

Trauma in the childhood stories of people who have injected drugs

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Abstract

Aim: To document childhood trauma in the life stories of people who have injected drugs.

Method: 55 participants (38m, 17f) recruited via Scottish recovery networks, who had injected drugs in the previous five years, were interviewed by peer researchers using the Life Story method.

Results: Remembered childhood trauma included persistent violence, repeated sexual abuse, neglect, and traumatic bereavements. Many traumas were related to adult alcohol use. Few participants told of no trauma, some of severe trauma contributing to subsequent drug problems, some recounted stories including traumatic events, but not linked to later drug problems. A few told of initial severe behavioural problems leading to trauma for the child and to drug problems. Drug problems followed trauma by various routes, without straightforward cause and effect: direct use of drugs as avoidant coping; juvenile heavy recreational use that escalated; forming relationships in mid to late teens with criminals. For men, this involved enmeshment in drug dealing, crime and prison. Some women formed relationships with men who injected drugs, who often introduced them to drugs, and some of whom were violently abusive. Heroin injecting was an effective means of blotting out distressing thoughts and feelings. Although childhood stories also contained positive memories, factors that might have promoted resilience were rarely mentioned.

Conclusions: Severe childhood trauma was common and gravitated people towards problem drug use via various pathways. Participants had often normalised the problems and did not remember adult help. Parental alcohol use contributed to trauma. Addiction services need to be more trauma minded.

Trauma in the lives of drug dependent people has been recognised at least since the 1970s (Aron, 1975), but only recently has it been given serious consideration as a precursor to and possible cause of dependence. Drug and alcohol service users have high prevalence of post-traumatic stress disorder (Brady & Back, 2012; Evren et al., 2013; Ford, Hawke, Alessi, Ledgerwood, & Petry, 2007) and childhood physical / sexual abuse (Asberg & Renk, 2012). Standard psychological interventions for childhood abuse involve PTSD treatment with some additional features (Cohen, Mannarino, & Deblinger, 2012).

There is substantial research on the effects of childhood trauma. Much of this is retrospective (as here), identifying a high prevalence of trauma in adolescents and adults with a wide range of mental health and other problems. Space precludes review of this literature. Some longitudinal studies follow participants from childhood to adulthood (Robins & Rutter, 1990). These are important because with longitudinal designs it is possible to make strong inferences about causality. While trauma and adult problems are correlated, and adults with problems have often experienced trauma at many times the rates experienced in the general population, far from all traumatised children have problems as adults. More severe trauma leads to poorer outcomes and severity increases with a number of factors including (Cohen et al., 2012): (i) repeated or persistent trauma; (ii) involving family members or other carers; (iii) that the child internalises some responsibility for the events; (iv) events that had, or could have had, major consequences. Major consequences include things such as death or serious physical injury, the breakup of the family, or the child being committed to care.

The concept of resilience is also theoretically important (Cyrulnik, 2009; Werner, 1993) because it explains why some severely traumatised children recover. Resilience is created in part by the interaction between the presence of positive social support in the child's life, and by the child's ability to elicit support from adults. This is particularly likely to occur at school, because school is most children's main sphere of activity and source of adult contact outside the home. However, such support can come from other sources, such as neighbours or extended family members, and the most resilient children are unusually skilled at interacting with available adults in ways that lead to their being supported (Werner, 1993).

Neither PTSD, nor childhood physical/ sexual abuse are specific precursors of substance use disorders, because both are associated also with much other psychological morbidity (Alisic, Jongmans, van Wesel, & Kleber, 2011; Athanasos et al., 2010; Carr, Severi Martins, Stingel, Lemgruber, & Juruena, 2013), including problems commonly comorbid with drug problems such as depression, anxiety, personality disorders, anti-social behaviour and psychosis. Additionally, childhood trauma adversely affects endocrinological functioning and the stress response (Kempke et al., 2015), and the prevalence of childhood trauma is high amongst the homeless (Sundin & Baguley, 2015), and the incarcerated (Singleton, Meltzer, & Gatward, 1997), contributing to people with serious multiple deprivations, including substance use problems, homelessness, mental health problems and prison records (Bramley et al., 2015). Drugs and alcohol also can be used as avoidant coping to escape the intrusive thoughts and feelings of PTSD (Brady & Back, 2012; Garland, Pettus-Davis, & Howard, 2013). Moreover, childhood trauma

additionally worsens the progression and outcome of problematic drug use (Heffernan et al., 2000; Lake et al., 2015). In summary, there are multiple ways in which childhood trauma may affect substance use, and one would expect that the life stories of problem drug users would contain stories of severe and repeated childhood trauma.

Qualitative research with adult problem drug users also identifies issues of childhood (and adult) trauma (Biernacki, 1986; Bourgois, 1995; Carpenter, Glassner, Johnson, & Loughlin, 1988; Macintosh & McKeganey, 2001; Maruna, 2008; Neale, 2000; Taylor, 2003). Most of this research theorises drug use as the product of a deviant subculture where deviant activities such as drug use and supply serve normal social, cultural, economic and personal functions (Agar, 1973; Bourgois, 1995; Johnson et al., 1985), such as power, signifying social status, earning a living, and meaningful occupation, often in conditions where access to conventional sources of these functions are limited. This contrasts with theories of drug use as disease-like, compulsive, addiction and is an approach extending back to the 1950s (Becker, 1953; Whyte, 1955). Deviant subculture theory is informative about drug use, notably marijuana use, which involves specific dialect and artefacts (Golub, Johnson, & Dunlap, 2005), but it may be less helpful as an account of problematic drug use. Indeed, the ethnographic research underpinning the theory does not strongly differentiate 'drug use' and 'problematic use'. Yet, entirely functional accounts are limited in their capacity to explain why some people choose drugs widely perceived to be much more dangerous, or engage in drug supply, or why some people get into trouble related to use whereas others do not.

Deviant subculture theory also finds it difficult to explain why many people avoid problematic use in disadvantaged neighbourhoods or settings where it might be functional (Hammersley, 2011a), and additionally has to assume that the complaints and concerns of addicts regarding the severity, even wickedness, of their addictions are self-justifications and rationalizations, or excuses proffered to the conventional world, and that 'addiction' is essentially a social attribution rather than a distinct biological condition (Davies, 1997).

