‘You Can Die With Me But I Won’t Let You Live With Me’, Exploring Social Influences on the Continuation of Heroin Use in Men Who Use Heroin

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ABSTRACT

BACKGROUND: Heroin is a substance with a unique social profile in that it is commonly used by individuals alone but there is a paucity of qualitative research exploring how social influences impact the continuation of heroin use, particularly when people are trying to stop using heroin. This study explored social determinants which influence the continuation of heroin use in males in UK community treatment who use illicit heroin alongside opioid replacement therapy.

DESIGN: Participants were self-selecting from an initial purposively recruited sample. Using Janis (1972) 8 symptoms of Groupthink as an a priori framework for analysis, the study method utilised qualitative interviews with fourteen males. The discussions were digitally-recorded, transcribed verbatim, and analysed thematically.

FINDINGS: Contrasting with the evidence base, the sample included people who transitioned from recreational drug use to dependent heroin use without experiencing trauma of any kind. Far from becoming socially isolated when actively using heroin, interviews identified a shift in social networks from networks built on shared moments to networks underpinned by transactional exchange. Components of Groupthink were identified when participants described belonging to heroin using networks and continued to use heroin whilst trying to abstain though individual accountability was central to the decision to continue to use heroin.

CONCLUSIONS: The conflict between the individual goal of abstinence and the group goal of continuation suggests that social network interventions could be more successful if delivered to cohorts of people who buy heroin together.

KEYWORDS: Opiates, groupthink, relapse, qualitative, substance use disorder, heroin

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Introduction

Prior to the 1960s heroin addiction was extremely rare in the UK, thought to be the preserve of those who had become opiate dependent as a result of taking medication for other conditions. In 1959 there were 47 known people who used heroin listed on the Home Office Addicts Index, by 1964 there were 328 with a younger demographic and the initiation of heroin thought to be recreational rather than of medical origin. Stigmatisation started at this point with people who use opioids thought to be a deviant subculture who posed a danger to the physical and moral health of society.[1]

By 1987 the heroin epidemic had reached 10,389 known people who use heroin with thousands more undetected.[2] The government response was a largely stigmatising education campaign at preventing heroin use which was not supported by experts in the field. Concurrently socioeconomic deprivations facilitated the progression of heroin use and amplified fear.[2] Within 10 years, 1996, there were 30 000 people known to use heroin.[3] In 2010 the government launched a new drug strategy which minimised a harm reduction approach, increasing law enforcement to reduce supply and focussed on an abstinence based treatment approach for people who heroin use. In the same year there were record arrests for possession of drugs and although the RIOTT report called for wider rollout of heroin assisted treatment finding that it significantly reduces use of street heroin, heroin assisted treatment was not widely implemented. A pilot scheme during this period where treatment providers were compensated for achieving recovery outcomes was unsuccessful, finding people were less likely to complete treatment and more likely to decline continuing with treatment.[4] Opioid use continued to be viewed by policy as the moral failing of an over-simplified choice without providing

adequate resources to address any socioeconomic catalysts behind the choice of people who use opioids.

Opioid-related mortality fell between 2010 and 2012 due to a supply drought but has increased since 2013.[5] The 2017 and 2022 UK drug policy updates only reinforce what had already been laid out in the 2010 policy without including evidence based harm reduction such as drug consumption rooms, drug testing or decriminalisation. As such, UK policy has failed to reduce opioid-related deaths. Current data from 2022 reports 2261 opioid-related deaths in the England and Wales[6] representing a 1358% increase since the 155 deaths recorded in 1993.

Additionally, despite efforts to integrate treatment for heroin use alongside treatment for psychiatric comorbidities, stigmatisation is also found by the professionals working within services.[7,8] When support services are judgemental towards people who use opioids then people cannot confidently trust in those services to provide support. No other health condition has been so widely stigmatised and misunderstood by the policy and wider professionals charged with providing the healthcare.

The situation is clear that policy changes over time have not halted the rise in UK opioid-related deaths, that the introduction of synthetic opioids is elevating the risk of opioid-related mortality[9] and that stigmatisation of people who use opioids has been a theme throughout history contributing to mortality, however well intended the initial intervention (public education,[2] widespread adoption of the disease model[10]). If opioid-related deaths are to be reduced then it is critical to reduce stigmatisation by increasing understanding of the day-to-day interactions between people who use opioids. Treatment solutions can then be tailored to compliment the established pharmacological interventions.

