A Qualitative Study of Self-Managed Change in Substance Dependence Among Women

Jan Copeland

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PREFACE

This research was conducted as part of a larger national study on the treatment needs of women with alcohol and other drug problems. That study interviewed four hundred clients and staff from a variety of treatment services on their experiences and views about the treatment needs of women.

It was recognised that a voice and perspective that has been missing from research into women with substance use problem was from those women who did not or could not access existing treatment services. This phase of the study, therefore, was an exploration of the question of recovery from alcohol and other drug problems among women who sought no formal intervention or assistance from self-help groups.

The aims of this study were to identify techniques developed by women with alcohol and other drug dependence in the process of their recovery which may be incorporated into existing programs, and finally to explore what changes could be made in program outreach or content which may lead to their being appropriately utilised by such women in the future.

1.1 *Introduction*

The question of the existence of spontaneous or natural recovery, its prevalence and processes, has been a controversial issue in all domains of psychotherapy. This is particularly so in the addictions field (Chiauzzi and Liljegren, 1993) where the prevailing view is that alcoholism and drug addiction are irreversible diseases for which abstinence is the only palliative measure (Alcoholics Anonymous, 1976). The notion of natural recovery is almost as controversial as the related concept of controlled drinking, which identifies the possibility that someone who has been dependent on alcohol may become a successful social drinker (Sobell and Sobell, 1976; 1973(a); 1973(b)).

1.2 *Prevalence Studies*

The prevalence of natural recovery from alcohol and other drug dependence has not been well documented. Several lines of evidence suggest, however, that the incidence is higher than previously estimated. These include prevalence and longitudinal studies in the general population (e.g. Robins and Regier 1991; Vaillant, 1983; Robins, 1973; Cahalan, 1970), treatment evaluation research which employed control groups (e.g. Alden, 1988; Burt Associates, 1977), and the small number of studies that specifically interviewed people who had recovered without treatment (e.g. Klingemann, 1992; Ludwig, 1985; Tuchfeld, 1981; Saunders and Kershaw, 1979).

The ratio of untreated to treated alcohol misusers has been estimated to range from a conservative 3:1 ratio up to a 13:1 ratio (Nathan, 1989; Roizen, Cahalan and Shanks, 1978). The recent Epidemiologic Catchment Area (ECA) Study has provided the most cogent evidence on the prevalence of recovery from alcohol and other drug problems without formal treatment. Using the Diagnostic and Statistical Manual of Mental Disorders IIIR (American Psychiatric Association, 1987) (DSM IIIR) criteria for alcohol abuse and dependence they found in their study of 20,000 persons from the general population in five sites in the United States of America, that 23.8% of men and 4.6% of women satisfied the criteria for a lifetime incidence of alcoholism. Of those, 63% had not had a period of heavy drinking in the past year. This translates to an overall remission rate from alcoholism of

51% for men and 53% for women (Helzer, Burnam and McEvoy, 1991). Most of those alcoholics who stopped, or moderated their drinking, did so without professional assistance. Overall, only 12% had ever told a doctor about their drinking problems.

The higher rates of change in problem drinking without treatment among women compared with men has also been reported among late onset problem drinkers (Atkinson, 1994).

The ECA study also examined lifetime prevalence of drug abuse and dependence for cannabis, stimulants, sedatives, cocaine, opioids and hallucinogens, also using the DSM IIIR criteria. They found a lifetime prevalence rate of 7.7% for men and 4.8% for women. Of those so diagnosed, 47% of men and 71% of women had not reported any symptoms in the last year. Of the total sample of those receiving a lifetime diagnosis of drug abuse or dependence, only 26.4% of men and 36.9% of women had spoken to a doctor or other professional about their drug use problems (Anthony and Helzer, 1991). It can be seen, therefore, that alcohol and drug abuse and dependence are common disorders in our society and the vast majority of those who recover, do so without formal treatment. This phenomenon also appears to be more common among women than men.

1.3 Theories of Self-Managed Change

These figures highlight the importance of exploring the processes of natural recovery, as most individuals with alcohol and other drug problems never come to the attention of clinicians or researchers. The understanding of the natural recovery process would, therefore, inform the treatment community on the development of more accessible and effective treatment services for those people who might be willing to seek treatment if it were more able to meet their needs. The development of intervention strategies to facilitate self-change for those who remain unlikely to seek formal treatment, but would be interested in more remote forms of assistance such as self-help manuals and public health campaigns, would be an additional benefit.

In their review of spontaneous remission from over-eating and the problematic use of alcohol, opiates, and tobacco, Stall and Biernacki (1986) comment on the paucity of studies that address the question of *how* natural recovery occurs. Researchers have reported a variety of factors associated with behaviour change in the addictions field. These include concerns about deteriorating physical health (Stall, 1983; Tuchfeld, 1981; Saunders and Kershaw, 1979), strong social sanctions such as fear of imprisonment (Stall, 1983; Tuchfeld, 1981), life events such as marriage (Saunders and Kershaw, 1979; Goodwin, Crane and Guze, 1971) and the positive influence of family life and spousal support (Klingemann, 1981; Tuchfeld, 1981; Edwards, Orford, Egert, Guthrie, Hawker, Hensmen, Mitchison, Oppenheimer and Taylor, 1977).

An additional factor, more commonly nominated in the opiate literature, is that of "maturing out". Winick (1964, 1962) first reviewed the records of opiate addicts maintained by the U.S. Federal Bureau of Narcotics and found that, as addicts neared the ages of 35-40 years there was a tendency for their names to no longer appear on the files. Winick proposed, therefore, that opiate addiction is a self-limiting condition, in that as addicts mature they learn to manage the problems of life. Vaillant (1973) argued that Winick's view was unrealistically optimistic, as more than half of the active addicts in his study of 100 males avoided being placed on the register.

In the alcohol literature the concept of "maturing out" has been linked to a reduction in alcohol consumption as men and women make the transition into marriage. A study by Miller-Tutzauer, Leonard and Windle (1991) reported a significant reduction in alcohol use among those entering marriages, during the three year transition period, compared to those who remain single or married. Room (1977) also argues that within any given population the spontaneous remission of alcohol problems is associated with normal socialising processes such as marriage and employment.

Various terminologies for the process of behaviour change without formal treatment have been discussed by a number of authors. The terminologies invoked include "maturing out" (Winick, 1964), "spontaneous remission" (Stall and Biernacki, 1986), "autoremission" (Klingemann, 1992), "natural recovery" (Waldorf, 1983), "spontaneous recovery" (Ludwig, 1985), "de-addiction" (Klingemann, 1992), "self-change" (Sobell, Sobell, and Toneatto, 1991), and "self-initiated recovery" (Biernacki, 1986).

Waldorf (1983), Biernacki (1986) and others have criticised a number of these terms as simplistic and inaccurate. The notion of "maturing out" does not explain the complex and/or idiosyncratic motivations and processes that lead people to initiate and maintain changes in addictive behaviours. As Biernacki (1986) points out, recovery is not always self-initiated as many people are sufficiently sensitive to the concerns and pressures of others to change their behaviour. The terms which include the words remission and recovery arise from the medical model, and either imply inevitable relapse or that behaviour change is an effortless and inevitable process.

The most appropriate of the existing terms is self-change, as it is not specific to any model and does not imply that it is a natural and effortless process based purely on temporal variables. The term I have adopted, "self-managed change", has the additional benefit of conveying the notion of a process, rather than an event, and a process that requires some effort and invariably demands some form of behavioural plan for its successful completion.

Biernacki (1986) has described four phases of self-managed change. The first stage was resolving to stop. In his study, a small minority of subjects did not make a firm decision to stop but drifted into a pattern of less use and eventually stopped without conscious decision making. The resolution to stop, however, was more frequently accompanied by a personal "rock-bottom" experience such as being imprisoned, or an existential crisis such as questioning their identification with the label of "addict" or "alcoholic".

The role of humiliating experiences in the motivation to stop has also been discussed by Tuchfeld (1981) and Klingemann (1991).

The second stage was breaking away from addiction. The decision to change a lifestyle of dependence on alcohol and other drugs frequently requires the person to change many aspects of their accommodation, friends and social life. New activities are required to fill the void, both temporal and symbolic, that is left by time that used to be required for the acquisition, consumption and recovery from alcohol and other drugs.

The third stage was staying abstinent. This phase involved a relapse prevention plan to deal with craving. Two strategies identified by Biernacki (1986) were substitution of one psychoactive drug for another, or the cognitive restructuring of craving by focusing on the negative experiences of drug use, or distracting oneself with positive activities.

Biernacki's final stage was becoming and being ordinary. This phase involves dealing with the long-term changes in identity from being a member of a deviant sub-group to conventional society. The successful transformation of identity requires dealing with the stigmatising label of "alcoholic" or "addict" and having access to tools such as education, employment and social relationships with which to fashion a new identity.

The stages identified by Klingemann (1992) of motivation, decision implementation and a struggle for maintenance are very similar. He identified coping mechanisms which include diversions, such as religious experiences and drug substitution, self-monitoring and distancing or breaking away.

1.4 Treatment-Seeking

While the nature of treatment-seeking remains poorly understood (Jordan and Oei, 1989), it may be conceptualised as the result of an interplay between the characteristics of the individual and structural characteristics of the treatment service (Beckman and Kocel, 1982). In an initial

examination of the factors underlying the choice between self-managed change and formal treatment seeking, a number of studies have compared those who have and have not sought formal treatment. Graeven and Graeven (1983) investigated the differences between treated and untreated addicts involved in a suburban adolescent heroin epidemic in San Francisco over a ten year period from 1965 to 1974. This study compared 22 untreated addicts with 53 treated addicts. Unfortunately, no inferential statistics were performed by the authors. They reported that untreated addicts had better family lives, more positive self-esteem, less experience with the criminal justice system, smaller habits, and fewer symptoms of physical dependence than treated addicts. Waldorf (1983), reporting on the same sample as Biernacki (1986) compared 101 untreated opiate addicts and 100 treated opiate addicts. The only significant differences reported were that the untreated sample were on average 5 years younger and were more likely to have been legitimately employed during their years of active addiction than the treated sample.