Neither deviant subculture theory nor social attribution theory can explain the extensive psychological comorbidity, including childhood trauma, which is associated with and often precedes problem drug use. Problematic use of drugs cannot just be a deviant lifestyle choice that involves functional equivalents to conventional behaviours.

Moreover, longitudinal research on drugs and crime (Athanasos et al., 2010; Hammersley, 2011b), suggest that there are multiple pathways between childhood trauma and offending/ problem drug use including: (1) The persistent psychological effects of trauma leading on to heavy substance use as a form of avoidant coping. (2) The deleterious effects of trauma on wellbeing and self-esteem weakening resilience, for example by making educational and other conventional success unlikely. (3) Trauma and poor, neglectful, or dysfunctional parenting tending to go together, in turn weakening resilience. (4) Trauma tending to lead to the child being placed in care, where further abuse and trauma may occur, and children and adolescents can be socialised into crime and drug use. Notwithstanding these pathways, many adolescents are resilient against even very severe challenges and the normal outcome of delinquency and drug use is to desist in late teens or early 20s (Hammersley, 2011b).

Relatively little research directly documents the lived experience of being traumatised,

then developing a substance use problem. Etherington (Etherington, 2007a; Etherington, 2007b) collected the life stories of people in Southern England who have used drugs and recounts the stories of four people in depth. Two of the stories tell of cannabis use and cannabis dealing as responses to difficulties with identity and forming normal relationships with parents. The other two stories tell of childhood abuse and neglect that the respondents felt led on to drug use.

Another paper focussed on facilitators and impediments for women in recovery in Washington DC (Harris, Fallot, & Berley, 2005). Childhood trauma was one cause of bouts of depression and despair that could hinder recovery. Another relevant finding was that substance use and adjunct problems were endemic in some women's extended families to the point that quit attempts could be met with "derision." Two other USA studies (Daniulaityte & Carlson, 2011; DeHart, Lynch, Belknap, Dass-Brailsford, & Green, 2014) report similar findings from women, where childhood trauma, parental substance use and diagnosable PTSD were among the factors that were related to substance use, and made treatment and recovery more difficult. Another American study of homeless youth (Martinez et al., 1998) reports similar findings for both genders. A study in Germany (Schaefer, Lotzin, & Milin, 2014) reported similar findings for stimulant users seeking treatment, with about 2/3 of the sample reporting some form of neglect, abuse or trauma in childhood, which they considered related to the onset of problematic drug use. In these studies childhood trauma tends to beget further trauma, exacerbated by problem drug use. People who had recovered successfully from childhood trauma would not appear in any of the samples.

In previous life story research, getting out of a life of drugs and crime was associated with changes from explaining one's behaviour as the unavoidable consequence of unfortunate circumstances, including an addiction one cannot control, to having more of a sense of personal agency and responsibility (Maruna, 2008). This is aligned with common recovery discourse. Recovery from PTSD requires the person to be able to accept and move beyond the traumatic events rather than persistently being victimised by them mentally; for example by intrusive thoughts, flashbulb memories and panic feelings in certain situations. The issue of personal responsibility is more complex, as people who have been abused often accept more responsibility for this than they should (Brown, Harris, & Fallot, 2013; Harris & Fallot, 2001).

The research reported here did not aim to study trauma, but to record the life stories of people who had injected drugs but were in recovery, with the objective of developing a more nuanced comprehension of drug users, their experiences, and the issues that they face. The purpose was to inform an enhanced drugs policy response in terms of prevention, treatment and recovery, by offering a more sophisticated and person-centred understanding of "problem drug users" than is currently available. An overview of the entire research has been reported (Hammersley, Dalgarno, & Scottish Drugs Forum, 2013).

However, trauma was one major emergent theme, so this paper aims to describe and theorise the impact of childhood trauma on the development of problem drug users. Nearly half the cohort told stories of extensive childhood trauma that they believed had adversely affected their subsequent lives and substance use, some others described behaviour

problems in childhood that led on to their being traumatised. Yet others mentioned some traumatic events but did not consider these to be consequential for their subsequent drug problem, while only 11% told of apparently entirely non-problematic childhoods. A related question is the extent to which the stories described people and factors that might have promoted resilience.

Participants here are referred to as 'heroin injectors', which does not mean that their drug use was limited to heroin or to injecting drugs. Drugs commonly used with opiates in Scotland in approximately 1980-2011 included benzodiazepines, alcohol, methadone, and cannabis, while relatively few Scots had a primary problem with stimulants. Participants and fieldworkers were in recovery. Practices and philosophies of recovery are varied in Scotland (Scottish Recovery Network, 2014). Variations include: the appropriate role and prescribing regime of substitute prescribing; whether abstinence involves abstaining only from substances that caused problems, or also from others with the potential to cause problems; and whether prescribed medication, especially substitute opiates, are exempt from abstinence; as well as the use of mutual assistance organisations (e.g. Narcotics Anonymous).

Method

Dan McAdams' Life Story Method (see <http://www.sesp.northwestern.edu/foley/>, accessed 23/5/2012,) was used to collect narrative data about the person's entire life. Theoretical assumptions include that personal identity is constructed as a story, and that life stories have common, classifiable themes, characters and structures, which are informative about the person's identity. As with literary criticism, the method assumes that it is both possible to understand narrative as deliberate personal sense-making, and to interpret and analyse life stories in order to discover things about the person that they did not deliberately present in the story, including what is normal and taken for granted by them and how they go about telling the story, both of which may be due to their times and culture.

Specifically relevant to this paper, some people's stories were in part explicitly about being abused or traumatised in childhood, but more people remembered bad events without telling a trauma-focussed story. All participants were in recovery, which for many had included some form of group or individual therapy where they had told their story. Data not reported here suggests that for this cohort therapeutic processes varied greatly in quality, depth and the extent to which the respondent had given a full and accurate account. For example, one respondent was asked to leave a residential rehabilitation programme because staff felt that telling his abuse filled story in group therapy was upsetting him too much.