Human beings are 'ultra-social' animals[11] having evolved to become interdependent on each other in social behaviour (hunting, grooming, formation of cultures) as well as cognitive processes (morality, rationality, and perception of social norms). The underlying concept of interdependence is that group partners are extremely valuable and so must be cared for to preserve the ability to pursue shared goals. Social Identity Theory[12] suggests people form in-groups based on shared interest. When people who use substances decide to enter treatment, their individual goals can conflict with the goals of the substance using groups to which they belong.

There are many theories suggesting how social networks influence drug use. Social Influence Theory suggests that the observation of others substance use within the network will influence an individual's substance use until their substance use is the same.[13,14] In contrast, Social Selection Theory suggests that people who use drugs will change networks in order to spend more time with people also using drugs.[13,14] Both of these theories share commonalities with Social Learning Theory.[15] Social learning theory views addiction as an evolving biopsychosocial disorder where individuals are continually influenced through internal and external factors.[16] Central to social learning theory[15] is reciprocal determinism, a social-cognitive theory postulating that behaviour is influenced by an interplay between personal factors and the external environment.[17] Stimuli become conditioned substance-related cues triggering craving,[18,19] with craving a predictor of heroin use.[20] Examples of internal cues include negative self-image and striving for acceptance from others[21] but positive feelings can also elicit cravings to experience highs once more.[22,23] Applying coping mechanisms to resist cravings is influenced by self-efficacy but repeated relapse erodes people's belief in their own self-efficacy to maintain abstinence.[24] One further idea is that of a moral economy of heroin use.[25] Wakeman suggests remaining within the heroin using social structure provides instrumental and emotive purpose alongside a sense of order and belonging which far outweighs returning to 'normal' society. Within a 'normal' or non-drug using social structure the rules of their identity would then become redundant leading to uncertainty in self, anxiety and loneliness. Common to all social theories, the ability to self-manage the response to substance-related cues is a crucial obstacle to achieving treatment goals.

People who use opiates report internal conflict, lack of self-control and momentary unawareness of the influence of substance-related cues. Craving is described as 'thought of using', 'my brain is confused', 'wanting', 'I can't think,' and 'severe stimulation'[26] making relapse feel inevitable and uncontrollable. A feeling of powerlessness is then cultivated perhaps initiating learned helplessness, where a person is unable to engage with solutions to a problem even though a solution is available.[27] Diminishing self-belief in the ability to resist using substances is reported to increase the longer treatment is attempted and repeated relapse is experienced.[28] Increasing understanding of how internal conflict is influenced by the surrounding environment is crucial to developing relapse prevention interventions.

It has been proposed from translational research that heroin is utilised both by animals and humans at home in isolation in a context of peace[29,30] contrasting with contemporary social science theory and conceptual frameworks suggesting a bidirectional relationship between heroin use and the social network.[31,32] Empirical frameworks and conceptual theory are limited in providing evidence on how people within these networks influence each other. In contrast qualitative research has provided rich insight. In UK consumers of alcohol[33] there is strong evidence of peer pressure as well as in US consumers of alcohol and cannabis.[34] Conversely Belgian people who were abstinent from powder cocaine stated that central to recovery was a difficult necessity of breaking away from old contacts in order to maintain abstinence and rebuild their lives.[35] North Americans who were currently using MDMA have described a tight-knit clubbing scene where quality assurance from dealers who relied on repeat custom is seen as a harm minimisation technique.[36] Though heroin is typically a substance used in isolation from others, systematic review has highlighted social influences in the initiation of intravenous use.[37,38] What is missing from current empirical and

qualitative research examining individual and network drug use is exploration of how social networks impact the experience of people who use heroin but are trying to abstain. The gap is addressed by this paper.

It is vital to increase understanding of the individual and the group psychology of people who use heroin in order to better understand how relapse happens. One such way is through the lens of Groupthink.[39] Groupthink describes when individuals in a small group accept a viewpoint thought to represent the whole group irrespective of whether the individual in the group accepts the viewpoint. Janis describes 8 components of Groupthink as 'symptoms', evidenced by; stereotypes (people view others who aren't part of the in-group as enemies), peer-pressure (the in-group applies pressure to individuals who go against the in-group ideas), rationale (continuing with the in-group belief despite advice and warnings from the out-group), morality (people ignore ethical or moral consequences of actions, believing unquestionably in the in-group morality), invulnerability (the group encourages risk-taking due to collective excessive optimism), illusion of unanimity (members of the in-group assume every member of the in-group thinks the same), self-censorship (members of the in-group censor themselves from speaking out against the in-group consensus), mind guards (members of the in-group intentionally hide information which may contradict the in-group consensus). The analysis conducted here used a framework of Groupthink in order to compartmentalise individual reflections of a group social interaction.

