Heroin users’ experiences of depression: a qualitative study

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Received 10 August 2011; Revised 19 January 2012; Accepted 28 January 2012.

Introduction

Although many GPs find their care challenging,\textsuperscript{1} heroin users are a particularly needy group with high levels of morbidity.\textsuperscript{2} One such example is the high prevalence of depression.\textsuperscript{3–5} For instance, a longitudinal cohort study showed that 24\% of new entrants to treatment services for opioid dependency had evidence of depression compared to the national prevalence of 6\%, and antidepressants were used by 31\% of the group at some stage in the 3-year follow up.\textsuperscript{4} Though the management of depression in non-drug-using groups is relatively well established, it cannot be assumed that methods such as watchful waiting, self-help and exercise\textsuperscript{6} are appropriate in heroin users; even prescribing may pose particular problems including chaotic use and selling or giving away of prescribed antidepressant medication.\textsuperscript{7}

Known professional explanations for the association between drugs and depression include depression as a cause for drug use, drug use causing depression and both depression and drug use sharing common causes.\textsuperscript{8} Heroin users with depression compared to heroin users without depression are more likely to use a variety of illicit drugs, engage in risk-taking behaviours and have poorer physical health.\textsuperscript{5,9–11} Depressed mood in adolescence, particularly in girls, predicts later substance misuse\textsuperscript{12,13} and chronic and...
acute stress are associated with relapse of drug use.\textsuperscript{14} Results of studies measuring the effectiveness of treatment for heroin users with depression are mixed; treatment of depression in drug users may be less effective than in non-drug users\textsuperscript{15} but entry into treatment for the drug addiction has a major beneficial effect on associated depression.\textsuperscript{4} 

Although the personal experience of depression has been relatively extensively investigated in qualitative studies,\textsuperscript{16–19} there remains a gap investigating the experience of depressive symptoms in drug-using groups. The aims of this study were to investigate beliefs about depressive symptoms in a group of patients receiving treatment for heroin dependency. This included ideas about causation of both drug taking and depression, the relationships between drug use and depression, the effects of drug taking and ways in which the depression was managed.

Methods

The study took place in a general practice in Middlesbrough, an industrial and relatively deprived town in the North East of England.\textsuperscript{20} The practice specializes in the treatment of drug addiction. Each patient receiving treatment for opioid addiction has an individual key worker (one of 11 specialist nurses, support workers or GPs). Approximately 1100 patients are registered for ‘General Medical Services’ (‘GMS’) which include the usual range of primary care services. These GMS patients are either also receiving treatment for opioid addiction (methadone or buprenorphine), have received such treatment previously or are children of either group. At any one time, ~700 patients registered for GMS are also receiving treatment for opioid addiction. The GPs are responsible for treatment of depression in the GMS patients, including prescribing, follow-up and referral to outside services. The practice also provides treatment for opioid addiction to ~600 patients who choose to register for GMS with other practices; they were excluded from this study.

Inclusion criteria were a current record of antidepressant medication and current treatment for opioid dependency (methadone or buprenorphine). Patients under the age of 18 years, those with cognitive impairment or those whose language would make interview and subsequent interpretation difficult, were excluded.

Procedures

The medical records of patients due to attend for treatment with methadone or buprenorphine on one of two weekdays were reviewed before the appointment. A list of all patients who met the entry criteria was given to each of the key workers. The key worker was asked to discuss the study with each patient on the list and to record those who declined and those who accepted. For those willing to participate, a choice of venue was provided, and an appointment was made for at least 1 week in advance.

Those patients attending were given £10.00 for participation and travel expenses were reimbursed. One of the authors (CSC), a GP at the practice, carried out the interviews. Patients for whom he acted as both GP and key worker for drug addiction treatment were excluded from the study. Two patients were interviewed as a pilot. It was not thought necessary to change the interview schedule as a result of the pilot interviews. Because the findings of the pilot interviews were not obviously different, they were incorporated into the main study. Recruitment continued until no new codes were identified from the transcripts.

The interviews

The interview schedule included the patients’ ideas about the causes of their low mood and causes of drug taking. The effects of the low mood and the effects of drug taking on themselves and relatives and friends were discussed. Views about the relationship between depressive symptoms and drug use were explored. Also included were questions relating to treatment and other management methods for the depression and how others had helped or hindered them. All interviews were fully tape recorded and transcribed. The Hospital and Anxiety Depression (HAD) score\textsuperscript{21} was completed at the end of the interview as a description of current depressive status. The individual interviews lasted between 40 and 80 minutes.