The life story method encourages systematic recall of key aspects of the person's life, which in turn allowed participants to place drug use as centrally or peripherally in their stories as they wished. This was deliberately to contrast with the normal tendency for research with drug users to focus on drug use, risk factors for drug use, and harms caused by drug problems (Hammersley, 2014).

The life story method was adapted by simplifying the definition of different periods to childhood, adolescence, adulthood before heroin, adulthood with heroin, and afterwards, and dropping the metaphor of life 'chapters'. In semi-structured interview, participants tell

the story of each period and identify the best and the worst experience in each period. It also asks specific questions about life. It was chosen because its structure encourages systematic recall of key aspects of the person's life, which in turn allowed participants to place drug use as centrally or peripherally in their stories as they wished. This was deliberately to contrast with the normal tendency for qualitative research with drug users to focus on drug use. The interview protocol is shown in Appendix 1.

Fieldworkers

Fieldworkers were Scottish Drug Forum (SDF) volunteers themselves recovering from substance use problems and free of illicit drug use. They were assessed by the User Involvement Development Officer (UIDO, 5th author) for their stability and ability to cope with this research. They were also subject to full disclosure of criminal records. At the end of each day that they conducted research interviews they discussed with UIDO how they were feeling and thinking about the day and were debriefed. The fieldworkers could access further support if any issues arose.

Fieldworkers received some 50-60 hours of general training from SDF staff and additionally some nine hours of specific training facilitated by the first and fifth authors. Sixteen volunteers began the specific training, of whom six completed it and conducted research interviews. Amongst those who left the programme were people who felt that they would be unable to cope with the interviews.

Participants

Eligible participants had injected drugs within the previous five years. All the achieved cohort were currently in recovery and had received some form of intervention for their drug dependence at some point. The original intent had been also to interview active heroin users, but this proved impractical due to issues around safety, non-attendance and intoxication. Participants were recruited through drug agencies, support and recovery networks, and personal contacts during April to July 2011. Deliberately, recruitment occurred in cities, for example Edinburgh, in post-industrial towns, for example Kilmarnock, and in predominantly rural areas, for example Dumfries and Galloway. To ensure confidentiality, precise recruitment sites are withheld. Participants were given a £15 shopping voucher as a disturbance allowance.

Interview method

Interviews were digitally recorded, then transcribed by a company specialising in medical and research transcriptions and accustomed to transcribing Scottish accents. Transcripts were passed to the researchers for analysis, along with the recordings for reference.

There were some differences between peer-to-peer interviews such as these and the more typical interview where a researcher interviews a participant who can be from another social world. Interviewers and participants had similar life experiences and shared understandings on many levels, so some issues that might have been explored by professional researchers were taken for granted. For example, there was very little discussion of why people wanted heroin so badly when dependent on it or how this felt. However, the common social world also allowed participants to talk naturally about what concerned them, to discuss stigmatising matters openly, and sometimes with dark humour.

The common social world also permitted understandings of slang and allusion, which were occasionally difficult for those undertaking the analysis to understand.

Data analysis

Two types of analysis were conducted. (1) The answers to the structured questions were subject to a content analysis classifying the answers, then if appropriate over-arching themes were extracted from the content in a top-down way. In some interviews, the interviewer omitted to ask some of the structured questions, or phrased them differently. (2) A thematic analysis was conducted to extract common themes from both the life story structured into episodes and the answers to the more structured questions. This analysis was more inductive. One of the main themes to emerge was that of trauma and abuse, which is the focus of this paper.

The results will consider the different types of story told about childhood including: Severe abuse/trauma causing problem drug use; Behavioural problems leading to abuse/trauma; Trauma, usually less severe, not causing problem drug use. Two further types of story are not explored, where there was no trauma, and where the life story contained scant details about childhood. There were also different pathways to problem drug use in the stories: Substance use precociously for fun to escape problems; Enjoyable heavy drug use gradually escalating; Ties to criminals (men only); Relationships with heroin users who were also abusive (women only). Finally, data about resilience and positive aspects of childhood are presented.

Confidentiality

Participants provided extremely frank information about their lives. It is therefore essential to protect the participants' identities by not publishing anything that could identify them to someone else who knew them. For this reason, as well as anonymising all personal names in the transcripts, all names of places and organisations were also anonymised. To this purpose, it is sometimes necessary to be vague about details that might identify them. Moreover, contrary to standard practice, quotes are not attributed to individual participants. This is in order to prevent anyone linking several unusual features or incidents together and identifying a person.

It was felt that it is also important to protect the identities not only of the people, but also of places and organisations that were mentioned in the interviews. Participants sometimes described the illegal, or simply less than ideal, activities of others. They were also sometimes critical of some of the treatment and other agencies and individual staff within them that they had encountered. Transcripts were read, then all identifying material was removed from them. This included all names: people's names and the names of places and organisations that might make the person identifiable. Also, any information judged so unusual as to constitute a potential risk of breach of confidentiality was altered. Examples included participation in newsworthy crimes. The anonymised transcripts were then used for the main analyses and the original transcripts and the interview recordings were deleted once this process was complete.

Ethics

This research posed a number of risks for participants, fieldworkers and researchers.

Participant risks included:

- *exposure as a problem drug user*, managed by ensuring that only people who already knew about participants' drug use knew about their participation and strict standards of anonymisation;
- *Distress caused by interview topics*, managed by fieldworkers being trained to offer basic emotional support, by the support of the fieldworker manager and by use of appropriate referral pathways to address issues raised.
- An ethical concern was that participants could disclose information that suggested that they posed a risk to themselves or others. The consent procedure was explicit about the limits of confidentiality and allowed participants to make the informed choice NOT to disclose such information to researchers. In fact, while participants disclosed many highly dangerous events, these were all from the past. Nobody reported current dangers.

Fieldworker risks included:

- *Being upset by harrowing life stories, either through vicarious trauma, or because of stories reminiscent of their own lives possibly resulting in relapse to drug use.* Fieldworker assessment and screening (see above) addressed these risks.
- *a hypothetical possibility of being placed at physical risk during data collection*, handled by conducting interviews in safe places, such as the premises of local drug services.

The researchers risked:

- *Vicarious trauma because some of the events narrated were harrowing.* This was managed by restricting the time spent reading transcripts and interspersing this work with less stressful activities, scheduling time to mentally shift away from the life stories before engaging in other activities, using cognitive behavioural techniques to avoid ruminating on particularly upsetting details, and making occasional use of support.