The purpose of this study was to explore which social determinants influence continuation of heroin use in males who are trying to abstain when prescribed opioid replacement therapy.

Methods

Using Janis[39] 8 symptoms of Groupthink as an a priori framework for analysis, the study method utilised qualitative interviews to explore the research question in order to inform future research. Semi-structured interviews were conducted to explore the influence of other people on continuation of illicit heroin in males currently receiving opioid replacement therapy from a UK community treatment centre and continuing to use illicit heroin.

Rationale

The quotes reported here were collected as part of a wider proof-of-concept crossover study which sought to understand the mechanism by which a nasal spray of oxytocin might impact cue-induced heroin craving. The study included only males (n = 24) as the effects of nasal oxytocin are sexually dimorphic. Males who had not used heroin in the last 7 days as confirmed by urine drug screen prior to the first appointment were excluded from the proof-of-concept study. There were 4 appointments, the fourth being an optional interview. Participants were briefed that the purpose of the interview was to explore craving management. However during the interviews it became apparent there was a consistent influence of others on continuation of heroin use despite intention to stop using heroin. Participants were unaware that Groupthink would be coded from the interviews.

Recruitment

All recruited participants to the initial purposively recruited proof-of-concept study gave written informed consent to take part in an optional qualitative interview. Participants were then asked to verbally confirm consent prior to the interview. The sample was self-selecting from 4 community drug and alcohol treatment services in England. One service was operated by the NHS and 3 were operated by the same non-statutory provider. All 24 participants from the proof-of-concept study were offered the opportunity to be interviewed. Eight declined as they were not comfortable with being recorded or had a conflicting appointment so could commit to the interview, 1 was intoxicated and was deemed inappropriate to continue, another was too late to the appointment for the interview.

Data collection

Interviews were conducted with fourteen participants by 1 white, male author (BH) who was a PhD student at the time of interview. The interview schedule was designed by BH with no pilot testing and reviewed by CN prior to interview start. Interviews took place once between January 2021 and October 2022, digitally recorded in treatment rooms familiar to the participant with nobody else present during interview. Participants had 3 experimental visits prior to the optional interview and so had begun a relationship with the research assistant. One interview was terminated early by the researcher as the participant became uncomfortable and 1 participant consented to be interviewed but then declined to answer. Interviews ranged between 02:50 and 30:30 minutes in length, no hand written notes were made and no interviews were repeated. All participants were offered visibility of their final transcript, 1 requested this and no amendments were made following review. Participants received one £20 voucher for visit attendance at all completed study visits.

This study was approved by the Brent NHS Research Ethics Committee in July 2020 (Ethics approval number 20/LO/0758).

Analysis

Interview recordings were transcribed verbatim and participants given pseudonyms. For the qualitative analysis inductive content analysis[40] was undertaken combined with a deductive analysis using the Groupthink concept as a framework. The Groupthink framework was identified by 1 white, male author (BH) who knew the participants from the 3 clinical appointments prior to interview only. Themes were constructed during coding and interpretation of the data. Coding was checked by one, white

Table 1. Participant characteristics.

PARTICIPANT IDENTIFIER	AGE	ETHNICITY	EMPLOYMENT STATUS	TYPE OF SUBSTITUTE OPIATES	DAILY DOSE (MG)	DIAGNOSED PSYCHIATRIC PROBLEM 1	DIAGNOSED PSYCHIATRIC PROBLEM 2	DIAGNOSED PSYCHIATRIC PROBLEM 3
Luke	31	White British	Sick > 4 wk	MTD	100	Anxiety	Depression	None
Kyle	43	White British	Full Time Employed	MTD	90	None	None	None
Jack	43	White British	Unemployed	MTD	50	Anxiety	Depression	None
Martin	45	White British	Sick > 4 wk	MTD	50	Anxiety	Depression	None
Roland	48	White British	Sick > 4 wk	MTD	60	Dissociative Identity Disorder	None	None
Alec	52	White British	Sick > 4 wk	MTD	60	Anxiety	None	None
Sebastian	25	White British	Full Time Employed	MTD	45	None	None	None
Ashley	59	White British	Unemployed	BUP	14	Bi-Polar	PTSD	None
Nigel	47	White British	Sick > 4 wk	MTD	36	Anxiety	Depression	Bi-polar
Roger	44	White British	Unemployed	MTD	70	Anxiety	Depression	Borderline personality disorder
Bilal	37	Asian Pakistani	Sick > 4 wk	MTD	50	Anxiety	Depression	None
Dave	54	White British	Unemployed	MTD	60	Psychosis	None	None
Geoff	54	White British	Sick > 4 wk	MTD	60	None	None	None
Duncan	40	White British	Sick > 4 wk	MTD	70	Anxiety	Depression	Personality disorder (undefined)