1.5 Gender Bias

Consistent with the vast majority of scientific research, studies on the prevalence and processes of self-managed change among women have been notable for their absence (See Appendix One for an overview of the relevant literature). No study reported in the literature has provided information on a gender analysis of the process of self-managed change among women. All of the published studies on self-managed change *per se* have included females in their samples, ranging from 7% in Ludwig (1985) to 45% in Graeven and Graeven (1983), and 50% in Klingemann (1992; 1991).

Only two studies provided any data on gender differences. A study by Sobell, Sobell and Toneatto (1991) reported on an analysis of gender differences in group membership between self-managed change involving abstinent or non-abstinent outcomes. A later study by Leung, Kinzie, Boehnlein and Shore (1993) provided information on gender differences in the prevalence of alcohol abuse and dependence among their sample, but the remaining studies provided no comment on gender issues.

A recent Australian qualitative study of "becoming an ex-user" interviewed 18 Canberra-based ex-opiate users about stopping their drug use (Bammer and Weekes, 1994). There was a very small, but unspecified, number of subjects in the study who had never received treatment for their substance use and no gender comparative analysis was reported.
This paucity of research into gender differences in self-managed change is of particular concern, as women frequently face a greater number and variety of barriers to treatment-seeking than do men (Jordan and Oei, 1989), and are particularly under-represented in the residential treatment population (Webster, Mattick and Baillie, 1991).

1.6 Study Aims

This study had two main aims. The first was to explore the barriers to treatment seeking among women who have managed to change their alcohol and other drug misuse without formal intervention. This involved an examination of the subjects' knowledge and perceptions of existing treatment services and self-help groups and ascertaining the kinds of treatment services and models which may have attracted them into formal treatment. The second aim was to explore the process of self-managed change among women, and to ascertain the similarities and differences between men in the existing literature and women in this study. A third aim was to derive suggestions for clinicians and policy makers on how they might enhance motivation for behaviour change among women, and to mobilise the strategies that were successfully adopted in achieving and maintaining resolution of alcohol and other drug dependence by this sample of women, a group who have not previously been accessed by clinicians or researchers.

2.1 *Subject Recruitment*

Thirty three women were recruited through print media advertisements in local metropolitan weekly newspapers, a week-end nation-wide newspaper, and a free weekly rock-music magazine during the period from September 1993 to January 1994. One subject was excluded when it was revealed during the interview that she had been enrolled in a methadone program during a pregnancy some years previously, leaving thirty two women in the study.

The advertisements were worded as follows: "*The National Drug and Alcohol Research Centre would like to talk to women who have recovered from alcohol and other drug problems, for more than a year, without any special treatment or self-help group. The interview takes about an hour and is conducted by a female psychologist and we guarantee that the information is anonymous and confidential. We pay $20 to reimburse travel costs and will arrange a convenient time and location.*" One of the advertisements in a local newspaper did not include the reimbursement information but had the most successful relative rate of recruitment. To avoid selection bias there were no snowball or chain referral sampling techniques used in the study.

2.2 *Screening Procedure*

Anyone who responded to an advertisement was screened by telephone for symptoms of dependence, length of recovery and absence of formal intervention or self-help group attendance for alcohol and other drug problems.

The first exclusion criteria was absence of symptoms of dependence during the period the subject identified as one of problematic use of alcohol and other drugs. The symptoms of alcohol or psychoactive substance dependence as defined in DSM IIIR were used to assess dependence. The subject was asked by telephone whether they had symptoms of loss of control, alcohol-related problems, or tolerance as described in DSM IIIR. Recovery was defined as significant improvement in the consumption behaviour which no longer includes any features of dependence (Hodgson and Stockwell, 1985). Consistent with Klingemann (1991) and Tuchfeld

(1981) the period of one year of problem resolution was chosen as a realistic one to maximise subject recruitment and is well past the periods of highest risk of relapse (Miller, 1988).

Formal intervention was defined as any intervention by recognised individuals or programs whose main goal was to treat people with alcohol or other drug problems, even where that treatment was only one session, as the brief intervention literature suggests that such interventions can be effective in ameliorating substance dependence (reviewed in Heather, 1989). Unlike Sobell, Sobell, and Toneatto (1991) inpatient admission for detoxification was considered formal intervention in this study and such subjects were excluded. Subjects who merely received a warning or advice without assistance from medical practitioners and other health care workers were included, as in the studies of Tuchfeld (1981) and Sobell, Sobell and Toneatto (1991). Subjects who had attended health care professionals for other problems where their alcohol or other drug problem was not discussed, were included in the study.

Women who had attended more than five Alcoholics Anonymous or Narcotics Anonymous meetings during the first year of their recovery were also excluded. While twelve step self-help groups do not consider themselves a treatment *per se* (Mattick and Jarvis, 1993) they promulgate a particular model of substance dependence and a method of achieving recovery. As the aim of the study was to explore ways in which women come to their own understanding of their problems and developed individualised solutions, it was felt that membership of twelve step groups in the first year of behaviour change would have coloured their perception in a systematic fashion. Therefore, a number of women who had treatment or attended twelve step groups in the past, even when they found them unhelpful, were excluded from the study.

As this study was designed to be hypothesis-developing rather than hypothesis-confirming, no validity measures were employed except for the researcher's examination of the internal consistency of the interview. The

question of self-report in addiction research is raised continually. Sobell and Sobell (1990) have provided a large body of evidence that alcohol misuser's self-reports of distant and recent alcohol-related events are generally valid on a group level, when obtained under conditions of confidentiality, and when subjects are alcohol-free. The adequacy of self-report in the context of natural recovery from alcohol problems has been specifically explored by Gladsjo, Tucker, Hawkins and Vuchinich (1992) whose findings questioned the use of collaterals as an appropriate verification method in research of this nature.

2.3 Procedure

The study had received approval from the Committee for Experimental Procedures Involving Humans at the University of New South Wales and subjects were informed that they did not have to answer questions they did not feel comfortable answering and could terminate the interview at any time. The majority of subjects were interviewed in their own home, with the remainder interviewed in the researcher's office at the University. The interview took between one and three and a half hours and was audio-tape recorded. The subjects were informed that the tape-recorded interview would be transcribed and that the tape-recording would be destroyed on completion of the study. The interview schedule (please see Appendix Two) was open-ended and subjects were only prompted when they did not mention key areas of interest.

The interview schedule covered the following domains:

Demographics: age, current marital status and living arrangements, number of children;

Life experiences: family background and most salient memories of childhood; education and employment; significant relationships; obstetric history; unwanted sexual contact and physical and sexual assaults, and domestic violence;

Alcohol and other drug use history: drug use history including: age first used alcohol or other drugs; circumstances surrounding initiation into use; transitions in use; escalation in use; when it was found to be a problem and why; and the Short Dependence Scale administered retrospectively (Gossop, Griffiths, Powis and Strang, 1992);

Lifestyle and substance dependence: having to do things they would rather not to obtain alcohol or other drugs including crime and sex work; physical and psychological health including eating disorders and suicidal thoughts or behaviour;

Factors associated with behaviour change: talking to people about alcohol and other drug problems; being told to make changes; awareness of treatment options; opinions on treatment options; stigma (with counter-balancing of gender mentioned first); exposure to and opinions of twelve step programs;

Factors associated with cessation of misuse and maintenance of behaviour: experiences of withdrawal and its management; techniques for early recovery and maintenance; length of recovery; current alcohol and other drug use patterns; and suggestions for improvement to treatment services.

2.4 *Sample Demographic Characteristics*

The median age of the subjects at the time of interview was 35 years with a range of 21-77 years. At the time of interview 37% of the sample were single, 22% were married, 19% were in a defacto relationship or divorced and three percent were widowed. Ninety one percent of the sample were heterosexual, six percent lesbian and three percent bisexual. Twenty (62.5%) of the women in the sample had no children, with the remainder having a mean of 2 children (range 1-4). The majority of the sample was born in Australia (72%) or of Anglo-Saxon ethnicity (94%). They were generally well educated, with 38% having some tertiary education and only 12% not having finished four years of high school. Half of the sample were not currently in paid employment with 19% engaged in full-time household

duties and six percent were retired. A little over half of the sample (56%) lived in rented accommodation with the remainder owning their own homes. The sample were from a selection of metropolitan and surrounding areas with 37% of the sample from the innercity and Eastern suburbs of Sydney, a further 37% from the Northern beach suburbs of Sydney, 9% from the inner Western suburbs, and 6% each from the surrounding semi-urban areas of the Blue Mountains and Central Coast of New South Wales. The remaining three percent came from the Southern suburbs of Sydney.

CHAPTER THREE CHILDHOOD HISTORY

3.1 *Family Background*

The vast majority of women in the study talked about the unhappiness of their childhood, whether or not their parents had alcohol and other drug problems, with the predominant theme being one of abandonment.

The sample was unusual in that 37.5% of them had a father and 12.5% had a mother who was employed in a professional occupation. In comparison, the current figures for employed persons aged 15 and over per occupation engaged in managerial or professional employment is 20.6% percent for women and 28.5% for men (Castles, 1993). Nine percent of the fathers and 41% of the mothers were not working outside the home during the majority of the subject's childhood. The majority of the mothers in this figure were home-makers and the fathers were unemployed.