Findings

Achieved cohort

Of 61 interviews, 6 were discarded due to recorder malfunction leaving n=55. Women were over-sampled 1:2. Table 1 shows basic characteristics of the achieved sample. Most of the respondents had been children in the 1970s or 1980s.

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Trauma and normality in childhood

A few respondents told stories of traumatic childhoods from the outset, but most respondents initially described their childhoods as happy or normal. Then, it was later in the interview, when asked more details, for instance about their best and worst memories, that the stories of trauma were told.

Participants told five types of story about their childhood: (1) Twenty-five people described abuse or neglect that was persistent which they considered had affected their subsequent drug problems. (2) Nine people told stories of having behaviour problems as children, which led on to further problems including early substance use, and later trauma. (3) Another nine described traumatic events during childhood, but these did not involve repeated abuse or neglect and the narrators did not see the events as particularly linked to their subsequent drug problems. (4) Only six reported no trauma in childhood, described relatively ordinary childhoods (in the research team's opinion), and told stories of getting into problematic drug use in other ways; most commonly heavy recreational use leading to dealing then to drug problems, or heavy recreational use turning into problematic use after trauma in adolescence or adulthood. (5) Another six told stories that included possibly traumatic events, but the stories did not go into enough detail to judge whether they had been traumatic or not. This was in part due to the fact that a minority of participants elected to tell stories that were mostly about their drug problem and recovery, and provided relatively little detail about other matters. Moreover, some respondents mentioned during interviews that they found their childhoods difficult to remember. Also, many of the life stories were told in a way that however bad the childhood had been, experiences whilst injecting drugs tended to have been even worse. Categories 4 and 5 are not discussed further here.

It is important to emphasise that the quotes that follow are illustrative of what was told in the stories, not the more extreme cases. Indeed we have attempted to minimise lurid details and have avoided quoting some of the most upsetting stories. Also, many of the respondents were clear that the levels of violence and other trauma that they were recounting were in excess of what they considered to be normal and acceptable. In traditionally working class, often now deprived, areas of Scotland, it is long accepted that people get drunk and that some men do this habitually, say once or twice a week (Wight, 1994). Domestic violence and misadventures whilst drunk are traditionally common (Hughes, 2007). Within this tradition, some participants told of occasional violent fights between their parents while the father was drunk, usually leading to injury to the mother. They emphasised that these were unfortunate but did not have lasting effects on them. Many participants also felt that it had been appropriate for their parents to administer the occasional 'slap' or 'backhand' to them, when they deserved it. A few even accepted that they occasionally had deserved a 'good leathering'. Within the social context, occasional corporal punishment was commonplace when participants were growing up. As will be seen, much of the violence, neglect and abuse described in respondents' stories was far in excess of such cultural norms.

(1) Stories that were explicit about the impact of violence and abuse

Those with stories of violent abuse in childhood often carefully distinguished this from violence or punishment that was normative. For example, one man described how his father had beaten him:

Aye he was strict, he used to get me (i.e. hit me) left, right and centre. It wasn't just a father and son, it was a pal do (i.e. fight as if between equals), I couldn't sit.

Another man who came from a family where all eight children became heroin users said that his worst childhood memory was getting sent to a List D school for stealing:

I remember (...) going to the house and not expecting my mum and dad to have two social workers. They had phoned the social workers round to the house to transfer me to List D School at eleven year old. I can remember (the social worker) telling my dad, saying to my dad "look you need to do this". Not in the neighbours, but my dad was really strict, my dad never thought it would ever happen. When my mum passed away I have seen my dad shed a tear, but I have never seen my dad shed a tear beforehand.

He was terrified of Dad, whom he remembered voluntarily taking himself to the police station for days at a time, rather than fly into another violent drink-fuelled rage with his children. Many respondents used the word 'strict' to describe being beaten, often whilst the parent or carer was drunk, and sometimes for relatively minor infractions. 'Strict' was not used recalling incidents of corporal punishment that the participants believed had been appropriate or deserved, and was not used in stories that did not involve extensive violence and abuse.

Some respondents remembered fathers or stepfathers being abusive to their mothers:

Well basically my mum was always good but my dad was a drinker. ...so I haven't really got that good a memory of that (childhood) bar my mum getting battered all the time, him bugging about with other women and things like that.

Alcohol was a common contributor to remembered childhood trauma. One man had been abused by his father to the extent that he remembered routinely jumping out of the back window when he saw his father coming back to the house after drinking. Asked to recall a good memory of childhood he said:

Nothing really. I never really had much of a thingummy (a childhood); it was just school or either kept in or out (of the house), you know? My mum and dad were dead strict...

Another woman described her worst childhood memory as: "I would say my Dad battering my mother. Aye, that happened quite a lot" (when he was drunk). However, one of her best memories also involved her Dad:

Doing the garden; I used to do that with my dad. Just things like that I think being all of us because there was a lot of us. Aye, doing stuff with my dad. I don't really have many specific things.

Although physical abuse was more commonly reported, there were also cases of repeated sexual abuse by family members. Additionally, some participants had gone into care, often to be abused there. The woman just quoted was raped aged 14, started misbehaving and was put in care. Another woman described events that led to her going 'completely off the rails':

Well my granddad killed his self when I was eight, jumped under a train, so that had quite a large impact on me, because he ... you know all about this though don't you? He walked in on my uncle abusing me so he killed his self on his son's birthday.

Although physical abuse was more commonly reported, there were other cases of repeated sexual abuse by family members. Additionally, some participants had gone into

care, often to be abused there. One man, who became a child arsonist before developing a drug problem described abuse by his adopted mother:

And there was a lot of violence and a lot of abuse all that kind of stuff in that family, and I missed a hell of a lot it was like I never had a childhood because it was totally destroyed. And a lot of that has to do with where I am now and why I have got to where I am now. But from the age of zero to eight it was all about getting battered, and the kind of things she used to do to me was you used to get these big ornamental wooden spoons and forks that used to hang on the walls, she used to batter me about the head with them. And have you heard of the Scholl? Like the old hard Scholl shoes she used to smash me around the head with them, she was a nasty, nasty woman.