Abbreviations: BUP, buprenorphine; mg, milligrams; MTD, methadone.
Table of the 14/24 participant demographics who completed the interview.

female author with no relationship to the participants (CN). Inconsistencies in coding were agreed by consensus. Analysis was conducted concurrently with data collection using Nvivo 12 software. Interviews were transcribed by hand without the use of digital transcription software by BH. Digital recordings of interviews were deleted immediately following transcribing for security of anonymity. The preconceived deductive approach of our analysis means achieving data saturation was neither appropriate nor useful for our study design which relied on individual reflections of a group process.[41,42]

The study was conducted in accordance with the Declaration of Helsinki. This paper complies with COREQ reporting standards.[43]

Results

The sample was predominantly White British, representative of the UK treatment population. All but 1 participant was in receipt of methadone reflecting the sample from the parent trial where all but 2 people received methadone. All but 3 had at least 1 diagnosed co-existing psychiatric disorder (Table 1).

Pathways to heroin use

Heroin use was described as a solo activity fortified by an embarrassment of other people seeing you physically and mentally impaired post-use, but the role of others in sourcing heroin and other substances was a strong theme throughout. Typically, though not exclusively, friendships formed in adolescence led to experimentation with solvents, nicotine, cannabis, alcohol and prescribed benzodiazepines within a social context. Early use was not always linked to trauma and instead was described as an enjoyable group experience without regret. Jack reminisced about the 90s rave music culture and how this was a bonding experience between friends,

> *'We experienced a lot of stuff that a lot of youngsters nowadays will never. You know we went through a scene, a movement and it was a lot of fun and I did have good times. . .Then as I hit 19, one night we got back and we dropped a couple of Valium and stuff and then someone pulled out some heroin and put it on some foil. I was like 'no I'll never touch that stuff' and I stuck with that a while but I ended up in a moment of weakness. Another time we came back, smoked some and when I did it I was like 'whoah this is really nice' you know, I really enjoyed it'.*

He went on to explain that he chose to isolate from his social circle as his heroin use increased before someone 'regretfully' convinced him to use a needle, promising that he would experience a greater high. Alec shared a similar pathway from recreational club substances to intravenous heroin use,

> *'I had a bloody good time thinking of it. . .I had a mate that was doing it and he said to me 'I've been frightened of introducing this to you because I know you'll love it'. . .I think I'd been doing it about four*

months and everyone kept saying 'fuck me you never had a hit? You never had a hit?' and I goes no I'm alright smoking. That was it, they gave me this hit".

Duncan converted to Islam whilst incarcerated aged 15 to 19 and first used heroin and crack cocaine use during his prison release party when introduced to a new social group. He assumed that using heroin and crack cocaine was how people celebrated because his transition to adulthood was not typical.

Where family members were involved in the initial use of heroin and other substances they typically belonged to the same social group. The exception was Roger, a white British male diagnosed with anxiety, depression and borderline personality disorder who was introduced to powder cocaine aged 16 by his uncle in order to help him stay awake during the night shift at work. He described this as normal amongst co-workers. His cocaine use continued for 15 years where he lost family members, relationships, money and property before going to residential rehabilitation. After 12 years abstinent he met a woman who, unknowingly to him, used heroin and crack cocaine and as they began a relationship he began to use both substances.

