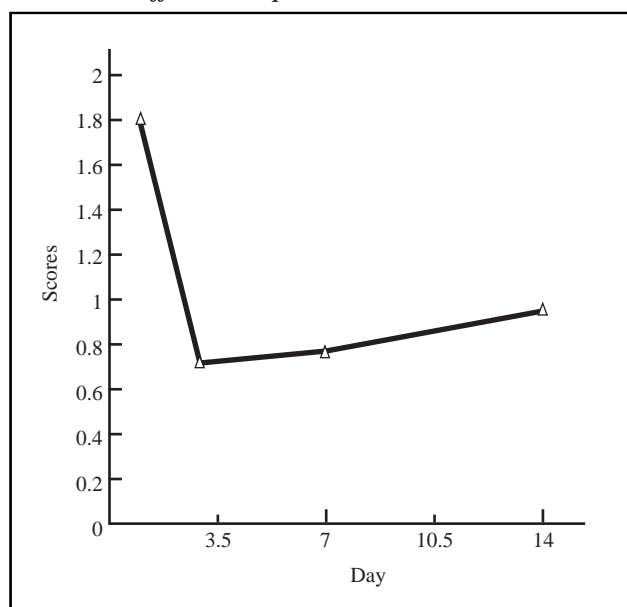


Table 6. Paired *t* test values among various time points in the revised Subjective Opiate Withdrawal Scale and Objective Opiate Withdrawal Scale for study 2.

Revised Subjective Opiate Withdrawal Scale				
	Day 1	Day 3	Day 7	Day 14
Day 1	—			
Day 3	1.61	—		
Day 7	2.21*	1.21	—	
Day 14	1.99†	0.98	0.00	—
Objective Opiate Withdrawal Scale				
	Day 1	Day 3	Day 7	Day 14
Day 1	—			
Day 3	1.62	—		
Day 7	1.39	-0.15	—	
Day 14	1.18	0.32	-0.23	—

* $p < 0.05$.

† $p < 0.07$.

summarised as follows. Firstly, the revised SOWS had an anticipated trend of decline in scores from day 1 to day 14, whereas the OOWS had only an initial decline of scores from day 1 and remained relatively stable afterwards. Secondly, consistent with expectations, some residual symptoms were present in both scales at the last rating. Thirdly, as expected for both the revised SOWS and OOWS, scores at day 7 and day 14 remained constant. Table 6 presents the paired *t* test values of the 2 scales at different times. There were significant differences between the day 1 revised SOWS scores and those at days 7 and 14, whereas there was no statistically significant change among the paired comparisons for the OOWS.

To evaluate specific changes in scores detected over time, paired *t* tests among factors of revised SOWS were subsequently performed. A trend of non-significant reduction was revealed between day 1 autonomic symptom scores with those at days 3, 7, and 14 ($p < 0.09$). The scores for gastrointestinal symptoms at day 1 were also slightly lower than those for day 7 ($p < 0.08$).

Discussion

This study aimed to investigate the psychometric properties and factor structures of the revised SOWS and OOWS among local Chinese opiate addicts. A major caveat needs to be addressed here before interpreting the results. It may be argued that some important reliability indices such as the inter-rater and test-retest indices were not included and therefore the reliability of the scales should be challenged. However, the satisfactory reliabilities of the revised SOWS and OOWS shown by the item-total correlations and α coefficients argue against this point. Furthermore, test-retest reliability may be a conceptually blurred psychometric indicator in the opiate withdrawal measures. This is because good test-retest reliability usually implies the presence of

constant scores measured across times, whereas sensitive opiate withdrawal scales denote a changing pattern of symptoms found at different times. An obtained coefficient of test-retest reliability is therefore confounded by the nature of changing of withdrawal symptoms.

Several findings should be highlighted in view of the present findings. Firstly, the factor structure of the revised SOWS indicates the presence of multiple factors of opiate withdrawal symptoms during detoxification. These factors not only reinforce the concept of multiple domains or structural validity of opiate withdrawal features,⁸ but also generate an insight in the design of future detoxification treatment. For instance, in the study 2 methadone detoxification programme, the factors autonomic symptoms and gastrointestinal symptoms tended to have a quicker reduction in scores.* In contrast, the scores of the factors negative affect and craving are slower to respond to the methadone detoxification. Alternative drug treatment or psychological treatment may be considered useful to alleviate these factors' scores in the process. Consistent with this assertion, interventions that include contingent reinforcement for opiate-free urines may be effective in reducing opiate drug use among patients during methadone withdrawal treatment.²⁰ One plausible explanation for the mechanism is that an inclusion of the behavioural components such as reinforcers may reduce the negative affect scores or distract the craving effects. Hence, withdrawal symptoms could be much more effectively controlled during the process. Future empirical investigations in this area can illuminate the validity of this assertion.

While most of the items in the revised SOWS have been meaningfully categorised under the umbrella of corresponding factors, the item diarrhoea appears not to fit well with the factor craving. One explanation may be related to the inadequate relevant items in the pool, a condition that allows less theoretically similar items being grouped together due to statistical rather than conceptual relevance.²¹ In the present analyses, this factor has been reliably reproduced under different factor structures (including the 3-factor, 4-factor, and 5-factor models), and the item 'craving for an opioid' consistently bears the highest factor loading. This finding indicates that this factor tends to be a robust factor distinct from others. Theoretically speaking, the factor craving may consist of different kinds of craving such as affective, behavioural, cognitive, and sensory cravings.²² We speculate that craving can be an important factor of withdrawal symptoms and that new items such as affective, behavioural, and cognitive cravings can be added. We suggest that future research can re-examine the factor structure of the revised SOWS if additional items of craving are incorporated.