Unusually, his story of abuse did not involve the adult being drunk. Another woman was placed in foster care and separated from her siblings, subsequently her mother was murdered and she also moved multiple times within care, which she found difficult and disruptive, although she was not abused. She said that she had turned to drugs as a result of this.

In contrast, some respondents had taken as non-noteworthy: being surrounded by heavy drinking and drug use; being highly disruptive at school; being involved at a young age in substance use and crime; fighting with other young people, including in gang fights.

For instance, one man's father had been a heroin dealer and, although he felt that he had a normal childhood he had tried heroin aged 15, wanting to be like his father. Another man whose father and stepfathers had been violent, alcoholic, and criminal said matter-of-factly:

I got hit with a claw hammer and went into a coma for twenty-two days, and I still suffer from migraines today with that. Every time I get clean I suffer with them. I think the drugs have just suppressed it. I had a blood clot it ended up I picked out myself. It was in between your skull and your brain. That was just gang-fighting stuff, and my pal died that day.

Not all seemingly traumatic events were judged traumatic by respondents.

(2) Trauma and drugs emerging from behavioural problems

One woman depicted her childhood as:

Just getting into trouble all the time. I used to fight a lot because my ma was disabled and folk used to make a fool of her all of the time so it used to get me really angry and I just used to batter them for it.

Her story illustrates the complexity of child agency. She did not have to react this way to defend her mother, but her doing so probably amplified the difficulties of living with a disabled parent. Some of the men remembered much worse from very young. One said:

School, my earliest memories of school was actually getting the belt [...] I just did destructive things and that. I got took into care, I was actually five or six at the time I got took into care and that was not a good experience for me. [...] I can even remember at that age kicking off with the staff. I think what started off (was that) I made a raft (run) for the front door and the staff sort of grabbed me and that was it; I started kicking off, screaming and shouting. They had me pinned on the floor, the staff. That is sad I do not know if that is how they had to deal with me.

One man described himself at primary school: "I became a serial school-bunking little cunt [Laughter]." This led on to solvent and pill use by age 13. His story then skipped over the rest of his teens so we do not know what else happened, until at age 21 when:

I shot my wee sister's boyfriend during a stupid drunken fucking pill fuelled fucking anger rage thing. Anyway, I got the sentence, done eight years out of it. I was just coming out from that, two months short of my thirtieth birthday. I was getting lib'd on the Friday. The Saturday previous to my liberation two boys kicked in my wee brother's front door, sprayed him with petrol, torched him. I got out on the Friday and he died on the Tuesday. Two weeks after they buried him, my mum died. My head went right up my arse.

He had started using heroin during his prison sentence, use intensified after these bereavements and he received another custodial sentence. One could not say that truanting from primary school caused his drug problem, but his problems grew and intensified from there.

Another man with hindsight believed that he had ADHD as a child, which meant he misbehaved at school, including fighting, and was sent to a special school initially as a day pupil where:

You are basically dealing with all the outcasts from most of the West of Scotland were all flung into this one school, and you started learning things about crime that you didn't know. I learned how to break into a house, I learned how to do shoplifting properly, I learned all the criminal intents.

Before age 14 he also began drinking, using cannabis and other drugs, then at 16 went almost straight from the special school to prison after breach of the peace whilst drunk, subsequently serving repeated sentences, and consequently feeling more institutionalised than traumatised. He said he knew more people in prison than in his neighbourhood. These stories were more stories about delinquency in general, including impulsivity and conduct disorder, rather than specifically about child abuse and neglect.

(3) Other trauma not involving abuse and not being seen as a cause of drug problems

Some respondents told of traumatic events that were horrible but that they did not feel had affected their subsequent drug problem, again alcohol was often involved:

It was alright for me and my brother but we heard an awful lot of stuff, mental abuse, he never hurt my mum it was all mental. It was horrendous.

Another man remembered:

But when I was about eight or nine I would hear my mum and dad arguing and stuff like that, and I remember I had this thing I would be lying in my bed and it would be usually at weekends when they had a drink. [...] I hated that and that would come into my mind all that stuff, and I suppose I was a bit insecure then knowing what was going on. [...] And I remember my mum, they were arguing. And my dad went to the toilet, and my mum came into my room, and I was sitting doing something. And she grabbed me and said get your clothes on quickly, and get your jacket on, and all the rest of it, we need to go. And she grabbed me, and we left the house when he was in the toilet.

With that, they had left his father and his story did not explain why. Another man's family had to stay at his uncle's, where he was exposed to heavy drinking and fighting:

My other uncle's, my auntie's, seeing the fights after it, the laughter, there were always tears do you know what I mean? So you can see I was probably full of fear, from the age of five, six. These fights you know I was rushed into a room (away from the trouble), aye, that's my first memories of all this alcohol, do you know what I mean?

Another woman said:

My dad ended up with full custody of us. My step mum was nasty, but not nasty as in hitting us, just weird stuff. Her kids were treated differently, so my brother stopped seeing my mum so he would be treated the same, but I wouldn't stop seeing my mum.

Additionally her mum may have had a mental health problem, and was very tolerant of, even encouraging of, her daughter's precocious alcohol and drug use. There was also a diversity of other possibly traumatic events in childhood, as summarised in Table 1., including health problems in the family, bereavements, and other issues, which the story tellers did not feel were particularly related to their eventual problem drug use.

One man had been sexually abused by a stranger as a child, but the story was that this was recognised and effectively treated at the time, with no enduring consequences; his subsequent drug problems developing in late adolescence quite separately. He was one of the younger respondents, who had moved relatively rapidly through his drug problem to recovery, via methadone, within about a two year period.

Summary of trauma in childhood

The remembered traumas had a number of important common features. First, many people described them in a matter of fact way that suggested that they had normalised such events and did not fully appreciate the potentially devastating impact that they had had on their lives. This normalisation extended to many participants describing their childhoods as happy and not spontaneously bringing up the traumatic aspects of it until asked specific questions such as what their worst childhood memory had been. "Strict" was a common euphemism for being beaten by a drunken parent. Second, trauma often involved violence or sexual abuse. Even when it did not, many participants remembered sustained cruelty, maltreatment or chaotic and disrupted lives due to a variety of parental and familial problems. Third, alcohol use by adults was commonly implicated in both kinds of trauma, both directly, as when abuse occurred when the perpetrator was drunk, and indirectly, as when trauma was caused by neglect of the child, or by fleeing an abusive parent (usually a man).