Participants were not explicitly asked about their relationship with their parents and so their presence in each interview can be assumed as being significant parts of the story for each individual. Around half of all participants reported their parents were not together when they were children. No participant described childhood as stable and instead reported a period of dysfunctional families inclusive of single parenting, step-parenting, the suicide of a parent and differing forms of abuse. Only Kyle used the word trauma and that was to dismiss trauma as a reason for his substance use. Instead there was compassionate understanding for the difficulties of parenting and a normalisation of turbulent early family life which people then adapted to. For example, Geoff had received emotional and physical abuse from his non-substance using mother and his father attempted to sleep with his then 16 year old girlfriend, but had forgiven his mother stating she did the best she could with such a large family.

Only Luke and Nigel clearly stated parental substance use. In both cases this was alcohol. Bilal was a Pakistani man who described his father joining him and his mother in the UK at age 7 when he was then subjected to violence. He began using cannabis after his father wrongfully accused him of smoking it and assaulted him. At age 17 he was introduced to heroin by a friend,

'My mum basically fled from Pakistan to come here because she had a violent relationship with my father, obviously she had me in England so I was born in the UK and when I was growing up I used to see people with dads and I was like 'where's my dad?' so my mum must have felt 'he needs his dad there, he needs a father figure'. . .After that I thought things would be good with my dad and everything but no, all I see was violence. I never got no love, no gratitude or nothing so that made me go down the wrong kind of path".

In all cases initiation of heroin use was rooted in availability from existing social networks. Participants then began to describe a transition to a new community. Jack described this transition,

'As time progressed I stopped going out. I started just doing the heroin. I knew it was a problem when I started to just go off on my own and do it you know'

The presence of groupthink

Figure 1 displays prevalence of each Groupthink symptom within coding.

Stereotypes

Many participants felt judged by society within the new in-group. Judgement from others within his religious community hindered Duncan from engaging further with his religion due to embarrassment, feeling 'dirty' because of his heroin use. The consistent belief amongst participants was that only other people who use heroin understand them. Stigma and judgements fortified their belonging to the in-group as leaving this community became unattractive when it required isolation from group acceptance and understanding. Nigel explained, 'If I don't smoke then I don't see no one. So it gets like a social thing' whereas Kyle rejected being labelled with any group stereotype,

'this is the very thing I am striving not to become, a 'one of them'. . . Trouble is, I don't want to be part of no 'us' either. I'm me!'

Peer pressure

Although participants said they preferred to stay away from people who used heroin, group contacts were maintained should they need to source heroin. The influence of peer pressure was described throughout as something other people did. Luke stated that although he would not encourage heroin use he had 'seen some people keep hassling people who were trying to stop'. In-group encouragement of heroin use was not uncommon where one person helped another person financially or through sharing of contacts to buy heroin in exchange for a share. Interviewees reported retaining up to seventy individual telephone numbers plus internet social messenger groups as means to buy heroin. People who were known to use heroin therefore held value in having access to dealers and other people who use heroin. Roger stated he can crave when someone directly asks him to do this. This transaction was offered even when the in-group knew people were trying to stop, as described by Bilal,

'I think it was more for their vested interest. So obviously there's another person smoking gear so if he's on it we can go to him in the morning so if we can't got none then he'll have something. So it was their vested interest, you know what I mean? They don't care if I'm off it, they would rather see me on it because it benefits them. . .I've tried stopping