Related to the parent's professional obligations 31% of the women spoke of frequent moves during childhood and attending multiple schools. Esther,[1] a 22 year old woman with a past poly drug dependence talked of a father who was physically absent because of his work, and a mother who was not available because of her mental illness and associated self-medication. She was obliged to travel overseas as a child so her father could study and consequently attended 11 different schools. Around half of the women attended state schools with 31% attending private schools and 16% boarding schools. While 53% stated that they enjoyed school, around 60% rebelled against authority at school, and many spoke of sabotaging their education either in response to high demands and expectations placed upon them, or because of a perceived lack of guidance and attention from their parents.

While the majority (72%), of the parent's marriages remained intact, the majority reported that their parent's marriage was unhappy. A quarter of the sample had a father with an alcohol or other drug problem and 22% had a mother with such a problem. Invariably the father had a problem with

[1] All names used in the text have been changed to protect anonymity.

alcohol and the majority of mothers had problems with benzodiazepines and analgesics.

3.2 *Feelings of Abandonment*

The theme of abandonment arose in many different ways. A number of women spoke of feeling abandoned because their fathers left home after divorce and their mothers engaged in multiple relationships and neglected their caregiver role. The consequences of parents devoting themselves to their careers and being unavailable physically or emotionally to their children was frequently raised. The effects of sexist stereotypes was a common theme. Alison, a 37 year old women who had been dependent on cocaine noted:

> "I am an only daughter and should have been a son. I was excluded from the family from an early age. When I was old enough that they could get rid of me by putting me in a boarding school they did. When they went on holidays I was put in a foster home....At 13 I was sent to boarding school (in another country) at the time my parents separated so I had a new culture, a new language and a new school. By that time I had decided that nothing was going to happen for me, I've got to do it by myself."

Karen, aged 35, was another subject formerly dependent on cocaine who spoke of her feelings of abandonment and lack of support:

> .."basically I can't remember them being around a whole lot. My father said you either go to university to become an accountant or you become a secretary and find yourself a good husband. I won art awards in school and could have got a scholarship but he said 'we're not having any basket weavers in this house.'"

Families were not only severely disrupted by the parent's alcohol and other drug problems but also by the death of a parent or severe mental illness in the family. Strict religious beliefs in the family were reported by 19% of the women and the role this played for some of them will be discussed in later sections.

Despite the high levels of disturbance and distress in most of the families of origin none of the women were involved in family counselling during childhood.

3.3 *Sexual and Domestic Violence*

Twenty two percent of the women in the sample had experienced sexual assault in childhood. A little over half of these were incestuous experiences with fathers and grandfathers. The women who had been sexually assaulted in childhood by strangers, such as Janet, appeared to have a clear memory of the incident. She described hers in this way:

> "when I was 5 I was raped, by strangers who were teenage boys who lived in the village. I knew who they were. I told my parents and they did something but I don't know what it was - it was never brought up. It doesn't seem to have been a problem in my life."

The women who believed they had incestuous experiences often had a very vague memory of an incident. For example, Lillian, a 37 year old woman who was formerly dependent on marijuana, who made this comment:

> "I'm now in relationship counselling and the woman said 'I think you have something in your early life that you're repressing.' I've always wondered because I used to do co-counselling and whenever anyone did anything in that around sexuality and rape I would get incredibly anxious. I wondered why I got so terrified and started to suspect that something had happened.... My mother says its impossible and wrote to my father who didn't reply."

Around a third of the women in the sample (37.5%) had experienced domestic violence, often in the context of a relationship with a substance dependent partner. Janine, a 53 year old woman who had been dependent on barbiturates and alcohol spoke of her violent marriage in these terms:

> "The 18 years were biff and thrust right from the very beginning - that's how my first son was conceived, out of rape and bashing. The bashing went on and I couldn't look at or talk to anybody if I went out. I woke up on my 26th birthday with the mumps and he gave me a hiding that morning - he didn't need to be drunk at all. I didn't report it because he told me he'd be discharged

from the army and then we'd have no money, no food, no housing. I think he was trying to send me mad. The only time that I went to the doctor was the last time when I told them I'd been in a car accident at work but that time he'd hit me around the face and arm - I still had bruises 2 months later."

3.4 *Psychological Health*

Two of the women in the study suffered from serious mental illness, paranoid schizophrenia and bi-polar affective disorder, which required intermittent medication. A further five women felt they had significant problems with depression that had never been properly diagnosed. Amelia, a 43 year old women who was dependent on alcohol, spoke of her experiences:

> "I didn't do very well at university - I passed and I went through a stage, when looking back on it now, I think I had a major depression which nobody picked up. I feel that I've been battling depression all my life. The episodes when I was 17 and post-natally."

Many of the women spoke of suicidal thoughts and attempts. Colleen, a 46 year old woman who was dependent on benzodiazepines recounted:

> "I made my first suicide attempt at 13 on Nembudeine - I went off to bed happily waiting to die - death was a constant theme in my life. If they'd sent me to counselling, instead of worrying about the family name, at that point of my life I would have done a heap better."

Eating disorders were the other major psychological disorder to be mentioned by 41% of the sample with 18% of the entire sample having a primary eating disorder, most commonly bulimia followed by anorexia nervosa. For many of those women the eating disorder was even more difficult to manage than the alcohol and other drug dependence. Esther commented that:

> "I was anorexic at 11 and again at 19. I got over it at 11 through drugs. At 19 I went on to become bulimic and the nightmare began. The obsession with food and weight and body image totally took over my life but the bulimia is what got me into the depths of despair and depression."

CHAPTER FOUR A COMPARISON OF CHARACTERISTICS OF WOMEN WHO DO AND DO NOT SEEK TREATMENT FOR ALCOHOL AND OTHER DRUG DEPENDENCE

4.1 *Introduction*

This self-managed change (SMC) sample of women were compared to the sample of one hundred and sixty women who participated in an evaluation of women-only and mixed-sex treatment services in Sydney (Copeland and Hall, 1992). Their demographic characteristics were compared, in order to explore the differences between women who were recruited into existing services and those who were not attracted to such services.

4.2 *Statistical Analyses*

Chi square tests and correlations where applied to test for variables that predicted group membership. These inferential statistics, however, should be considered with the following cautions. First, the two data sets were gathered using different methodologies and research designs. The former being a qualitative methodology and the later a quantitative methodology employing a quasi-experimental design. Second, these inferential analyses were not planned and a number of tests have been conducted, therefore, the multiple comparison problem is relevant and may give rise to an inflated type 1 error (Hall and Bird, 1986). Consequently, these results should be viewed then as hypothesis generating and not hypothesis confirming, and are provided only to highlight those variables that are worthy of further exploration in studies of help-seeking behaviours among women. In addition, it must also be emphasised that given the small sample size of the self-managed change (SMC) group, the failure to detect a difference between the two groups on any variable does not imply that there is no real difference in the population.

4.3 *Results*

The median age of women attending treatment services was 32.5 years compared to a median age of 27.6 years when the women in the SMC group made the changes to their alcohol and other drug misuse patterns. The women in the SMC group were more than twice as likely to be in a stable relationship at the time of behaviour change than were women in the treatment group. Women in the SMC group were also four times as likely to

Table 4.1

Comparisons Between Women in Treatment and Women in the Self-Managed Change Groups on Demographic Variables

Variable	Treat	SMC	χ^2	p	OR	95% CI
Stable Relationship (n (%))	31 (19%)	11 (41%)	4.39	.04	2.14	[1.04, 5.58]
Lesbian	22 (14%)	3 (6%)	.45	.5	1.54	[0.43, 5.49]
Dependent Children	71 (44%)	9 (18%)	2.9	.09	2.01	[0.89, 4.68]
CSA	75 (47%)	7 (22%)	6.8	.01	3.15	[1.29, 7.70]
ASA	78 (49%)	7 (22%)	7.8	.01	3.4	[1.29, 8.30]
MFH	58 (36%)	7 (22%)	2.46	.12	2.01	[0.83, 4.98]
PFH	79 (49%)	8 (25%)	6.39	.01	2.93	[1.24, 6.90]
Employed	85 (53%)	27 (84%)	10.71	.00	4.76	[1.75, 13.0]
Tertiary Education	11 (7%)	6 (19%)	4.66	.03	3.13	[1.06, 9.19]

Stable relationship: included married, de-facto and lesbian couples co-habitating;
CSA: childhood sexual assault;
ASA: adulthood sexual assault (after the age of 16 years);
MFH: a positive maternal family history of alcohol or other drug problems;
PFH: a positive paternal family history for alcohol or other drug problems;
Employed: refers to the period of treatment seeking or behaviour change;
Tertiary education: refers to completed university degrees.

be employed at the time of making changes in their substance use and more than three times as likely to have completed a university degree than were women seeking formal treatment. There were no significant differences in the proportion of the sample who were of lesbian sexual orientation or who had young children in their care at the time of alcohol and other drug dependence.

In addition to appearing less socially stable and more educationally disadvantaged, the women in the treatment group appeared to have a greater degree of trauma and disruption during their childhood and adult life. The women in the treatment group were three times as likely to have experienced childhood sexual assault and three times as likely to have experienced sexual assault in adulthood than were women in the self-managed change group. While there were no significant differences in the rates of maternal family history of substance misuse, the women in the treatment group were almost three times as likely to have a father with a history of alcohol and other drug problems than were women in the SMC group.

The consumption and dependence measures were not directly comparable between the two samples because of the differing sampling methods. The mean scores on the dependence questionnaires used for both groups, however, fell in the severely dependent range.