Pathways to problematic drug use

Participants told of four different pathways from childhood trauma to problematic drug use: (1) Fun and escape; (2) Gradually increasing use; (3) Abusive relationships (women only); (4) Criminal ties (men only). Here 'pathway' does not imply 'cause' for this is narrative data. In the stories, three of the pathways could continue from any of the five stories of childhood, but abusive relationships only came after childhood trauma.

1. Fun and escape

Two men described inhaling glue vapour aged 10-11 to escape their problems. A few other participants described drinking alcohol and using drugs heavily from very young in ways that seemed fun at the time. One woman remembered that after being bullied on the internet, aged 14 she:

...started drinking during the week. Not a lot. But I would sit and have a bottle of wine, when I was watching the telly or something.

She went on to develop a serious alcohol problem, as well as eventually a drug injecting problem. Another man hated alcohol because his father was a heavy drinker and got into drugs instead:

so I just basically keep away from pubs, but then because of not going to the pubs I kind of justify drugs, but well it's OK for me at least I didn't drink eh? But then I'm talking about the beginning when I didn't know much about them (...) it was fourteen and you start taking mushrooms and acid and whatever, but then again I was born in the beginning of the sixties so a lot of the older lads were actually coming through the sixties so they were all cool, kind of law of the sixties and whatever, but I as I say, I was just into mushrooms and hash and all that effort, and then there was a boy down the road, (...) yes, he got knee-capped for something he done anyway so he was first, first of the people I've ever known to get opiates

People's experiences were complicated by the fact that many of them had continuing serious problems as young teenagers, such as bereavements, being in care and being abused there, or prison, or being homeless. In the stories, the combination of continuing problems and heavy but pleasurable substance use led on to heroin use, often quite young.

2. Gradually increasing use

Most people initially found drugs fun and a part of socialisation, although perhaps they were consuming more heavily than their peers:

If I wasn't doing anything in the day, at night, even if it was during the week, we would be like, "We'll just have a beer." Or "Oh, we'll just get a bottle of wine." I started smoking dope regularly. And then we'd go out on a Wednesday night, and be out all weekend. The nights I wasn't working. Even if I was working, I'd end up going out after I'd finished in the pub. Going to the casino, or whatever, and just getting hammered.

Again use escalated. Some people's use escalated into heroin use in the context of partying, often while they were employed and raising children. Heroin use remained relatively controlled at first, then got out of hand in response to a bereavement, relationship breakup, or cessation of access to children. Sometimes these losses were related to the person's drug use, but often they were not. A few men, including some who had spent a long time in prison, were first given heroin to help them cope with such a loss. Another form of escalation was to get involved in drug supply:

But I left school at the age of fifteen. (...) I got to sell drugs, and I got to be a gangster, and I think that was my idea. I went up to people that were doing that on the street, people that I knew.

Is that what you done then when you left school rather than work, do the drug dealing and that?

I did aye I got into it early, I had an uncle that used to supply all the drugs in my area. And it was easy for me to sell the drugs, they (the drugs) were jumping about in the area and plenty of people took them. And I was known, and it was easy to sell them to people; I didn't have to try. I earned money on drugs, plenty of money. I had more money than I knew what to do with to be honest with you, wasn't interested in getting a job. Wasn't interested in doing anything, I was quite happy getting out of my bed whenever I wanted. I was living with my mum and putting my mum through hell at the time. (...) You know for the future I wasn't interested at all.

3. Problematic relationships

Many women had been in relationships with men who also used heroin, some of who were abusive and violent. None of the women told of such a relationship with a non-user. Some women described more than one abusive relationship. Abusive partners often introduced women to hard drugs - although so did non abusive partners - and some women worked with the partner selling drugs. Women described drug use intensifying due to the abusive and dysfunctional situation that they lived in. One woman described meeting an abusive partner when aged 14:

...guess what he done to get my attention? Put his head through a window so I would take him home and pick glass out his head. I should have known then he was a fucking nutter.

Two examples of abusive relationships with heroin users:

...he battered us right, but it was more mental torture with him. Right, and he wanted me in the house but he wanted to fuck me about (mess me about) at the weekend, because I never started taking smack until I was twenty four.

What age were you when you started seeing him?

Seventeen. So I went through all sorts of shit with him, as in (due to) the people he went about with, and he was involved with. People were getting murdered, people were getting done in, this that and the next thing, doors were getting done in, and all that kind of crazy shit. And bringing things up to my house and all that...

The second example:

Then when I was twenty I met my first wee one's dad. He was into heroin but I still didn't touch it at that point. I was out working, keeping his habit going and then he started lifting his hands to me. Ended up broke my jaw. I was hospitalised every second day of the week or something probably. I was very lucky; I had jumped out a two-up window to get away from him. Broke my leg, damaged my back. I had loads of stuff going on.

In short, the women were vulnerable to forming abusive relationships and their drug problems often formed in the context of such relationships. However, other couples who used heroin together and had children often stayed together in relationships that were complex and varied over the years, and sometimes abusive, but sometimes not.

4. Criminal ties

Men did not report relationships with women who abused them, but some men became involved in serious crime and drug use by age 16, usually through close ties to criminal family members or friends. Consequently, several men had spent most of their adult life in prison, three had initiated heroin injecting in prison, and several remembered being involved in awful crimes and events, one example being the gang fight described above.

Using heroin as avoidant coping

Many participants emphasised that compared to other drugs, or anything else, heroin was a superb means of reducing thoughts and feelings. This made it possible to avoid: (a) the pain of trauma; (b) reflecting upon whether or not avoidance was a good idea; (c) recognising the dysfunctional and harmful nature of the lifestyle associated with problem drug use. One man who had previously experienced multiple traumas described why he started taking heroin after losing his partner and child while being treated for crack use:

So I thought I'll leave it and see what she does and then I found out she'd met somebody else. It was about that time I just started, I started taking kit; I started injecting kit. I started

smoking it in the clinic, kipped at my mum's, started smoking it at the clinic, I liked the feeling – it took everything away, you know the madness, not the madness, the emotions.