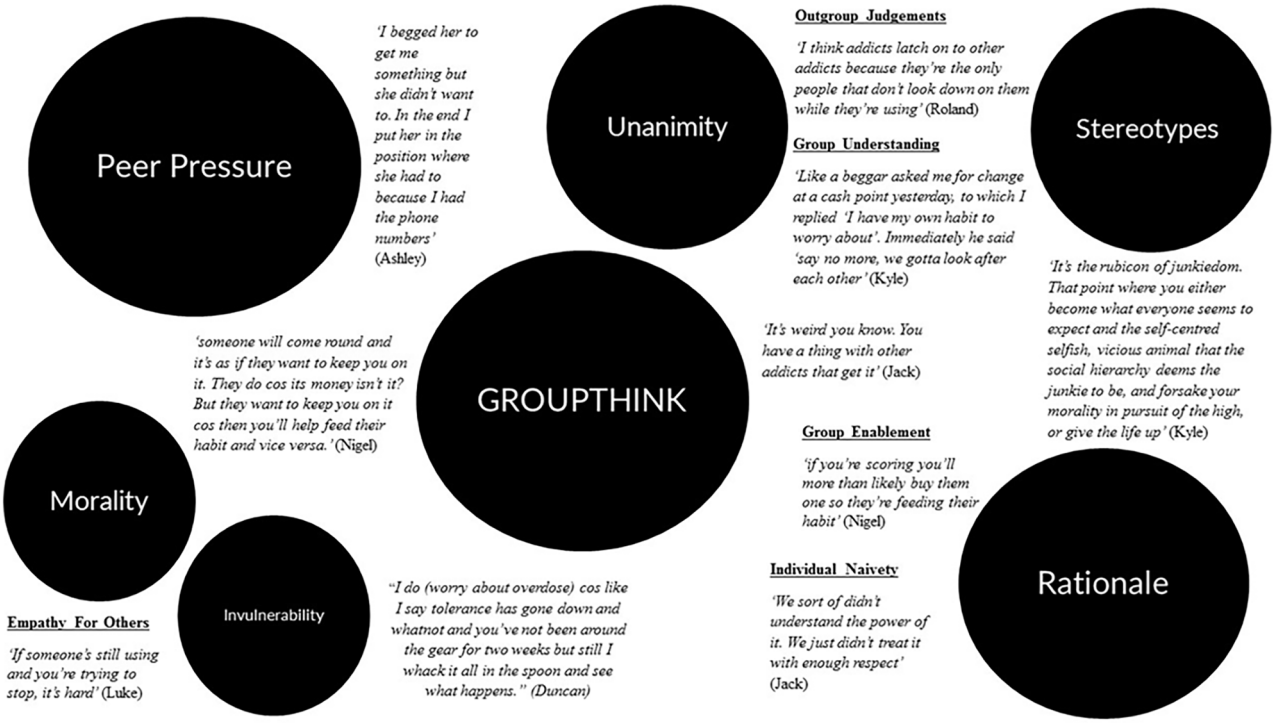

Figure 1. The deductive Groupthink themes of heroin use and subthemes.
Groupthink appeared in the majority of interviews. The above circle size denoting prevalence within the interview set.

a lot of times and people don't really like to see, mainly people who use heroin they don't want you to stop. They try to say 'go on, have a little bit it'll make you feel better'

Rationale

Despite understanding the role of peer pressure in their heroin use, in-group influence was protected from blame through rationalisation that individuals were solely responsible for their own situation. Kyle explained,

'should someone have saved me or whatever? Maybe, maybe not, it's my choice at the end of the day. It's part of you. . . I could sit here and blame all the pain and trauma and everything but It's nobody else fault that I've chosen that route to use. . .suffer or whatever you wanna call it as. I know what I'm doing to myself'

Alec made it clear repeatedly throughout the interview that he only became physically dependent on heroin because he enjoyed it too much, would continue to use heroin whilst he enjoyed it, that he could guarantee the purity by using the same dealer and would use substitute opiates to manage any withdrawals when he was unable to access his trusted source of heroin. Despite also repeatedly expressing a desire for his dealer to stop dealing so that he could stop, Alec was steadfast he made the sole decision whether to use heroin or not.

Roland explained how being part of the group enforced his own decision making indicating a conflict between his own goals and his beliefs when part of this community,

'if we both do it, it feels as if its right and it's not such a bad thing, such a terrible thing'

There was a feeling throughout that others in the in-group—but not the interviewee themselves—would prefer people to remain on heroin so that they could support their own habit. Roland expressed resentment for how he felt the community was self-serving and lacked interest in helping someone improve their situation,

'No-one will give you a chip. Won't give another person a bit of food but they'll kill him and give a cancer stick but not give him food. They'll say 'yeah you can suck on that cancer stick mate' and they've paid more money than they've even paid for their chips. . .and it's the whole thing that yeah you can die with me but I won't let you live with me. . .They'll let you die and they'll help you to die as long as you don't try and get out of where you're in'

Morality

Although the in-group enabled heroin use through entering in to business-like exchanges in order to maintain heroin use, individual participants were empathic to people trying to stop using and would not actively encourage heroin use. Should someone make an individual choice, the in-group was again shielded from the responsibility as Luke stated,

'I wouldn't want to put the idea in their head. I'd leave them alone. If they came to me, that's different. . .it's hard to be around if you're trying to stop but then everybody makes their own choices'

Roger made an individual choice to pressure his partner in to helping him first use heroin. Although initially resisting, he had the money to pay for heroin for both of them. Consequentially his partners own moral standing changed when he was able to help her meet her need.