4.4 Discussion

While women in the two samples had similar levels of dependence and patterns of substance use, there were clinically relevant differences between the two groups. The finding that women in the self-managed change group were significantly more likely to be in a stable relationship at the time of behaviour change, and significantly more likely to be employed and to have completed a tertiary degree, appears to suggest that they were more socially stable and had greater social resources available to them. This finding is consistent with those of Goodwin *et al.* (1971), Hingson, Scotch, Day and Culbert (1980), and Graeven and Graeven (1983). The importance of stable

social support and employment as predictors of successful outcomes from substance dependence have been reported by a variety of authors (e.g. Edwards, Duckitt, Oppenheimer, Sheehan and Taylor, 1988; Elal-Lawrence, Slade and Dewey, 1986). Another factor which may have affected the willingness for a number of the SMC subjects to seek formal treatment was that some subjects reported that they felt that treatment services were not designed to cater to middle-class women but only to anti-social men who were homeless, while private services were prohibitively expensive.

A further finding related to social stability is that women in treatment were significantly more likely to have a father with an alcohol and other drug problem and also apparently more likely to have a mother with such a problem than were the women in the SMC group. Only one other researcher has addressed a similar question and he also reported that male prisoners with a father who had an alcohol problem were significantly less likely to have remitted their alcohol problems than those with non-alcoholic fathers (Goodwin *et al.* 1971). As noted by Orford and Velleman (1990) the trauma associated with a parent drinking in the home and the correlation with diminished family support may contribute to an explanation for this finding.

The final set of findings, that women in treatment were significantly more likely to report a history of sexual assault in childhood and later life than were women who self-managed their behaviour change, has important clinical and policy implications. If the presence of such traumas in a woman's life makes it less likely that she could manage to resolve her addictive behaviours without formal treatment and motivates her to seek professional assistance, then it is clearly a therapeutic issue which should be addressed in treatment. As discussed in previous chapters, this should be done in a way which provides the woman with an opportunity to explore the trauma at her own pace, in an environment which is respectful of her wishes, and which provides her with on-going, professional counselling.

5.1 Initiation into Alcohol and Other Drug Use

The first use of a legal psychoactive substance, for the vast majority of the subjects, was nicotine or alcohol in the early teens. The notable exceptions include Karen (previously introduced) and Sally. Karen spoke of regular drinking at 10 years of age:

> "I remember I had a friend and we'd hit the liquor cabinet and get drunk before school 'cos both her parents worked and would leave before we went to school. I'd ride my bike miles to get to her house and we'd drink a small bottle of gin and go to school. There was a real pain I was burying and it was finding the right friend who wanted to do it too."

Sally was a 22 year old women who was formerly dependent on heroin. She was brought up in an alternative lifestyle co-operative community and resented the lack of discipline and guidance during her childhood. She noted that drugs were a central part of the community lifestyle and reported that:

> "I first smoked dope at 9 and heavily when I was 11 or 12 - every day I was stoned all day. We were given it by my girlfriend's father who wanted to get rid of us, he grew a lot of it - he'd say 'piss off girls and play'. I used to binge drink - we used to get into his alcohol cabinet when I was 9 or 10. I had more of an alcohol problem than dope."

Sixty five percent of the sample had tried illicit drugs. Cannabis was by far the most common illicit drug used by the women. Caitlin, a 26 year old women who was formerly dependent on opiates spoke of the romantic aura surrounding heroin: "my boyfriend and I both wanted to try it and we knew a lot of people who were taking it, we had to beg them to do it for us. I injected it from the first time." The nightclub scene introduced a number of women to amphetamines. Joy, a 23 year old woman who used oral speed very heavily for four years reported that:

> "I used to go out every night, living in Central London I'd go out every night to clubs, this is during my school time as well. My parents didn't even pressure me too much if I was to go out and come back at 2 o'clock in the morning on a

school day. I had a terrible temper at that time and used to challenge everything so it was easier just to let me have my own way."

Some subjects had unusual initiations into substance use. Belinda was a 28 year old woman who was formerly dependent on heroin. She said:

"my first experience with drugs was the weekend dad left when I was 15 and I had a maths exam on the Monday, and mum accidentally killed the cat with a flying ladder, and all these things happened and so I took a handful of Sudafeds and got incredibly ill. I missed out on my maths exam and so then I realised the power of drugs."

A quite distinct group of women were introduced to substance dependence iatrogenically. Fiona was a 51 year old woman who was prescribed a benzodiazepine hypnotic to deal with work-related stress as one of the first female corporate lawyers in a large company. She noted that:

"it was really strange, they didn't have a clue how to treat women, they don't treat you like a normal human being (in the workplace). It's getting better by leaps and bounds but there's still the glass ceiling and that creates lots of stress. When I got my first Mogadon prescription he said to me - these are great, they are the great new discovery, these won't kill you, they won't be habit forming and he really promoted them. I felt very safe, very safe and he said the dose is 4 but you don't need that many."

A more atypical case was that of Vanessa, a 54 year old widow who told a story of:

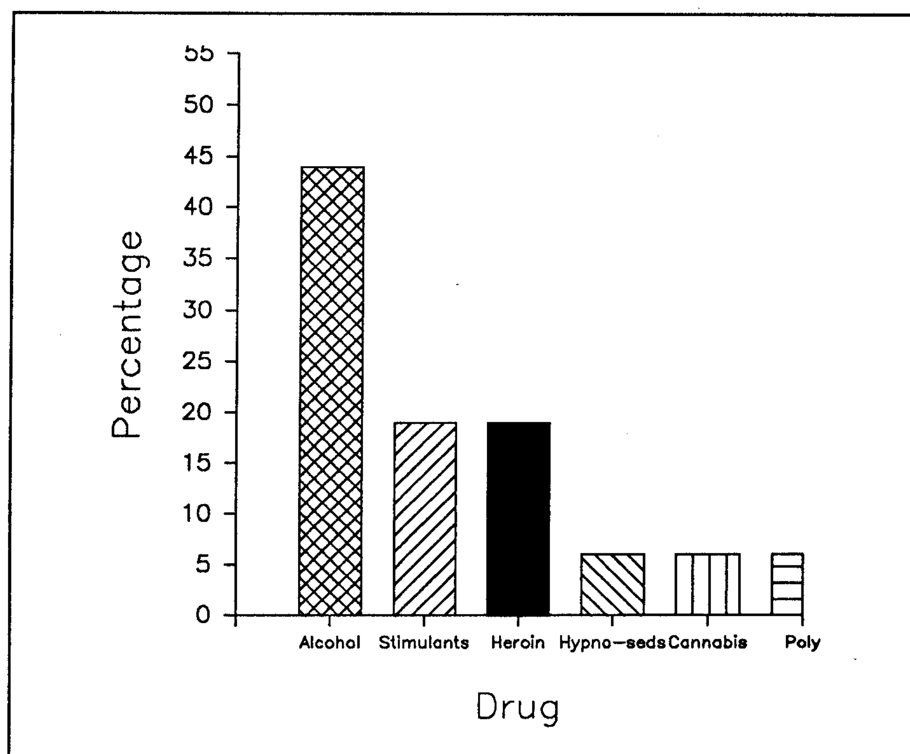
"When I came back to London, it seems terribly silly, but everyone was so thin. I wasn't fat, a bit on the chubby side and I thought I've got to get thin, thin, thin. I was recommended to a London doctor who looked after lots of models. I was about 38 and I went to see this doctor and he gave me injections of amphetamine and then pills. I took those until one year after I came here - 13 years. Then I had problems sleeping because of the amphetamines so he gave me Mogadon. So all that time I was taking Mogadon as well and I needed to increase the dose of amphetamines and then I'd have to increase the Mogadon - 3 at a time. We didn't know anything about the dangers of these things. When

I came here my doctor in England gave me 500 Mogadon and God knows how many amphetamines, because I was paying him you see."

5.2 *Development of Dependence*

The substance that the subjects reported as their drug of choice is reported here, although many of the clients substituted and supplemented their drug of choice with other substances and used other drugs opportunistically. Subjects were classified as poly-drug abusers only if they used a number of drugs with relatively equal frequency. This was the case for around 5% of the women in the sample (please see Figure 5.1).

Figure 5.1 **Primary Drug of Choice**



The majority of women in the study had been dependent on alcohol (44%), with psychostimulants and heroin the next most common drugs of choice (20% each). Hypno-sedatives and cannabis were the drug of dependence for around five percent of the sample. Thirty percent of the sample were injecting drug users.

Despite the pharmacological and sociological differences between the drugs of choice among the women in the study there were similar themes on the topic of establishing patterns of misuse and dependence. The primary motifs dealt with social and personal discomfort and work and family environment.

A number of women spoke of the role alcohol and other drugs played in facilitating their social interactions. Lorna, a 23 year old woman who was dependent on alcohol commented that:

> "It started as experimentation and then it got to the stage where I thought I was better off with alcohol in my system. If I got really blotto it would make it easier for me socially, less painful. I was always very shy and nervous and it eased the pain of trying to feel like you belong when I didn't really feel like I did. I thought alcohol was the key to that and of course it did the complete reverse and I turned into my own worse nightmare."

A number of women used alcohol and other drugs to medicate the dysphoria associated with significant mental illness in themselves or family members. Lynette was a 38 year old woman who had used alcohol to deal with her emerging paranoid schizophrenia. She reported:

> "When I was 22 I drank to get drunk and then I lived in the streets of (interstate city) for months in a tent on a mountain and lived on alcohol - Baileys and water from the creek and didn't eat. I was a mess but it wasn't just the alcohol, I was really sick."

A related story is that of Victoria, a 33 year old who was formerly dependent on amphetamines and alcohol. She tells her story that:

> "It was not a close family - my brother is a paranoid schizophrenic and he's quite violent so it wasn't exactly a happy childhood. He started to get sick when I was 8. When I was 26 and he'd not long moved out of home he murdered my father - that's when I started to use heavy drugs. He poured a can of petrol over my father and lit it. I'd been a heavy drinker before that, I must admit, but that's when I really hit it. You know every junkie's got a sob story but that's mine."