Another man, already a heavy drug user, started in prison:

I didn't start taking heroin until I was thirty. That was when I was in the jail when my mother passed away, and I got offered it in the jail and that was it.

That was when... What did you just – what was the reason for taking it?

To block everything out of my head more or less, but it blocked it out that night but it was there the next day again, even worse.

A woman described how while using heroin she had not cared what she did:

It's mad when you think back to the things that you did. It really is. And at the time, you just didn't care. You just didn't. You were just interested in scoring and in getting a bit of drugs.

As one man put it “It does kind of make you feel quite numb.”

Resilience and the positive

The life story method offers respondents the opportunity to describe positive people and forces in their lives, as well as problems. Positive things that might have promoted resilience were not common in the life stories told here. Some parental figures were abusive, often in ways that had been taken for granted, and which had attracted little or no sanction from the other parent, or others. There were few stories that told of being protected from abuse by other concerned adults. Moreover, the stories that included being taken into care often told of abuse there also. At best, being in care was less bad than not being in care, but few respondents told stories of feeling supported by foster parents and other professionally caring adults. The normalisation of abuse, as simply part of life, extended to some respondents continuing to have family relationships in adulthood with the people who had abused them. An extreme example was a woman whose grandfather had repeatedly sexually abused her. Despite this, she had routinely left her own child in the care of her grandmother, still living with the abusing grandfather.

One of the standard life story questions asks respondents to tell their best childhood memory. People's answers to this question give some indications about positive factors that might have promoted resilience. Answers were coded to as few themes as possible, allowing up to three themes per answer. First, there were positive memories of things that seemed unlikely to have promoted resilience, but more were pleasures away from routine life. The majority of answers referred to holidays (n=39). Six further answers mentioned receiving a gift, and two mentioned meeting a celebrity. Finally, one man said:

Finding drugs, that is probably my best memory. It was the only thing that made me feel any better. Then after a dramatic pause he said: But doing drugs was the worst thing.

Four people said that they could remember nothing positive from childhood, and another 8 remembered something after thought and prompting, but said that it was hard to remember anything.

Turning to memories that suggested factors that might promote resilience, the most frequent of these regarded personal activities and accomplishments, such as in sport (n=14). A few of these respondents expressed regrets that these achievements had not gone further. Six remembered an activity with a parent, although usually this was with a father who had been abusive to the mother at other times. Two remembered large family gatherings positively. Outside the home, only four people remembered things involving school, and two of these involved trips away from school. Finally, only five people's best memory was of someone who supported them in some sense, including one man whose best childhood memory was of the social worker who had finally listened to him:

I could always remember him, because I had him for about a year after I got taken away from them. He was the only one that sat there and listened, and believed me, and listened to what was happening. Because all these years before, all my pals whose mums and dads, and all that, had been seeing what was happening to me, the social worker was going in there sitting all day and telling them this is happening and that is happening. And nobody would believe me, they would just send me back to the hell I was living in. It was horrible.

But it was just this one guy, he stays in [an island community] and I keep in touch with him now, but he is the only social worker I ever had any respect for really.

There was one other mention of a social worker as a source of support, and three people mentioned family members as supporting. For some people, even their positive memories were tinted with sadness:

Going swimming in the sea, and building bonfires, and toasting marshmallows. And the thing about my foster parents having money: I mean I did not know that they got paid for us until after I had left and they just put everything I had in black bags, and handed it to me, and changed my room into a kitchen.

This is an extreme illustration of the tendency for many respondents to report their best childhood memories as things that stood out as positive in the context of relatively negative overall stories, despite being quite banal. For example, one man's most positive memory was of his mother buying him a cardigan.

Discussion

The data presented here add to existing knowledge that people with drug problems often have experienced trauma by documenting the severity of those childhood traumas, which humanises the neutral clinical terminology often employed regarding 'PTSD' and 'abuse'. The data also emphasise that childhood trauma is a major component of the lives of many problem drug users.

Many of the stories told of severe abuse according to standard criteria of severity. This does not fit readily with deviant subculture theory for it appears that some problem drug users are not simply making functional 'career' choices within a deviant subculture but at minimum gravitated to that subculture because they were already psychologically damaged by trauma. It is sometimes suggested, including by ex-users (Mullen & Hammersley, 2006) that the subculture of heroin use and supply is inauthentic and dysfunctional, so perhaps damaged people thrive within it, for instance because they are already inured to violence. Also, some people may be attracted to such subcultures because their severe traumatisation and PTSD makes it difficult for them to access

conventional social resources. The well-known links between lack of education and multiple personal deprivation (Bramley et al., 2015) is one example. Considering problem substance use as a dysfunctional lifestyle that is produced by a complex interaction between life difficulties in childhood and adolescence, and social, economic and cultural factors, has the potential to develop understanding further than has been possible by considering problem drug use as only the product of a deviant subculture.

If problem drug users are often severely traumatised prior to developing drug problems, then attributing the manifest problems of addiction solely to the pernicious properties of a drug is also simplistic. Severe childhood trauma, such as described here, would have enduring effects into adulthood even in the absence of heroin or other drugs. Trauma may also help to differentiate unobtrusive heroin (and other drug) users from those who develop problems (Dalgarno & Shewan, 2005). Being traumatised makes it less likely that people will approach substance use in the measured, informed and planned manner that reduces risk.

Here, traumatisation could directly lead to problematic drug use, or there could be other pathways including: heavy but not problematic substance use followed by difficulty coping, then problematic use; being attracted to partners or associates who were abusive or criminal and facilitated heroin use. Some men told of deliberately seeking out a life of drugs and crime. This initially could be an exciting, prestigious and affluent life for a youth, but such a life was also physically dangerous and stories included substantial time in prison. Some stories told of getting involved in such lifestyles as a matter of choice, at least to start with, and did not consider trauma as a factor. Some stories, such as the one about “just gang-fighting stuff” simply took extreme violence for granted. Yet, emotional detachment is a symptom of PTSD, not a protection against it.