By remaining within the in-group, even if a person achieves a period of abstinence, the opportunity for heroin use is unlikely to be denied as Roland continued to highlight,

> *'you know other drug addicts would always pat you straight on the back and say 'well done mate, I'm so proud of you' but if you turn around and say 'tell you what give me one more line' they'll go 'yeah alright!'. They're never going to turn round and argue'*

Invulnerability

Whenever a change in substance, quantity or route of administration was made it was instigated by in-group assurances that minimised fear of overdose. Length of time using was viewed as a protective factor for overdose due to established tolerance. No participant, individually or through warnings from in-group members, felt they may be vulnerable to overdose from changes in purity or presence of adulterants.

Illusion of unanimity

Statements of 'all in the same boat' and 'a problem shared' were used to describe other people who used heroin. Participant quotes highlighted the conflict between individual goals for abstinence and the goals of the in-group centred on the reciprocal enablement of heroin use. There were no instances where people spoke of unanimity when attempting to stop heroin use. All attempts to stop using were described as a process requiring a period of self-isolation rather than in-group support, finding a new group to belong to or reconnecting with friends and family.

Discussion

Our sample reflected those in UK treatment and those receiving opiate replacement therapy globally where methadone is prescribed more widely than buprenorphine despite a greater pharmacological benefit to buprenorphine in reducing overdose,[44] likely due to patient choice and cost of prescribing. The framework of Groupthink was useful in identifying factors associated with the influence of others on continuation of substance use which may conflict with individual goals. By conducting the interviews individually we were able to avoid the neuronal changes which occur and influence responses when people communicate in in-groups.[45] The narratives at times contradicted Groupthink by rejecting group influence and asserting personal autonomy throughout. The contradiction provoked questions as to whether individual perspectives would change when interviewed within focus groups of people who buy heroin together. For example, quotes regarding morality suggested that individual moral beliefs alter when group needs can be met. The Groupthink symptoms of self-censorship and mind guards did not appear. Whilst it is understandable that both these may only become visible during coding of a group based discussion, further research comparing the same individuals within peer groups of the same network are required to further inform the involvement of Groupthink when peer goals conflict with individual goals to stop using heroin. However our results show an obvious dissonance between individual goals focussed on achieving abstinence and changes in individual behaviour when engaging with peers who do not share the same goal, often compounded by a need to belong and having empathy for others.

Our findings regarding the initiation of substance use were unsurprising given the evidence base for social influences on substance use.[31,32,46] However whilst professional interpretation could reflect the evidence that the early life experiences of people who use heroin are traumatic,[47] it was the sense of belonging that was cultivated alongside the continued enjoyment of recreational use that was dominant in narratives and is not an area much explored by the literature. Belonging to a moment with others was important to people who used recreational substances and those who progressed to heroin gradually detached from the original social circle as they became physically dependent. In this respect our sample was novel within the evidence base to include the atypical experience of people who transition to use heroin following a career using recreational drugs. Although the vast majority of people who use recreational drugs do not transition to heroin use, our participants who did described becoming outsiders looking in to their old selves who had a rich and varied social life but were now trapped within a smaller circle where the governing shared interest was obtaining heroin. Any transition may have been facilitated in some by an underlying need to manage their childhood trauma which had become normalised by participants rather than reported as a conscious reason for using heroin. Importantly this was not the case for all participants. One participant clearly expressed enjoyment from using heroin and all participants believed in their individual autonomy despite the behaviour of others clearly influencing their choice when they had also expressed a long term desire not to use heroin. Participants held little ill feeling towards others for introducing them to heroin and held accountability for their own choice. The exception was when older family members or friends of friends, who were dependent on heroin themselves, were the ones to introduce heroin. Participants then expressed betrayal believing they should have been protected from something they were naïve to.

Supporting social influence theory, new in-groups then formed with people who use heroin where the enabling and encouragement of others to use heroin became central having lost the sense of belonging to a moment where substance use was supplementary. However social selection theory was not supported as participants expressed rejection of belonging to the new in-group and positioned themselves as different to other members of the group. This was despite interviewees engaging in the same reciprocal heroin exchanges as others.