The participants

A total of 26 patients receiving treatment for depression and opioid addiction were identified. Of these, 17 were interviewed (11 male, mean age 34 years) and 9 not interviewed (7 male, mean age 33 years). The nine not interviewed included one exclusion, four refusing interview and four agreeing but failing to attend. Of those interviewed, 16 (94%) had a HAD score of $\geq$11 indicating probable anxiety and 13 (76%) a score of $\geq$11 indicating probable depression. The current prescriptions for antidepressants included mirtazapine (six), fluoxetine (five), citalopram (three) and others (three). All respondents chose to be interviewed in the surgery. Three smelt of alcohol. All had used or were currently using heroin and all except one crack cocaine.

The focus group

The focus group were members of a service user group meeting weekly at the practice. They were all patients in the practice who were using, or had used, opioid drugs, but who might or might not have suffered from ‘depression’ personally. For the focus group, seven
(five men) took part in the discussion. Although no measures were taken to ensure that the participants had experienced depression, all stated they had suffered from it and drew on their own experiences. The group was asked to discuss causes of depression in drug users, relationships between depressive symptoms and drug use, the impact of depression, treatment of depression and the use of antidepressants. The discussion, which lasted 63 minutes, was recorded and fully transcribed.

Data analysis
Analysis followed the descriptions provided by Miles and Huberman. Codes—labels describing ‘units of meaning’—were identified from each transcript. Codes included purely ‘descriptive’ codes arising directly from the transcripts and more ‘interpretive’ codes. After analysing five interviews in this way, a ‘scatter diagram’ was used to identify ‘pattern codes’ or themes bringing together groups of descriptive and interpretive codes.

Constant comparative analysis was achieved through re-reading the transcripts to determine how the emerging analysis fitted in with existing data and through testing out the emerging data in new interviews. After writing up, all transcripts were re-read to identify disconfirmatory data. The focus group, carried out when the individual interviews had mostly been completed, was used to assess saturation. One author (CSC) coded the individual interviews and the focus group and a further author (NM) independently coded 10 of the interviews. The two authors (CSC and NM) discussed and agreed the results of their analysis.

From the data, six themes were identified. Of these, four were mainly descriptive themes consisting of data grouped directly from questions in the interview schedule: causes and onset of depression, management of depression, effects of depression and causes of drug taking. In this paper, effects of depression are not reported in detail and causes of drug taking are discussed in relation to the first two themes. Two themes were more interpretive—stigma and isolation—and are combined in this paper.

Results
Causes and onset of depression
The participants were asked to describe what they meant by depression. Descriptions were often vague in both individual and focus group interviews and included a mixture of anxiety symptoms, stress symptoms, personality traits and phobias. Some had problems distinguishing depressive symptoms from symptoms caused by withdrawal from drugs.

A few respondents claimed to have had no adverse events in childhood, although from an outsider perspective their experiences seemed less than ideal. More, as expected, gave examples of severe hardships, lack (as they saw it) of proper upbringing and control by parents, assaults, sexual abuse, breakdown in relationships within the family and subsequent problems with school, crime and later abusive relationships. Many dated and ascribed the onset of their depression to these events, though some claimed that they did not recognize it as such at the time and others found it difficult to date the onset precisely. This is one of the many examples:

It’s just, erm, the way I was brought up and things, what had happened when I was younger. I think that’s what—like my—started me off with being depressed and I used to suffer with migraines all the time … Yeah. It’s like my mum and dad used to fight all the time and my dad used to drink all the time, we had violence about and like I was adopted when I was about five year old like I was only adopted round the corner, taken round the corner, but I was sexually abused then by a stranger … And then it happened in my—like it kept on happening with people in the family and that’s where I think my depression started from … (15)

A common sequence according to their accounts was adverse social and personal circumstances causing depression and simultaneously placing them in social networks where drug taking was common.

Only a small number of respondents thought that drugs, including cocaine, led to depression through a ‘biochemical’ link. Most described how drug taking had various adverse consequences which were the cause of, or exacerbated, depression, including problems with crime, police, jail, violence and fights, lack of money and employment and illnesses including absences and operations. The need to rob had adverse effects on how they felt about themselves.