The choices made suggest that resilience had been weakened through trauma, leading to lifestyles involving drugs, crime and abusive relationships, which might have been rejected by young people with more personal and social capital. These were deliberate choices that seemed like good ideas at the time, but ultimately had become problematic and hard to control. As well as drugs themselves becoming hard to control, there was the need to care for children, and the problems of imprisonment. Another of the persistent effects of childhood trauma was that some stories told of people being unable to cope with further trauma, turning to opiates instead. A drug user experiencing trauma for the first time may escalate use temporarily but then reduce it again (Hammersley, 2011b), whereas in some of the stories here bereavements and other losses led to people going “completely off the rails”. It is nonetheless important to remember that not all respondents told of childhood trauma.

However, some of those who recalled trauma initially described their childhoods as normal or good. This was more likely when the trauma was less severe. It was also true that many respondents with harsh childhoods had experienced worse as adult heroin users. Consequently, many stories were ambivalent regarding the balance between normality and trauma or abuse. The idea of normality is difficult for problem drug users (Nettleton, Neale, & Pickering, 2013) and in many stories concepts of normality meant both “similar to

what most people experience” and “what I was used to at the time”. The more extreme stories chose words carefully to delineate that the level of repeated abuse and neglect described was beyond what most people experience, but there were also stories that were more ambivalent regarding whether or not the events told had been difficult beyond the norm, or had contributed to a subsequent drug problem. In some stories, there was further ambivalence regarding the appreciation that such problems had not seemed unusual in the neighbourhood where the respondent grew up, but that they had been undesirable nonetheless.

Childhood trauma was often accepted, but it was not normalised in any uncomplicated way. Acceptance may have been due background cultural norms tolerant of violence, and also because problem drug use can be a highly violent life (Neale, Bloor, & Weir, 2005), so many stories told of worse events during adulthood than had been experienced in childhood. Much abuse and trauma had occurred in the context of adult drinking, most often but not exclusively by fathers or stepfathers. Drinking had led directly to child abuse and to abuse of children’s mothers, and had also created circumstances in which neglect, vicarious trauma, and sexual abuse could occur.

The stories also told of a lack of proactive adult concern regarding child misbehaviours from family, school and other health and social care professionals. Only a few stories told of people and activities that could have promoted resilience. Some respondents recalled being treated as troublemakers rather than troubled. Troublesome children often have troubles at home, even when they take these for granted, cannot recognise them as such, or deny them. A continued problem for services is how to recognise this and how address this in an appropriate and sensitive manner.

The data also document the difficulties of retrospectively understanding a difficult childhood whilst recovering from a drug problem when difficulties tended to have been even worse. The data are retrospective stories told by people recovering from problem drug use. There is a tendency for human stories to seek bad past causes of bad things that happen, rather than attributing them to chance or the specific situation, because bad causes of bad things offers a narrative coherence that is psychologically functional (McAdams, 2008). Thus, the stories reflect two contradictory tendencies, to over-emphasise childhood problems as explanations of drug problems, and to de-emphasise them in favour of more empowering stories of personal choice and responsibility. The severity of the traumas where such that untreated they may have created PTSD, which can be a chronic and debilitating condition that people do not readily recover from without specialised intervention (Brown et al., 2013; Harris & Fallot, 2001). Taking responsibility appropriately (but not for being abused) is one desirable outcome.

There are questions about the appropriate approach to therapy, which may have to deal with drug dependence, trauma caused by the violent and dangerous drug scene, and trauma from childhood. Many of the stories told of childhood families that would have benefitted from some form of family or systemic intervention. It is now widely recognised that children in households where a parent has an alcohol or drug problem are at increased risk of neglect, abuse, trauma and subsequent problem substance use (Bailey,

Webster, Baker, & Kavanagh, 2012; McKeganey, McIntosh, & MacDonald, 2003; Mirlashari, Demirkol, Salsali, Rafiey, & Jahanbani, 2012; Stover, Hall, McMahon, & Easton, 2012). Implementing systemic interventions is challenging because the family may hide the problems, be concerned about children being placed in care, be resistant to accepting help, and be involved in illegal activities. Nonetheless, multi-systemic and intensive family interventions can reduce adolescent delinquency and behavioural problems, including drug use (Rowe, 2012; Wagner, Borduin, Sawyer, & Dopp, 2014; Waisbrod, Buchbinder, & Possick, 2012).

At a later stage, services also need to recognise that making the transition to heroin injecting is often a sign of prior trauma, even if the person does not realise this at the time. Early interventions at that point are needed, rather than waiting until the person is definitely dependent (Hunt & Chambers, 1976). Given the severity of trauma documented here, specialised interventions for trauma would be required. If trauma is not effectively treated, then its psychological effects are likely to persist and, even if a drug problem is averted by other means, the person is likely to have other serious issues. Finally, there is a global and urgent need for addiction services to be trauma-minded (Brown et al., 2013; Harris & Fallot, 2001). Many of the difficult behaviours exhibited by addiction service clients may be due to trauma, rather than to drug effects, drug dependence, fecklessness, or being antisocial or aggressive by nature.

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Table 1: Participant Characteristics: Raw numbers are shown. Where these do not add up to 55, there are missing data.

	Male (n=38)	Female (n=17)	Total (n=55)
Mean Age (SD)	38 (6.6)	33 (5.7)	37 (6.7)
Number of siblings in childhood family other than participant			
0	1	0	1
1	6	4	10
2	14	8	22
3	11	2	13
4+	6	3	9
Number of biological children of participant			
0	11	4	15
1	13	4	17
2	5	5	10
3+	9	4	13
Type of place participant had lived most			
City	14	9	23
Small city or larger town	18	7	25
Smaller town or village	4	1	5
Employment			

Has never worked	3	3	6
Worked at some point	14	8	22
Worked steadily for years	12	5	17
Much of adult life in jail	9	1	10
Recalled trauma in childhood			
None	5	3	8
Some but no violence or abuse	11	6	17
Violence and/or Abuse	16	7	23
Own behaviour caused trauma (e.g. into care)	6	1	7
Closest family member with a drug or alcohol problem			
Nobody mentioned	19	4	23
Parent	14	10	24
Sibling	1	2	3
Other	4	1	5