Judgement from society was a reason why people remain in the group as well as strong beliefs that people who did not use heroin lacked empathy for them. Both perspectives were prevalent throughout the quotes contributing to understanding their

ongoing interactions with a group they rejected as individuals. The quotes suggest a shift from enjoyable, willing relationships to reluctant belonging where individuals engage with others for the reward received rather than shared interests reflecting social exchange theory.[48] All reward was centred on transactions involving heroin. The lending of money to buy heroin underpinned temporary bonds on the understanding this would be reciprocated at a later date alongside sharing of any heroin purchased. The sex composition of each new network was not specified by interviewees. Many participants stated they knew females who would have been interested in taking part in the main study indicating a gender mix within the heroin using group just as in the previous groups who they used recreational drugs with. However unlike when using recreational drugs, there was no mention of shared wider interests beyond the mutual understanding of the effects of withdrawal from physical dependence.

Preserving the in-group through participating in the transactional nature and rejecting blame directed at the in-group for influencing their own heroin use supports Jelic[49] who found people with low personal self-esteem, as is seen with people who use heroin,[50] exhibit greater in-group bias when contributing to social groups to compensate for lack of self-worth. The participant experience contrasts with both Social influence theory and social selection theory for the continuation of drug use by explaining the utility of remaining in social groups despite differences in drug-related goal orientation. Remaining in the group could then be explained by the benefits of the moral economy.[25] Whilst Groupthink may provide a useful framework to explore the internal conflict between individual and group goals, the ramifications of leaving these social groups is likely more complex than merely losing transaction.

Johann Hari claimed that 'the opposite of addiction is connection'[51] but these interviews further support Wakeman[25] demonstrating there is no shortage of connection during active heroin use. It is the focus of shared goals within connections that is critical to people maintaining attempts to stop using heroin, supporting the existing literature.[52-54] Only attempts at abstinence were described as lacking connection. Participant expectation of requiring isolation from other people who use heroin conflicts with Australian research demonstrating that having a diverse social network is more important than having a network comprised of abstinent people in the early stages of reducing or stopping substance use and the number of people problematically using substances is not associated with recovery outcomes.[55] Speculatively the feeling of needing isolation could be initiated by the change in substance related shared goals amongst the in-group that is present within out-groups such as mutual aid meetings.[56]

These interviews highlight the importance of treatment which targets the social network rather than the individual.[57] The individual goal versus group goal conflict as described by participants suggests that social network interventions may be more successful if delivered to cohorts of people who buy heroin together. It is the group psychology that needs to change rather than the individual who will experience conflicting goals to that of the social group. Facilitating access to mutual aid or integration within lived experience recovery organisations will likely be beneficial to provide access to groups whose aims may be greater aligned with that of the individual.[58,59]

Limitations

Coding should be interpreted cautiously because the experiences explored are individual perspectives organised within the framework of Groupthink. Our sample was self-selecting and some participants declined to be interviewed meaning not all perspectives were able to be explored. The interview schedule was designed by BH, checked by CN prior to use with no pilot testing. Our results cannot be assumed to represent the experience of women who use heroin. All interviews were taken at face value to represent the truth of the individual at that time rather than a universal truth.

Conclusion

Far from becoming socially isolated when actively using heroin, interviews identified a shift in social networks from networks built on shared moments to networks underpinned by a moral economy. Individuals positioned themselves away from the heroin using group but were unable to break away fearing judgement from non-substance using society would leave them isolated. Other people within the networks were viewed as hindering attempts at abstinence. The greatest benefit to maintaining relationships with other people who use heroin was mutual understanding. This study adds novel contribution to the field in 2 ways. Firstly by adding individual context to attempts to stop using heroin, existing empirical social theories for continuation of substance use have been challenged. Secondly by challenging the belief that people who use heroin are socially isolated which is clearly not the case. However the heroin using goals within those relationships are not always aligned creating internal conflicts when interacting with people trying to buy heroin. Treatment approaches should focus on the group psychology of people who buy heroin together. Continuation of heroin use may be influenced by Groupthink. Further research is warranted where Groupthink implied in individual interviews can be compared with focus groups of people who use heroin in the same social networks.

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Author Contributions

All authors conceived the original study design. BH conducted the qualitative interviews and performed the analysis. CN confirmed the analysis. BH was the lead author of the manuscript, all authors contributed critical feedback to help refine the submission.

Ethics Approval

This study was approved by the Brent NHS Research Ethics Committee in July 2020 (Ethics approval number 20/LO/0758).

Consent

All recruited participants to the initial purposively recruited proof-of-concept study gave written informed consent to take part in an optional qualitative interview.

Data Availability Statement

The data that support the findings of this study are openly available on request from the lead author.

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Supplemental Material

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