The use of psychoactive drugs to deal with personal and social distress and discomfort was also frequently mentioned by the women in the study. Amelia spoke of the isolation and frustration she felt in her domestic role with a husband busy living his life and establishing his career (she is now divorced with her own successful business):

> "When the children were young I'd be drinking beer during the day because I knew my husband wouldn't be coming home and I'd pick them up from school when I was well over the limit. The thing that triggered it off was my first child being born - I didn't enjoy being pregnant, it was bad timing for me from a career point of view and I went for counselling for an abortion and my husband told his parents I was pregnant, so I couldn't do anything else but have the baby then. I was very upset about that. I'd say I had a post- natal depression but neither my doctor nor obstetrician acknowledged that that's what it was but through this whole time they prescribed Valium. I'm still very angry that no-one listened to me or took it seriously or tried to help."

The socialisation of women into dependency on relationships with men to attain true happiness was echoed by a number of the subjects, and this wider social pressure in concert with their unhappy childhoods led them to unwisely enter relationships with men who were frequently substance dependent and violent. Nicola was a 27 year old mother of two who was dependent on amphetamines. She spoke of her experiences with relationships:

> "I met the baby's father when I was 14, that was an addiction in itself I think - an addiction to get this happy family happening. It's taken me all these years to realise I don't need a male to do that."

Esther commented that her substance use was significantly affected by who she was having a relationship with at the time and their habits. She noted that:

> "the first significant relationship I had we did drugs together. Then when I was overseas, I had another major relationship with a man who wasn't into drinking or drugging so I didn't. There was another relationship that I got into for seven months where we just went on a massive binge together. I had very low self

esteem and it was a terrible relationship and I got into it because of that - wanting to connect with him on some level and feeling like drugs was the way to do it."

The work environment and work related stress also had a strong influence on the development of alcohol and other drug problems for a number of the subjects. Faith was a 36 year old woman who was dependent on alcohol and worked in the liquor and hospitality industry living in mining towns and tourist resorts where there was a heavy emphasis on entertainment and heavy drinking. In a different aspect of work and other stressors Lillian commented that:

"I always had problems sleeping and nursing was incredibly stressful, and I was terrified the whole time and didn't know how to say 'I'm frightened'. On top of that I had an enormous amount of family stuff and also trying to deal with my sexuality."

The complex inter-relationship of these issues was summed up by Alison in her comment that:

"that's the way I used it, I used it to cope with having to do a lot and having to work very long hours and having to perform as a lawyer and doing the court runs, it is very exhausting when you start out." Later on in her career she noted that "By that time my marriage was not good and work was everything. I don't know if there is a connection but for me there was - the two went hand in hand - the cocaine kept me at work and it made me work longer - I wanted to work longer, I needed that - I needed to be totally self absorbed in what I did, I liked it and also I had nothing else. I don't know - maybe if I had a happy marriage, if there had been a connection there..but I was married to a nut case..he was violent and emotionally abusive and I went from one family to boyfriend to husband like that ..and it was only once I realised there was a problem in several areas that I decided that I had to stop this."

5.3 *How Substance Use Came to be Viewed as a Problem*

The mean Short Dependence Scale score for the sample was 10.3 (sd 2.5) with a range of 6-14. The cut-off point for a score in the dependence range on this scale is 5, and all subjects scored above this point. The majority of

the women in the study responded that they became aware of the classical symptoms of dependence [as described by Hodgson and Stockwell (1985) and Sutherland, Edwards, Taylor, Phillips, Gossop and Brady (1986)] as a result of circumstances such as inability to access the drug, or a frightening event such as alcohol-related memory loss.

Many of the women reported that the experiences of loss of control of their alcohol and other drug use was an insidious process and it was only when they caught a glimpse of themselves in a mirror or had a sudden image in their mind of a relative or friend with a severe substance dependence did they reflect on their own situation and their possible future. The more obvious consequences of substance dependence such as losing their job or friends did not feature in the stories. The three main themes that arose were: concern for current and future physical or psychological health; a sense of losing their identity, or sense of self, which was often accompanied with a fear of turning into the substance dependent parent they did not respect; and concerns about the welfare of others.

Victoria described her experience of becoming aware of the seriousness of her substance use when she said:

> "my veins were collapsing, I looked a mess. I was gaunt, my skin was disgusting....I didn't look at myself for quite a long time and when I looked at myself in the mirror I thought 'Oh my God! I looked awful', black circles under my eyes, my skin was hideous, I looked seedy and I smelt like my whole body was rotting inside."

For those subjects with substance dependent parents the fear of ending up as their parents did was a very strong motivator for behaviour change. Faith reported that:

> "I was worried about feeling so bad that I knew it would take the whole day or another drink to get over it. I was also scared to death of becoming my mother, after seeing what she went through. She wrecked her whole life with it in the end - work, friends everything. I'd get numb hands and shaky and look like shit and smell like a bottle of bourbon."

Deidre, a 47 year old woman who described her mother as alcoholic and her father as a drunk (because she felt he had a choice about his drinking but her mother was severely dependent and unable to control hers), told of this experience:

> "when I finally stopped drink, I'd been drinking the night before and I was driving and I didn't know where I was, like amnesia, or where I was going and I thought 'this is brain damage' and I remembered how Aunt Gracie was (both her aunt and mother died of alcoholism) and I thought 'this is it', and I never drank again."

A number of the women in the sample talked about more existential crises related to their substance use. Edith, a 77 year old woman who was formerly dependent on alcohol spoke of her experience:

> "I woke in the middle of the night and I saw that I had a bottle beside the bed and I was shaking like a leaf and I had to have a drink - I simply had to - and I thought this has got to stop, I'm losing me. I've gone and I'm losing my dignity and that night - although I'm not a praying woman as a rule - I prayed as I had never prayed before and I begged for help and I said 'help me get over this bender and I'll never drink again'. By 30 I was drinking everyday, including in the early morning and all. I'd lost control of my own life and you get this awful feeling of shame, shocking remorse and you can't live with yourself - it's a dreadful feeling."

For Colleen the decision to stop taking benzodiazepines was a suicidal gesture. She explained it in the following manner:

> "all I know is one day I didn't want them any more - no that's not true - I did want them but I thought if life is just a round of pills then forget it and I'd rather die, and in my head it was only a matter of a short period of time and I would die. I wasn't giving up as a positive thing but because I thought giving up would kill me."

For the mothers in the sample, pregnancy and childcare issues were often a strong motivating factor for behaviour change. Tara, a 47 year old woman reported that:

> "I've wandered out of a restaurant and they found me in the gutter - pretty out of control. The next day I'd always feel terribly ill and I spent a lot of my life feeling like that. I was sick of being sick but I couldn't do anything about it. It was only when I became pregnant and was reading books about what alcohol did to babies. That finally was the motivation for me to stop because I thought 'I couldn't ruin somebody else's potential - I could ruin my own life but not anybody else's.'"

5.4 *Lifestyle Factors Related to Substance Use*

The lifestyle changes that are frequently associated with alcohol and other drug dependence were often mentioned by the women in the sample as integral to their decision to make changes in their lives. The themes that arose were not feeling as though they were like the other people they mixed with when using lots of alcohol or other drugs, the crime and sex work, the victimisation experiences and almost invariably, the sexual acts they engaged in when intoxicated that they subsequently regretted.

Rose, a 21 year old woman who was formerly alcohol dependent spoke of her experiences: "I did night work as a receptionist in an escort agency. I did sex work for a month but it wasn't for me I couldn't handle it. I was going to the pub by myself and meeting dickheads, men and women - associating with idiots." Caitlin spoke of the "junkie mentality" and culture and how she felt about it:

> "I hated it and I hated the people. Like the people you buy it off and the people you hung out with they all, it sounds really snobby, but they are all much less educated. I was living in Darlinghurst, a lot of them were much older and they'd been junkies forever and they were going to be junkies forever. That was one of the reasons I had to give up."

Almost half the sample (47%) had been involved in illegal activity as a consequence of their substance misuse and 16% had been involved in sex work. Overall, 16% had criminal convictions not directly drug-related and 9% had drug-related convictions. The 9% includes driving a vehicle while intoxicated, negligent driving, property crime and assaults.

As a result of intoxication many of the women made themselves more vulnerable to assault and 22% reported sexual assaults in adulthood. Meg, a 25 year old woman who had a poly drug dependence reported that:

> "I was raped, really brutally, by a guy who whacked me on the back of the head with a brick. He picked me off the road. I was tripping at the time and that's why I don't take anything like that now. All the streets reminded me of it, it was a 2 hour ordeal."

As a result of the intoxication many of the women felt unable to report the assault to police, and received little empathy or support from others, which led to intense feelings of guilt and shame. Peta, a 30 year old woman reported that:

> "I was raped when I was drinking but nothing I could report to the police because I was pretty drunk at the time. I got pack raped one time and I didn't remember how I got into that situation. I came out of my blackout as I was being raped and they were threatening me with a knife and they were saying 'why don't we kill her', but they let me go. I was wandering the street and eventually I got home, and I remember my sister was with this guy at the time and he called me a slut."

Related to the issue of sexual violence, are the almost invariable reports of sexual regrets the women spoke of that occurred during the time of their alcohol and other drug misuse. An example of this is Antonia, a 30 year old woman who said she:

> "was not an affectionate or especially happy drunk, but would often find myself in sexual situations where consent didn't seem to be an issue and I was so sexually inexperienced I thought pain was part of it and I didn't know how to say 'stop it you're hurting me.'"

A number of the women spoke of the concern they felt when they awoke to realise the risks they were taking. Deidre commented that:

> "I'd meet somebody and go home to their house and I'd wake up in the morning and think where am I and who am I with - disgraceful! Many times I was in

> situations where I could have been killed, and I've been badly mistreated by men who've dumped me in places where I had no idea where I was and had no transport. That's the thing, when I drank all my fears went."