Interestingly, factor analyses results of the OOWS indicate that the single solution factor model can explain the

* Although one might argue against the level of significance being set too lenient ($p < 0.1$), one should note that the small sample size of study 2 should have compromised the power and simultaneously increased the chance of a type II error. The option for a lenient significance *p* value is a balance of the trade-off.¹⁹

data well. Because the OOWS is checked by observers rather than by the addicted, the findings may merely reflect the observers' perception of a single factor accounting for the withdrawal symptoms. The results are consistent with the notion that although observation is less intuitive in the data-collecting process, observers may be relatively less sensitive to discriminate and identify withdrawal factors than the individuals themselves.^{9,23,24}

Although the results of study 2 generally support the anticipated trend of withdrawal symptoms measured by both scales, the revised SOWS appears to be relatively sensitive to such a gradual change.⁸ In the original work by Handelsman et al,⁸ their reported scores (on admission, mean, 2.0; SD, 0.4; after methadone, mean, 0.9; SD, 0.2) are highly similar to ours.

Taken together, these findings point to the fact that the OOWS is relatively less sensitive in measuring withdrawal symptoms among patients undergoing methadone detoxification programmes. Such an insensitivity can be explained by a number of previous studies in which objective withdrawal symptoms could only be observed at a very high level of distress.^{9,23,25} These findings appear valuable to clinicians and future researchers. For instance, in a drug treatment research design where adequate control of withdrawal symptoms is anticipated, researchers may be inclined to choose the SOWS rather than the OOWS to measure the withdrawal symptoms. On the other hand, in a highly distressing withdrawal condition where a subjective rating may be difficult to conduct, the OOWS could be a better option.

The low correlation (0.169, $p > 0.05$) between the revised SOWS and OOWS in this study lends support to previous findings that the OOWS and SOWS are scales designed to assess different aspects of opiate withdrawal features.²³ Therefore, patients undergoing methadone detoxification programmes may not present with severe observable withdrawal symptoms easily discerned by others. Consequently, the insensitivity of observing withdrawal symptoms at moderate or low levels of distress explains why the correlations between subjective measures and observed ratings of withdrawal symptoms have been reliably found to be low.^{9,23,25}

In sum, the Chinese versions of the revised SOWS and OOWS enjoy satisfactory psychometric properties. Results of factor analyses show that the revised SOWS is composed of 4 meaningful factors, whereas the OOWS has 1 general opiate withdrawal factor. Findings also indicate that the revised SOWS is relatively more sensitive for measuring the changes of opiate withdrawal symptoms than the OOWS in the present methadone detoxification programme.

Acknowledgements

We would like to thank Ho Kwok Hung, Eunice Lai, Pak Chui Sau, and Francis Tsui for their help with this project. In addition, we are grateful to the valuable comments of 2 anonymous reviewers.

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Appendix 1. Chinese versions of the revised Subjective Opiate Withdrawal Scale and the Objective Opiate Withdrawal Scale.

Revised Subjective Opiate Withdrawal Scale

病人填寫

姓名

填寫日期

請按照你在過去二十四小時內的情況，圈出最合宜的選擇

	完全不同意	少許同意	部份同意	相當同意	完全同意
1. 我感到憂慮	0	1	2	3	4
2. 我想打噁露	0	1	2	3	4
3. 我在流汗	0	1	2	3	4
4. 我的眼睛流水	0	1	2	3	4
5. 我流鼻水	0	1	2	3	4
6. 我有起雞皮	0	1	2	3	4
7. 我會發抖，打顫	0	1	2	3	4
8. 我會發熱	0	1	2	3	4
9. 我會發冷	0	1	2	3	4
10. 我的筋骨疼痛	0	1	2	3	4
11. 我會煩躁不安，無法安靜下來	0	1	2	3	4
12. 我感到噁心 (作嘔、作悶)	0	1	2	3	4
13. 我想嘔吐	0	1	2	3	4
14. 我的肌肉抽搐	0	1	2	3	4
15. 我的胃抽筋	0	1	2	3	4
16. 我現在感到刺痛	0	1	2	3	4
17. 我感情緒低落	0	1	2	3	4
18. 我有失眠	0	1	2	3	4
19. 我有強烈渴望吸毒的感覺	0	1	2	3	4
20. 我有腹瀉	0	1	2	3	4
21. 我有心跳加速	0	1	2	3	4

Objective Opiate Withdrawal Scale

職員填寫

觀察員姓名

填寫日期

病人姓名

請按照過去二十四小時內，你觀察病人的情況，圈出最合宜的選擇

1. 打噁露	沒有 / 有
2. 流鼻水	二次或以下 / 三次或以上
3. 起雞皮	沒有 / 有
4. 流汗	沒有 / 有
5. 流眼水	沒有 / 有
6. 瞳孔散大	沒有 / 有
7. 顫抖 (手)	沒有 / 有
8. 發冷和發熱 (如顫抖或蜷縮身體以保緩)	沒有 / 有
9. 煩躁不安，無法安靜下來 (如不時郁動，無法安坐)	沒有 / 有
10. 嘔吐	沒有 / 有
11. 肌肉抽搐	沒有 / 有
12. 腹部 (胃) 抽筋	沒有 / 有
13. 焦慮的徵狀	沒有 / 有

總分: