# Trauma and recovery amongst people who have injected drugs within the past five years

**“It does kind of make you feel quite numb”**

## Executive Summary

**Scottish Drugs Forum with**

**Professor Richard Hammersley**
**Department of Psychology, University of Hull**

**Dr Phil Dalgarno**
**School of Health and Life Sciences,**
**Glasgow Caledonian University**

This Research was funded by **Big Lottery Fund**

**We would like to thank all the people**

**who gave their time and effort to participate in this research**

**and the volunteer fieldworkers**

**who recruited the participants and interviewed them.**

 ISBN 978-1-903483-09-1

SDF Scottish Drugs Forum

LOTTERY FUNDED

GCU Glasgow Caledonian University

University of Hull

# Executive Summary

## Background

This research collected the life stories of 55 people who had injected heroin and other drugs within the previous five years but who were currently in recovery. “Participants were recruited through drug agencies and support/ recovery networks and personal contacts in different types of geographical areas in Scotland”.

The main aim was to record and understand the life stories of problem drug users, with a view to contextualising their drug problems within their lives and addressing the considerable issues of stigmatisation and stereotyping that problem drug users continue to face.

The interviews used Dan MacAdam’s Life Story method, which involves a semi-structured interview. The fieldworkers who conducted the interviews were Scottish Drugs Forum volunteers and in recovery themselves.

The research occurred in urban and rural Scotland, with areas for recruitment chosen to provide a cross-section of the types of locality in Scotland. Problem drug use in Scotland tends to involve injecting and tends to include the injecting of heroin and other opiates, although typically benzodiazepines are also used, often orally. A wide range of other drugs may be used as well, including alcohol (very often) and cocaine (sometimes).

Most problem drug users in Scotland are from disadvantaged neighbourhoods and are personally disadvantaged. This association between problem drug use and deprivation may worsen stigmatisation, as drug injecting is used as the cause, focus and explanation of all the drug user’s difficulties in life. In contrast, this life story research focussed on people’s lives as they narrated them, which allowed them to describe how drugs fit into their lives as they chose.

People described diverse lives that included much as well as drug use. Common strengths included the importance of family, particularly being a parent. Part of that importance was in moderating drug use and in encouraging recovery. Common problems included childhoods that involved serious abuse or other problems, as well as specific traumatic events before, during and as a consequence of, drug use.

Another strength was the ability to endure somehow extremely difficult and distressing events: for many in the cohort, drug injecting was a dysfunctional coping response to serious traumas or life difficulties which had frequently gone unrecognised before problem drug use developed.

Many people's stories implied that the severity and impact of what had happened to them had not been - at the time - appreciated by themselves, their families, or educational, health and social care services. Indeed, some stories took for granted problems that seemed very severe to the researchers.

## Childhood

Only a few people described childhoods that seemed genuinely normal and free of problems around them. Interestingly, most of them mentioned signs suggestive of having serious psychological problems from a young age, including anxiety, attention deficit, hyperactivity and conduct disorders. Their stories suggested personal psychological problems had led to difficulties, trauma and eventually to drug injecting.

Some people described childhoods that seemed to the researchers to be told as "good enough" and happy despite difficulties, because one or more adults had provided a core of stability. Nonetheless, many "good enough" stories included incidents that had the potential to have been traumatic, often related to parental alcohol or drug use.

Some described childhoods with one or more parents who were binge drinkers or alcoholics or who, in a few cases, had drug problems. The stories from these interviewees were of childhoods that were largely unhappy because of persistent, repeated abuse.

Finally, some told of childhoods that had been disrupted and made problematic by a variety of serious problems not to do with parental substance use or their own misbehaviour. This involved issues, such as serious health problems in the family, death of a family member or a difficult parental breakup that, as far as the participant knew, had not involved substance use.

Such problems were remembered as having complex negative effects on the participant, which typically led to them acting out, being defensive or aggressive about these problems, misbehaving at school and getting involved in substance use as a way of having fun and escaping from these problems.

Whether or not alcohol or drug problems were foremost in childhood problems, many people remembering being subject to, or witnessing, violence and abuse when a family member was drunk.

A small number of people recalled that their own misbehaviour from a young age had led to problems in the family and to ensuing traumatic experiences for themselves, such as violence and abuse whilst in care or prison.

**Traumas in childhood and early adolescence included:**

- repeated sexual abuse by relatives
- repeated physical and emotional abuse by parents (including biological parents, step-parents and foster parents)
- Multiple bereavements, or complex circumstances involving chaos and instability due to:
  - mothers fleeing violent fathers
  - parental mental health problems
  - having criminal or drug-dealing fathers.

## Starting and escalating drug use

Using alcohol and drugs relatively heavily from a relatively young age was usually in the context of socialising and having fun, although a few people remembered using drugs to escape from their problems from early on in their lives.

Some gradually escalated their drug use into heroin injecting because their friends were doing it or because they were dealing drugs. Many women started using because they were living with a man who was already using. Some of these relationships had been highly controlling and abusive, with drugs as one element of that; others had been mostly about mutual drug use, which led to various types of misbehaviour towards each other.

Other people described experiencing further trauma on top of what had happened in childhood and adolescence, which led them to inject heroin to cope with it.

Anyone who had begun heroin injecting but quit before developing a serious dependence would not be part of this recovery cohort, due to the recruitment criteria.

A few people had lived relatively conventional lives for years that included working and raising a family, while using drugs including injecting heroin. Things went wrong either because of further trauma or because drug use had a cumulative negative effect on work and income.

The most common additional traumas remembered as triggering problematic drug use were bereavements, particularly the loss of more than one person within a short period of time, and the loss or breakup of the family.

## ‘Escape coping’ with heroin injecting

For the people interviewed, heroin injecting served to obliterate thoughts that the person felt unable to cope with, including memories of trauma, and worries.

Problem drug use often added further trauma and life difficulties to pre-existing ones which, in turn, typically escalated drug use.

Commonly described traumas related to drug use included:

- incidents of very severe life-threatening violence over drug debts
- the murder of close friends and relatives, sometimes apparently in error
- first hand witnessing of death by drug overdose
- acquisition of life-threatening injuries and infections related to unhygienic injecting.

Discourse about heroin use often conceptualises these events as effects of drug use that are reasons to quit. For problem drug users, these traumas were also reasons to ***continue*** heroin injecting, to block out the psychological and physical pain that they would otherwise experience

## Recovery

People described recovery as involving the support of other people and, finally, being able to face up to the horrors they had experienced without feeling the need to block and deaden thoughts and feelings with heroin and other drugs.

Recovery often only occurred after years of problem drug use, which typically had involved many of the following: negative life events; housing problems and poverty; violence; serious health problems; imprisonment; estrangement from family; difficulties with care or custody of, or access to, children.

Therefore recovery was not simply a matter of people eventually being put off problem drug use as a result of appalling problems; many had experienced such problems, tried to stop using drugs, but had failed. Rather, people needed to become aware that, they had little or no option but to face up to their world without heroin.

Previously, their self-awareness had often been hindered by the sedating effects of heroin, which made the users – as they intended - less aware of their very challenging circumstances and less reflective about the causes of them.

This included not reflecting sufficiently on the contribution of their problem drug use to the other problems in their lives. Recovery needed to be with the support of other people rather than for the benefit of other people.

For example, many people had made previous attempts to give up their drug use in order to keep or regain access to their children but, despite these good intentions, found themselves unable to cope with distressing events and recurring thoughts, feelings and memories while un-intoxicated and eventually they relapsed.

Many people felt that their recovery had been hindered by people who either actively facilitated their drug use – such as drug-using partners – or who came to see them as 'incorrigible addicts' (such as family members, neighbours and some health care professionals, including some drug workers).

Recovery was facilitated by different types of relationship with a similar variety of people: new supportive partners, often well-recovered from harmful substance use themselves; drug service staff including auxiliary staff; members of the public who happened to offer support; and, of course, family members who could accept a new relationship that was not defined by the person being a "drug user".

Many people had attended self-help meetings such as those run by Narcotics Anonymous and had found these helpful. However, the stories told of "support" as being a one-to-one relationship rather than the product of a group. Support seemed to involve being able to accept non-judgmentally the recovering user as someone who had thoughts and feelings with which they needed to cope.

Methadone was regarded as an essential aid on the road to recovery. People were well aware that methadone did not automatically improve their substance use, their behaviour, or their thoughts. However, those who spoke of it felt that it offered the possibility for improvement. For many it had increased stability, reduced the need for street drugs, prevented psychosocial problems getting even worse, and bought time for them to come around to taking recovery further.

Methadone could also serve as an alternative, less potentially destructive, means of deadening distressing thoughts and feelings. Consequently, many stories included the theme of the difficulties of getting and keeping a methadone prescription.

Many people's view of recovery was that it involved being free of all ***opiates*** including substitute prescriptions. The extent to which recovery involved also being free of alcohol and other drugs varied.

Some people felt that their problem had been specifically with opiates and had found it possible to use other drugs in moderation. Others, usually from past experience, felt that alcohol, cannabis or anything else, were too likely to lead back to drug dependence.

Some people had found that, for them, recovery consisted of being prescribed methadone and using few or no other substances. People were quite clear that being stable, in this sense, was quite different from using a methadone prescription more as a supplement to the other drugs they also felt compelled to take. However, the latter sometimes led to the former, because lighter use of street drugs was a step towards stability.

## Types of life story

People's life stories represent how they thought about their lives, which is not an objective history. There were four types of story:

- Most people's stories were told around drug use, which included periods of chaos when little else had mattered to them
- However, some people told stories about being a career criminal, who happened to use drugs. This had typically involved spending long periods of time in prison
- Others told of being a drug dealer, which meant that drug use could often be taken for granted, but which brought its own problems of violence, intimidation and an entrenched and widespread reputation as a problem drug user
- A small number of people told of living relatively conventional lives for long periods of time, which included heavy drug use. As described above, eventually things went wrong.

People recovered with support from drug workers, partners or other people whilst in the community. Residential rehabilitation and substitute prescribing (as described above) facilitated recovery but did not by themselves produce it.

## Implications for intervention

Much previous research has found that drug dependent people have high rates of trauma, both before drug dependence and as a consequence of it. This research has identified the use of drugs, particularly opiates, to deaden the pain of trauma.

This has come to be known as 'self-medication' but we prefer to see it in terms of "coping through escape" or "escape coping". This is because drugs are not being used to medicate against a specific problem but rather as a means to avoid having to remember distressing events, having to feel anxiety, pain or fear and to "insulate" oneself away from the often overwhelming pressures resulting from complex life issues.

Escape coping can become a vicious and counter-productive cycle of behaviour, where increasingly the person is trying to escape from the harmful consequences of drug use by escalating use, and thus worsening the problems that they are trying to escape from.

Consequently, interventions against problem drug use need to take trauma more seriously.

### *Trauma-focussed services*

**First**, this research supports recent calls for services to be more trauma-focussed and to recognise that many problem drug users have been - and maybe continue to be - traumatised by past and current experiences. Problem drug use is both an escape from trauma and is itself traumatic.

It is essential that services do not see drug users' problems as ***necessarily*** predominantly caused by drugs, or that drug users' other problems are undeserving of serious consideration because they are "self-inflicted", or that their complex problems in themselves should be motives for quitting.

Being more trauma-focussed can involve simply appreciating that many problem drug users have been traumatised, which poses a range of problems for helping them, including:

- Assessment, particularly repeated assessment by different practitioners, may become highly distressing as clients are asked to go over past traumas repeatedly
- Addressing the client's problems prematurely may cause them to flee into further drug use

- Clients may exhibit a range of dysfunctional behaviours when engaging with practitioners, these are learned means of protecting themselves from further trauma. They can include violence, verbal aggression, insincere charm or compliance, withdrawal or shutting down, and detachment or disassociation from their problems (commonly called 'denial')

- Clients may have highly negative automatic reactions to people and circumstances reminiscent of their trauma. These can include having difficulties with practitioners who happen to remind them of their abusers, having difficulties with 'authority' and finding certain environments or cues reminiscent of their trauma to be highly upsetting.

Services need to appreciate that many of the difficulties of working with problem drug users are neither malicious, nor due to the pernicious effects of drugs, but are rather because the person may have been traumatised. Some clients may require specialised interventions to overcome trauma.

However, becoming more trauma-focussed should not always mean reframing problem drug users as totally debilitated. According to the stories told in this research, people had often managed to endure truly dreadful events and circumstances, both before injecting heroin and often while continuing to inject.

***Identifying trauma impact in children***

**Second**, 20-30 years ago, according to these stories, troubled children from socio-economically deprived areas of Scotland tended to be seen as problems rather than as deserving of help (although anyone who overcame trauma with professional help would not appear in this cohort).

However, the stories in this research support the idea that children who are acting out or misbehaving at school or elsewhere are often exhibiting signs of serious difficulties such as abuse, parental alcohol problems, bereavement or other serious difficulties in the family.

Alcohol and drug problems present both as a common cause of difficulties and as a symptom of underlying difficulties. As problem drug use becomes entrenched, drugs can be both a cause and a symptom at the same time.

This principle also applies to children who are using drugs and committing crimes, therefore understanding of the underlying issues affecting troubled children and the need for sensitive intervention require to be continually reinforced within relevant agencies.

### *Empowering clients in recovery process*

**Third**, services should empower clients insofar as this is possible. People described being unable to recover without entering into a mature, deliberate engagement in the process, so it is important that services try to promote the personal capacity of clients to do so.

The sedative effects of heroin and other drugs tend to reduce personal reflection - one reason why people use them. However, many participants in this research had, prior to recovery, also held to one of the dysfunctional beliefs sustaining heroin dependence; that the person is and will be incapable of coping with difficulties and pain without drugs and therefore cannot change.

Services need to be careful to challenge – and provide support to build the capacity of the drug user to challenge – this belief. In particular, they should desist from openly or implicitly assessing or assuming that people as not 'ready' to change until their problems have got almost fatally bad.

A care planning approach centred on the person's ultimate self-responsibility, which takes into account his/her prevailing social circumstances, is recommended. There is also a need for services to make better and increased use of psychological therapies that facilitate personal change.

**Main Office**

Scottish Drugs Forum
91 Mitchell Street, Glasgow G1 3LN
t: 0141 221 1175
f: 0141 248 6414
e: *enquiries@sdf.org.uk*

Edinburgh
139 Morrison Street, Edinburgh EH3 8AJ
t: 0131 221 9300
f: 0131 221 1556
e: *enquiries@sdf.org.uk*
*www.sdf.org.uk*

**Find drug services in your area:**
*www.scottishdrugservices.com*

**Hepatitis Scotland:**
*www.hepatitisscotland.org.uk*

**Take Home Naloxone:**

*www.naloxone.org.uk*

 ISBN 978-1-903483-09-1

---

Scottish Drugs Forum (SDF) *www.sdf.org.uk* is a company limited by guarantee, registration no. 106295 with charitable status and is also a registered Scottish charity registered SC 008075. Registered Office: 91 Mitchell Street, Glasgow, G1 3LN