Throughout their accounts, the participants spontaneously described frequent loses—loss of material possessions, lost years through drug taking, loss of the promise of a fulfilled life, loss of relationships with family members, loss of trust and lost children, as for this participant:

I’m talking like—I used to make five hundred pound a day some days so I’ve lost like a car, I’ve lost my driving licence, I’ve lost my girlfriend who’s got my kid. I lost everything. I lost the lot. I lost all my trust with my family and that and that’s the worst thing about losing your life is your trust with your family. When people like you go in my mam’s house, my mam knows not to leave money about …
But I can’t even get three pound now, mate, honest. I couldn’t borrow three pound off anyone, not even a pound because they just know like, they think he’s only going to get it for drugs.

The participants were asked to describe the effects of depression and the effects of drug taking. Although respondents discussed adverse effects of depressive symptoms, the adverse consequences of drug taking were much more prominent and linked in their accounts to the causes of depression. Two important consequences of drug taking were stigma and isolation, which came across in response to a number of questions in the interview schedule and which are described in the next section.

**Stigma and isolation**
The adverse consequences of drug taking included how others reacted to them (for instance, they reported how others noted obvious signs of heroin use) and also how the user felt about him/herself. The status of ‘drug addict’ was deeply discrediting and thought to be a cause of depression:

F1 Because you lose your weight, I think you lose a bit of your self esteem and you don’t feel as confident as you did before you were on drugs. Because you’re losing weight, you know yourself you don’t look as good as you used to.

M4 You’re not getting washed every day.

F1 Yeah, you’re not as clean and tidy and hygienic as you used to be and you know that yourself, you don’t need other people to tell you that. You are passing them in the street and they go ‘hey, you scruffy smack head’ and you think I am. (focus group)

Respondents described how a lack of meaningful relationships with people both contributed to depression and made it difficult to stop drug taking. Older friends were inevitably alienated when aims were driven by the need to obtain money and drugs. Friends were needed to improve, but improvement was necessary before meaningful relationships could be developed with others. The majority of respondents thought there were few meaningful friends for drug addicts—only drug acquaintances who did not care, who might be jealous if you showed signs of recovery, who would use you for what they could get, who could not be trusted and indeed would steal from you, as described in the focus group:

M2 I’ve been ripped off and taxed (taking money from) which is nasty and it does play a big part . . .

M4 But not everyone’s like that though, aren’t they?

M2 Not everyone but all I’m saying is the experience that I’ve had.

M5 I would say that a lot of service users are, to be honest, most people that use.

F1 They’re out for what they can get, aren’t they?

M2 Of course, yeah.

M5 Because it’s that focus, drugs, you’re focussing on that alone, you don’t focus about other people’s feelings.

M1 About taxing and that, I’ve done it myself (focus group).

In contrast, relationships with family members were more complex and positive. There were examples of family members driven away and of relationships that had been significantly changed and distrustful. There were examples of relationships where family members had appeared to struggle with how to manage and cope (in ways which sometimes seemed to the participants ill judged). However, there were unequivocally positive examples where family members had provided significant help including material support, human contact when contact with non-family had stopped and the incentive to change for the better, as in this example:

Like, got my nana, my sister, my brothers, my aunties and that, you know, they’re dead good with me, they’ll help me you know like if I get paid (i.e. receive benefits) then we’ll go and do this and that, and my mum she’s brilliant, she like comes round every day, you know, make sure I’m alright and the kids . . . And if she hadn’t been there, God knows what would’ve happened (9)

**Managing depression**
The participants rarely described self-help methods to cope with depression. ‘Talking therapies’ were felt to be unhelpful or even to aggravate the condition since depression might be caused by thinking too much or dwelling on things too much. Instead, the more common methods described were to use drugs, either illicit drugs or prescribed antidepressant medication.

‘Illicit drugs’. Once someone had become a user, drugs were regarded as a ‘natural’ way of dealing with problems, including depression. Consistent with wide ranging meanings of depression, a wide range of emotions were described as reasons to use drugs including anxiety symptoms, paranoia, poor self-confidence, stress, boredom and sleep disturbance. They were used to provide temporary release, and even a sense of fun, from stressful lives and to function better as well as feel better, as for this participant:
Resolved. Although occasionally respondents voiced concerns about being addicted to antidepressants, more common were concerns about taking any medication, including methadone, both because of possible long-term deleterious effects but also from being reliant on any medication:

I’m not happy about taking them because I don’t really want to be down to take them anyway but … yeah, if I had—if I had my choice I’d be completely drug free (8)

Discussion

In summary, drugs were recognized as causing low mood in a direct way by a few participants but more commonly were understood to lead to a variety of problems and loses that caused or compounded depression—though defining and separating depression from other emotions and thoughts was often difficult. Important depressive consequences of drug taking included the associated stigma and isolation. Once drug taking had started, depression was thought to lead to drug taking for a variety of understandable reasons, including blocking symptoms and as a ‘relief’. Continued relationships with family members were often important. Antidepressants were believed to work by levelling mood and blocking out or slowing down harmful thoughts.