(Please see Appendix Three for a summary of the motivations for behaviour change and relapse prevention techniques adopted by the women in the study).

6.1 *Help-seeking*

The mean age at the time of making changes in their alcohol and other drug using behaviour was 29.6 years (sd 7.9) with a range of 19-47 years. By that time, the women in the sample had been using for a mean period of 7.5 year (sd 4) with a range of 1-16 years.

As Orford (1978) has noted, the question of whether people solicit the aid and advice of people not usually seen as having expertise in the field of substance dependence is rarely explored. Among this sample the themes that arose in response to questions about their decision not to seek the assistance of recognised experts were their perception of the social stigma attached to women with substance dependence, their preference to rely on available social support, their past experiences with general medical practitioners, and the notion of self-reliance.

When asked whether they felt society looked down more on women or men with alcohol and other drug problems, 78% felt that women were more looked down upon. The notion of double deviance was often mentioned, in that women are looked down upon anyway and even more so when they have a problem that encompasses lack of moral and social restraint with overtones of sexual promiscuity and poor maternal instincts.

While substance dependence is inherently stigmatising, the additional stigma perceived by women was often noted to have negatively affected their willingness to seek treatment from specialist alcohol and other drug services. Caitlin noted that "it's something that I was so ashamed of myself by that stage that I didn't want other people to know or be involved or anything. I became very secretive." Sylvia, a 35 year old woman with a former alcohol dependency commented that:

> "there is the whole societal thing that women shouldn't show themselves to be so out of control - maybe we were poaching on men's territory getting into alcohol - I don't know. That stigma thing was part of the reason for not seeking treatment."

The perception of stigma is not only personal but also a family issue for some women. As Edith noted:

> "My family wanted me to go into a place to dry out and I rang up a friend and said 'I don't want to do it, I want to do it my way as it'd be ugly for the children if their mother had been put in a place - that'd be awful'. One doctor wanted to give me pills, calming pills, but I wasn't in the mood to be dropping one drug for another, and to me that didn't seem right. I knew about private hospitals but the shame for my family was too much. I'd have to have found somewhere for my children to be cared for also, but the shame for them that their mother was put away for grog, was too much."

The importance of support from husbands, in particular, was crucial for the minority of women in stable marriages at the time of making changes in their substance use, and will be discussed in the section on behaviour change. Many of the women talked about mentioning their concerns about their substance use problems to friends and boyfriends, but frequently they were also using alcohol and other drugs, so they tended to reassure them that they didn't really have a problem. It is of interest that none of the women had a sufficiently strong and nurturing relationship with their mother that they were able to discuss their problems and obtain any suggestions or guidance for their resolution from them.

A number of the women discussed their concerns with their general medical practitioners with varying degrees of openness and success. As a consequence of the stigma associated with their substance dependence they often did not mention their problems even when directly relevant to their health care. Antonia said:

> "I had hepatitis when I was 23. I got very ill. I finally went to a doctor and he said 'you've been a very sick girl, why didn't you come to me earlier'. He didn't ask me about my drinking and I didn't bring it up".

A number of women preferred female doctors and occasionally a stern warning in the context of an empathic relationship had a positive effect. Belinda spoke of her experiences with medical practitioners:

> "I was going to one doctor when I was genuinely sick, one who gave me the Doloxene and told me to get off the drugs and another one who just said 'what do you want?' and would have his pen poised above the prescription pad. I remember the doctor I went to when I was sick saying 'if you don't do something before you're 25 you can kiss the next 10 years goodbye' and that really stuck in my mind."

A proportion of the sample, however, had a strong sense of self-reliance and would not have sought help from anyone without protracted efforts to do it on their own. Janet expressed the view that "I told no-one - I've always had the view that if I have a problem and some one else solves it then I still have a problem. I only seek help if I can't do it myself."

6.2 *Sanctions from Others Affecting Substance Use*

A feature of many of the stories of the women in the sample is that their behaviour was very secretive, and frequently no-one knew of the severity of their alcohol and other drug problem and, therefore, they were not often faced with the censure or concern of others. Alison commented:

> "I think I was very good. It's like alcohol - once you realise that you're doing something for the need of it then you start hiding it and making sure it's a very discrete thing, 'cos you're doing it in a very serious way. But you start taking it to work, I went to job interviews stoned, I mean totally high. At work they said 'my God she's so efficient and sharp and she works such long hours, she never gets tired, she doesn't need to take tea breaks, she's so thin and lovely'.."

The younger women in the sample were the most likely to have experienced concern and pressure to reduce or cease substance use, largely from their parents, but this did not appear to have a strong influence on their behaviour. Esther spoke of:

> "lots of pressure, lots of pressure to not be how I was. Pressure from school, parents, friends and therapists. My dad sent me off to shrinks which I hated, it made me so angry - furious, because they were dick heads and treated me like one. I told them all to get fucked. My sister tried to send me to the Wayside Chapel and I told her I didn't have a problem, and the whole time I had this

> image in my head that I really wanted, I was striving to be this addict, I really wanted to be a full-on junkie."

The women in the sample most likely to experience concern and support for change were those in stable relationships. In addition to support from their partners some commented on the intervention by siblings. One subject spoke of the looks of concern she received from her teenage children as an impetus to behaviour change.

It was notable that none of the women were asked about alcohol and other drug use by medical practitioners unless they raised the topic, and one subject who drank heavily during two pregnancies had never discussed alcohol use with her obstetrician.

6.3 Management of Withdrawal

Most of the women in the study had plans for the detoxification period, some of which involved quite complex medication schedules. The withdrawals ranged from immediate cessation to 2-7 day plans, usually for alcohol, to one month regimes for benzodiazepine dependence. A typical heroin withdrawal story is that of Caitlin who managed the first two days with reducing doses of codeine phosphate tablets obtained illegally, and was then able to attend work taking dextropropxyphene napsylate (Doloxene) obtained from her medical practitioner for the next five days to manage her withdrawal symptoms.

Edith had the following strategy for her alcohol withdrawal:

> "I thought how am I going to do this?, I have to have a plan for this - and it was approaching a weekend and I thought if I stop now, suddenly I won't be able to lift a cup to my mouth I'll be shaking so much. So I went up to the hotel and bought a half bottle of brandy. In those days it was impossible to get a drink on a Sunday and I was counting on that. When I found I couldn't get up from a chair or couldn't do this or that because I'd started to shake that's when I decided to have one small nip to pull me together enough to get on with the day's work. I made it last all over the week-end, and that wouldn't have lasted me an afternoon normally, and though I was still shaking it wasn't as bad on

the Monday and I thought 'that's it I can't ever buy another drink - that's the end of it' and for a fortnight I still had the shakes."

6.3.1 Substitution

A number of subjects used drugs other than their drug of choice to facilitate the withdrawal process. Four women, however, developed a problem with the substitution of one problem drug with another. Caitlin, who used alcohol and marijuana to assist with her heroin dependence went on to use them daily at high risk levels for four months afterwards, as did Belinda. Yvonne had a problem with alcohol for a few months after she stopped using amphetamines, which was exacerbated by a relationship with an alcohol-dependent partner. Esther, who recovered from a severe poly drug dependency at 17, went on to develop bulimia at 19 and this triggered an episode of alcohol dependency. All of the subjects had recovered from these dependencies on substituted drugs for more than twelve months before the time of interview.

6.4 Strategies for Behaviour Change

The majority of subjects had a plan for the management of their behavioural change rather than it being an event that simply happened. The plans usually incorporated the central features of the relapse prevention model as described by Marlatt and Gordon (1985). They included self-monitoring if not pursuing an abstinence goal, an awareness and avoidance of high risk situations, an inventory of alternative behaviours, development of new skills, and a positive attitude and renewed determination if a lapse occurred.

6.4.1 Goal

The women in the sample did not strongly favour an abstinence goal, and more than half of the sample (56%) continued to use alcohol socially. Only two of the 14 women dependent on alcohol, however, continued to drink socially. Thirty four percent of the sample smoked marijuana on a social basis, but neither of the two subjects who nominated it as their drug of dependence continued to use it. Only 12% of the sample smoked cigarettes. As this was purely a qualitative study, rigorous standards for harm-free

social drinking were not applied and the women were allowed to label their current substance use as social and having no negative consequences in their lives, as they sought fit.

6.4.2 Intimate Relationships

Invariably the subjects reported that they had to make significant adjustments to their social networks. A number of women made radical changes in their lives by relocating interstate or overseas in order to avoid friends, sexual partners and family. Both moving into and out of sexual relationships figured prominently in the stories.

For women such as Nicola it was central to her recovery to get away from her husband, who she described as violent. She described how he harassed and intimidated her to continue using amphetamines during her pregnancy:

> "The baby's father used to assault me about once a year, the last one was a bit early. He strangled me while I was six months pregnant. It's a shock when someone you love does that to you and I never told anyone 'cos if you deny it - it doesn't happen. The whole idea was that we would have another shot together when the baby was born but I said 'no, no way I've put it at the back of me'. Now he's gone I've gotten less and less dependent on him and I can stand up and say what I think without fear of anything. I moved away from the area I was in because I knew a few dealers and real bad users in that area and I had to get away. It was such a waste of life."

Karen moved from North America to marry in this country and commented:

> "My husband is very conservative and I've changed too. Moving away from people was important - I could have done the same thing here and when I first came here I did sort of start checking out the happening spots. I was offered drugs and stuff but I would never take the risk of losing John. Once you start feeling good you don't want to go back to feeling bad."

For those women in stable relationships their spouse was considered vital to their recovery. Vanessa's comment about her protracted and severe withdrawal from antidepressants, which she was prescribed to deal with her withdrawal from amphetamines, was that in addition to reading self help

books and making sure no drugs were in the house: "my husband's support was the main thing, and my will to get better for my husband's sake as well as my own."

6.4.3 Social Activities

The women took a number of steps to alter their social network such as divesting themselves of unsupportive or substance using friends. They also avoided high risk situations such as pubs, places where they had used or scored in the past (including visiting doctors and chemist shops), and high risk forms of employment such as in the sex industry. They also usually had strategies for those managing high risk situations they could not avoid. Antonia spoke of her experiences:

> "Being around my friends who would get a couple of bottles and 'say go on have a drink we know you want some'. It drove me crazy. Then I started avoiding them and they just naturally fell away from my life. I would spend more time on the dance floor to get away from these people. It took me years to get away from that bad feeling that I wasn't drinking with them. I went through a really reclusive time. Then I went back on the nightclub scene after a couple of years and had no problems. Now I don't drink at all. It doesn't smell good or taste good anymore."

Janet built on an existing ten year habit of abstinence in January:

> "in February I said it was for my weight. Because I was adding to a normal pattern no-one was pressuring me to drink. I smoked for the first year and increased that to 60 a day to make up. I used the dieting as a ruse for a while and then at the end of 6 months they said 'your weight's under control now why don't you start drinking?' and I said 'because I think my drinking wasn't'. Now I just tell people I don't drink anymore because I was a lush and that stops people - they always try and give you what you don't want. I'm a soda water freak and always have a glass of soda water in my hand at parties."

Donna used another strategy: "I drink no-alcohol beer, and I take it with me anywhere there is alcohol likely to be served. I also go to BYO (bring your own) restaurants so I can take it with me."

6.4.4 Additional Activities
The development of new skills and more positive activities was mentioned by all of the women in the sample. Education, either through formal channels by doing courses or through planned reading programs, was a common feature. As Sarah pointed out: "it was important to get an education and feel like I have some choices in my life." The role of exercise was also frequently commented upon. Yvonne noted that: "I stopped drinking and went back to the gym and started going 5 days a week and eating healthily, trying to pull my act together. Going to the gym was my salvation." Many of the women became interested and involved in alternative health activities such as naturopathy, meditation, and tai chi.

Highlighting the idiosyncrasy involved in behaviour change, Janine told of how she recovered from benzodiazepine dependence by doing complex jig-saw puzzles every night for eleven months to give her something else to concentrate on.

6.4.5 Pregnancy and Lactation
As previously noted, pregnancy and lactation were also important in consolidating periods of abstinence that were built on by the women once those constraints no longer applied. Tara reported that:

> "I breast fed my children and that took roughly 2 years that I was off and then I had a taste of my favourite champagne and it didn't taste nice at all. Now when I think back to how sick and out of control I was now, I'd rather die than ever get back to drinking again."

6.4.6 Relapse Prevention Techniques
Those women who did not pursue an abstinence goal utilised self-monitoring and pacing techniques and appeared to have an intuitive understanding of relapse prevention techniques. Yvonne reported that "I'm now drinking socially about once a month and no spirits anymore, I only drink wine. After a certain point I drink water." Faith also spoke of her plan:

> "I self-monitor in my head all the time but I'm at the stage now where I can have a drink and it doesn't worry me. Initially I made some rules, but you're setting yourself up. If you say you're going to have 2 and you have 4 then you think you've failed and say 'oh bugger it I'll have the whole thing'. I'm aware now and I drink a lot of tea. There is no desire there like there used to be. I might sometimes have a beer with friends but I don't get out of control. It was difficult in the industry I'm in but I'm used to it now. I can have alcohol in the house that people bring and it doesn't bother me, it just sits there."

6.4.7 Alcohol and Female Sexuality

The relationship between alcohol and sexuality in society was mentioned by some of the subjects. Faith spoke of the adjustment required when she stopped drinking:

> "after you stop drinking you have to face sex sober - a whole different thing. Not having that confidence that alcohol gives you, having to deal with the way your body is whether you're happy with it or not."

The social perceptions of women and alcohol were highlighted by Amelia when she commented that:

> "women also use alcohol to relax their concerns in sexual situations. There's a bar in North Sydney that has a drinks list where the only non-alcoholic drink is called "not tonight darling" which I thought was a pretty interesting comment."

(See Appendix Three for a more complete account of each subject's motivations and strategies for behaviour change.)

6.5 *Comments on their Motivation to Participate in the Study*

In the planning stages of the project a number of clinicians and researchers commented that it would be difficult to access women with stories of self-managed change. The subjects often spontaneously commented on their motivation for participation. A number of them appeared to want to discuss their experiences and gain some sort of support for their efforts, with an objective professional person who would not be attempting to recruit them into any type of long-term therapeutic relationship, and thereby achieve some closure around the event. Peta commented that:

> "That's why when I saw the thing in the paper I thought here's a chance to talk to someone, objectively, because I've never talked to anyone before. My husband has always been involved and my parents are in Brisbane."

She went on to make some comments on her current anxieties:

> "I think my strict religious upbringing had something to do with it - my mother said my oldest sister is severely retarded because she's making up for all the rest of our sins, and that made me feel really bad and I thought 'she's like that because I'm so bad'."

The opportunity for honest communication was also commented on by Deidre who said: "I can't be honest with anyone else, I can be honest with you because I don't know you. People think I'm so capable and I'm coping but really I'm not." For other subjects the interview was the first time they had discussed their experiences of sexual assault.

6.6 Replication of Biernacki's Model

The model of self-managed change described by Biernacki (1986) appears to adequately characterise the broad categories of the process of resolving alcohol and other drug dependencies without formal treatment among women. There are, however, gender differences in some of the strategies described and in the degree of salience of some of the factors enhancing motivation to change addictive behaviours.

The most commonly cited motivating factors for resolving to stop were concerns for current and future psychological and physical health and existential crises. This is consistent with the work of Goodwin *et al.* (1971), Smart (1975/76), Tuchfeld (1981) and Klingemann (1991). The existential crises usually centred around no longer identifying with the sub-culture of heavy alcohol and other drug use. This dissonance between the impoverished state of their current circumstances and the view they had of themselves as intelligent, middle-class women often came as a result of a seemingly trivial event such as catching their reflection in a mirror and seeing someone they no longer identified with (Waldorf, 1983).

For those women with a substance dependent parent, the recognition in themselves of the behaviours and experiences of that parent, were powerful motivators. Many researchers have examined the influence of parental substance dependence on the subsequent development of such problems in their adolescent and adult children, and it has been accepted for some time that they are at increased risk (Cotton, 1979; Goodwin, 1979). The stressful effect of having two parents with alcohol problems and the alcohol dependent parent drinking in the home have been suggested as particularly important factors by Orford and Velleman (1990). The importance of primary and secondary interventions for alcohol problems in a family setting have been emphasised by a number of authors (McCrady, 1991; Orford, 1984). The gender-specific motivating factors reported by the sample included pregnancy, lactation, and concerns about vulnerability to sexual victimisation and risky sexual behaviours while intoxicated.

The second stage of 'breaking away from addiction' frequently involved major changes in place of residence, social activities and sexual partners. The women in this sample were far more likely to make radical changes in their lives, such as country of residence, than were reported in other samples (e.g. Waldorf, 1983; Tuchfeld, 1981). For the women in the study who had stable partners, the central role this encouragement and support had in their behaviour change was strongly emphasised. Researchers such as Nakamura, Takano and Iguchi (1991) have also reported that women in a "family-involved" treatment group had significantly higher rates of abstinence twelve months after treatment than those women who did not. The importance of harnessing positive social support and divesting themselves of unsupportive sexual partners were important features in these women's stories, as has been reported in other research settings (e.g. Wilsnack and Wilsnack, 1993; Havassy, Hall and Wasserman, 1991; Richter, Brown and Mott, 1991). While Biernacki (1986) and others also reported the importance of family and partner support in the process of self-managed change, none mentioned the concept of breaking away from unsupportive or violent partners which was emphasised by a number of women in the sample.

The phase described as 'staying abstinent' was very similar to that described by Biernacki (1986). Many of the women had quite sophisticated relapse prevention plans and all spoke of the importance of substituting positive social activities and the development of new skills and formal education to enhance their opportunities in life. Just as Waldorf (1983) and others reported drug substitution in their samples, the women frequently substituted one psychoactive drug with another in the withdrawal phase, and a small number experienced a relatively short period of dependence on that substituted drug.

The final stage of 'becoming ordinary', or no longer identifying with the sub-group of heavy alcohol and other drug users, was also a factor for the women in this study. One of the most common changes in identity involved motherhood (Waldorf, 1983), which had a strong impact on their perception of their responsibilities and future lifestyle. The cognitive shift implicit in motherhood, as described by the women, was that they could be responsible for destroying their own lives but they could not inflict that on another person whom they had *chosen* to bring into the world.

One of the most outstanding differences between this group of women and the extant literature on self-managed change was the absence of reported spiritual or religious conversions as a factor in behaviour change. While the sample was relatively small, most other researchers have reported this as an important phenomenon with similar sample sizes of men (Ludwig, 1985; Waldorf, 1983; Tuchfeld, 1981; Hingson *et al.* 1980; Goodwin *et al.*, 1971). A small number of women spoke of developing their spirituality as part of the process of staying abstinent, but religious conversion was not a motivating factor and the religious component of 12-step groups was unattractive for the majority of those women who were exposed to them or considered them an option.

The additional factors of fitness and exercise and alternative medicine (such as massage, naturopathy and tai chi) were also mentioned by the vast majority of the women as important in maintaining their new behaviours.

6.7 *Summary*

While the model of self-managed change described by Biernacki (1986) appears to adequately characterise the broad categories of the process of resolving alcohol and other drug dependencies without formal treatment among women, there were important gender differences. They include the role of pregnancy, lactation, and concerns about vulnerability to sexual victimisation and risky sexual behaviours whilst intoxicated. The failure of this group of women to cite spiritual or religious conversion as a motivating factor in their changes in substance using behaviours greatly differs from the extant literature of self-managed change, which predominantly employed male subjects.