The advantages and disadvantages of GPs conducting qualitative interviews on their own patients have been described previously. Potential advantages, it is argued, include improved access to and co-operation with, patients otherwise difficult to access (relevant in this study), the improved exploration of sensitive issues that patients might otherwise find difficult to talk about and a collaboration between patients and their doctors which may more directly lead to a change in services. Possible disadvantages suggested include undue coercion to take part and ‘bias’ introduced by the interviewer such as a particular ‘medical’ line of questioning or certain expectations by the subject as to what the interviewer as doctor wishes to hear (or actually does ‘hear’). The difficulty of distinguishing ‘private’ and ‘public’ accounts is not of course limited to studies involving GPs as interviewers. In part, the acceptability of whether it is appropriate or not for GPs to interview their own patients in qualitative studies may be a theoretical one based on the nature of ‘truth’ in qualitative studies; a realist, positive paradigm even within qualitative research might emphasize one truth to be obtained by rigorous eschewing of interviewer bias and would therefore find a GP interviewing his or her patients as problematic, whereas a more interpretivist approach might regard bias generated by any interviewer as an inevitable part of research.
The connections between drug use and depression—depression causing drug use, depression and drug use sharing common causes and drug use causing depression—were described in these accounts in various ways. The respondents noted that taking drugs to improve existing low mood was particularly understandable for existing drug users. They described adverse personal and social histories leading to depression and simultaneously placing them in marginal subcultures where drug taking was common. Drug use caused depression, sometimes directly, but more commonly because it led to further adverse consequences.

Their accounts, stressing the depressive social consequences of drug taking and by implication the beneficial consequences of not using drugs, are in keeping with the reduction in prevalence of depression noted on entering treatment for opioid addiction. Delinquency and lack of perceived parental support were described by the patients as causes of drug taking, as confirmed in other studies, though the accounts of the study participants stressed the importance of involvement in subcultures where drug taking was common. The role of drug taking in acute and chronic stress was described in the accounts, though for a variety of reasons and including the need to function as well as feel ‘normal’.

Negative views about depression have been extensively described in non-drug-using groups. In contrast, they were not prominent in this study. The most likely explanation is that the effects of drug taking were of greater importance. It is interesting to speculate as to whether this has implications for the experience of patients with two chronic diseases—whether the social and cultural effects of one dwarf the other (as in this study) or whether they are additive.

The patients did not regard ‘talking therapies’ as effective. This may be for a variety of reasons, including being more likely to view the solution to problems through drugs—prescribed medication as well as illicit—or because they lack the personal resources to engage in such treatment. A further explanation may relate to the high level of post-traumatic stress disorder in this group and which require specific therapies to address.

The participants’ methods to manage depression seemed mainly limited to antidepressant medication and using illicit drugs. For these reasons, the self-help methods advised in the NICE guideline for initial treatment of depression are likely to be inappropriate in this group. The subjects discussed how individual antidepressant drugs made them feel (compared to other antidepressant drugs) and may be the cause for requests to change medication. It may be useful to explore this further with individual patients. They described an absence of supporting friends and relationships with family members which sometimes were good but sometimes poor. The need to work with families was confirmed as well as the need to imaginatively attempt to improve networks with friends and with self-help groups. Further research in these areas is needed.

It was clear in this study that attempting to isolate depression from all the other major events in these patients’ lives is simplistic. Drug taking pervaded not only the causes of depression but also how it was understood, experienced and managed.

Acknowledgements

We wish to acknowledge the help of the participants and the service user group at the Fulcrum, ‘Flag’.

Declaration

Funding: none.

Ethical approval: ethical permission was granted by County Durham and Tees Valley 1 Research Ethics Committee (REC reference number 08/H0905/68).

Conflict of interest: None.

References