The significant differences in non-substance related variables between women who seek treatment and those who do not has important implications for the development of gender-appropriate alcohol and other drug treatment services. These include the importance of social stability and social support, the effect of having a family history of substance dependence, the paucity of outreach of existing services to middle class women, and the importance of appropriately addressing sexual victimisation in childhood in alcohol and other drug treatment services. This study also highlights the universal importance of primary and secondary prevention strategies in general health and welfare settings for women and girls with a family history of substance misuse and/or sexual violence.

The final issue to be explored in this study was the awareness and perceptions of available treatment services among women who self-manage change in alcohol and other drug use behaviours, and their knowledge of and opinions about appropriate community self-help groups. Finally, their recommendations were be sought about the ways in which such services could be improved in order to make them more attractive for those women with alcohol and other drug problems who are not currently accessing services.

CHAPTER SEVEN PERCEPTIONS OF EXISTING ALCOHOL AND OTHER DRUG TREATMENT SERVICES

7.1 *Introduction*

The second phase of the study of women who self-managed changes in alcohol and other drug use behaviours involved their perceptions of existing treatment services and relevant community self-help groups. In addition, they were asked what recommendations they might have for making such services more attractive to women like themselves.

7.2 *Awareness of Treatment Options*

The majority of women who had self-managed changes in their alcohol and other drug use participating in this study knew at least one option for specialist alcohol and other drug treatment. The most frequently cited options were residential rehabilitation programs and counselling from private psychologists or psychiatrists. The exception to this were the women who were dependent on cannabis. These women were not aware of any treatment options for cannabis problems and thought they were the only people with such a problem. Lillian reported that:

> "The Buttery (a therapeutic community) was just up the road but it never occurred to me there was anything around for me. I thought no-one was addicted to marijuana and I was the only one."

One other subject who felt she had a unique problem was Peta who didn't believe that anyone would have heard of her type of problem or know how to deal with it: "I had a problem that I'd never heard of - bulimia and alcohol that went hand in hand and I didn't think my problems related to services that I'd heard about."

Most of the heroin-dependent subjects were aware of the option of methadone but rejected it for a variety of reasons. Caitlin's comment was typical of the mixture of street mythology and the reality of methadone maintenance:

> "someone told me it is carcinogenic, it dehydrates you, you can't shit, I just hated the thought of it. I just thought if I got on methadone I'd be on it for ages and anyway I didn't want another drug of dependence I just wanted to stop."

The majority of women in the sample who were dependent on alcohol or opiates were aware of the twelve step groups Alcoholics Anonymous and Narcotics Anonymous and their perceptions of these self help groups will be discussed in a separate section.

7.3 *Perceived Barriers to Treatment Seeking*

The barriers to formal treatment seeking nominated by the subjects included the perception that they were different from the sort of people who used such services, the expense they felt was involved, childcare responsibilities, the time they believed was required, and the inappropriateness of the treatment models of which they were aware.

Alison's comment was typical when asked about her awareness of treatment options: "as far as I was aware there were none, and those that were, were for people out on the street." Many of the women spoke of the expense associated with treatment and were only aware of the model of private clinics. As there were very few private clinics in Australia at the time these women were making changes in their substance use, the image of this treatment model must have largely arisen from portrayals in American television programs. The American style chemical dependency treatment services left a strong impression on the minds of many of the women. Lorna summed up her response:

> "The rehabs and detox centres scared me - I'd read stories about the Betty Ford clinic and I thought the same sort of thing might happen in Australia. I think I would have been too overwhelmed, it terrified me to think I'd have to go cold turkey and to feel that someone was constantly looking over your shoulder. You can't get out of there, I felt I would be caged in. I thought there wouldn't be many women. With the other sorts of therapies, the psychiatrists and counsellors, once again I felt they would be too confronting and I wasn't ready for it and I resented them wanting to know anything."

Concern about the religious flavour and numerous rules and regulations of residential programs was a deterrent for others. Belinda commented that she knew about:

> "drug rehabs, but that didn't really suit me 'cos I like to have the control. I didn't want the rules and regulations and people would say 'what's the point of going in 'cos you're only going to make more contacts. If you want to get away from it don't go somewhere where all you're going to meet is junkies'. Up until that point I'd only had to deal with middle class junkies - not the real desperados."

The strong perception that treatment involved long investments of time and money was a significant barrier to treatment seeking for these women.

Childcare obligations were a major obstacle to treatment seeking for the 28% of women who had dependent children at the time of their alcohol and other drug problem. As Nicola noted:

> "I just knew about rehabs I suppose. That was an option I thought about but then I just couldn't imagine myself in that situation, especially with young children. I had no idea what went on there."

7.4 Perceptions of Twelve Step Groups

For the majority of subjects their comments on twelve step groups such as Alcoholics Anonymous, Narcotics Anonymous and Pills Anonymous were based on their portrayal in the media, or because they had attended associated groups such as Al-Anon, Nar-Anon, Overeaters Anonymous, Sex and Love Addicts Anonymous or Co-Dependents Anonymous. Four women in the study attended Alcoholics Anonymous (AA) after they had been abstinent for more than a year. The first, Lynette was advised by workers in a women's shelter, who she reported treated everything with AA, because it might assist in the management of her schizophrenia. Lynette described her experiences in AA:

> "After I'd been sober for years I used to go to the women's group but they never asked me to speak. I have no social life and that's somewhere for me to go. I was working as a bus driver which is all men and here were some women. I needed to belong to a sub culture. My medication was a problem for AA, after I got sick again 5 years ago they put me back on medication. The women also rejected me because I wasn't attractive looking and it's really just a social club. You've got to be a trendy inner city lesbian to get accepted. In AA there's a

> certain style of speech and I'm not able to get it. They call it low sobriety but I think it's programming. When I speak it comes across that I'm not confident and into it and they think I'm just hanging on, but in fact I'm doing a lot better than them. There's a certain AA view of success."

The second subject to have experience with AA was Janine, who attended after she had been sober for a few years, who felt she needed some support following a life crisis. She stayed in AA for twelve months but felt that she never fitted in. She described her experiences thus:

> "I didn't get much out of AA and I had a lot of trouble. I didn't have the story they were after and if I mentioned pills in my story - I couldn't talk about that...I had a go at a guy who tried to 13th step me [AA slang for a sexual relationship between members] from the floor and eventually I had to change my phone number to get away from him...I remember this woman had to bring her young child to AA and this female long-term member told her off from the floor for interrupting their meeting with children. If a woman came in obviously drunk the old girls would swoop on her to be her saviour, but if you looked OK or young they weren't interested. It's OK with them if you use pills, sex, gamble or whatever you like - as long as you don't drink you're straight and sober in AA. It's for pure alcoholics which just don't exist."

The third person in the study to attend AA was Deirdre. She commented that:

> "I went to see a counsellor at a hospital and told her I hadn't drunk for 2 years but I was still unhappy and my nerves are bad and I've still got all my fears and phobias. She told me I was a dry drunk ..and I needed to get to AA and do the steps. I wasn't impressed with AA. They weren't friendly enough and you'd go to meetings and no one would greet you at the door and welcome you... and then at the end of the meeting you'd have a cup of coffee and be standing there all alone. That's why I drank because I couldn't relate to people - no one was capable of reaching out. The other thing is I didn't want AA to be another crutch - a compulsion almost - you start to rely on meetings and I've heard people say that. People were going to 5-6 meetings a week for 15 years and were still so screwed up in the end because they're sober but not learning how to get on in wider society. Who wants to talk week after week about your drinking story - it was only a minute part of what was going on in my life years

> later.... As soon as you start getting into feelings they start judging you and I thought, 'oh is it me again not fitting in, where can you go for help?'"

The fourth subject was Edith who went to AA after a number of years of sobriety for social support and because she felt she should try and help others now she had her life under control.

Some of the themes raised by the women in the sample have already been touched on in the above excerpts. In summary there was an unwillingness to accept abstinence, a perception that it was very religious and rigid in structure, that it was male dominated and confronting, a rejection of the notion of powerlessness involved, and a concern that it was not a positive movement that imparts useful skills.

Commenting on the mandatory goal of abstinence in AA, Rose said:

> "I knew there was AA, but I didn't really want to go because I just thought if I'm going to give up I didn't want to stop, just bang give up, I wanted to do it slowly, and I wanted to do it my way. The idea you can't ever drink again, I wanted to be able to go to parties in a few years and have a few drinks. I wanted to tell people I wanted to tell, not a whole group of people - even though they're all going through the same thing I didn't want them to know my business or things that could pop up, I didn't want that."

The perception that 12 step groups were predominantly religious in nature was a very strong theme. Yvonne, a 23 year old woman formerly dependent on amphetamines and with a concurrent eating disorder, had attended Overeaters Anonymous and described her experiences there as the reason she did not seek assistance from Narcotics Anonymous for her drug dependency:

> "The idea of handing yourself over to your higher power has never clicked with me. I tried for my mother's sake to really get in there but there was just too much religion for me and my experiences with religion were that sour that I couldn't accept it. For my mother this is the perfect religion and she's still shoving it down my throat. I find those programs make you too focused on your problems and your life becomes nothing but the problem and you're

supposed to think of it 24 hours a day and I find I couldn't function 'cos all I was thinking about was food - I can't eat that because I'm supposed to be abstinent - and I have to ring up and check if I can eat this, it was too much."

A further aspect of 12 step groups that a number of the women rejected was the notion of powerlessness. As Lillian explained:

"I wasn't interested in God or higher powers and wasn't interested in saying I couldn't deal with it myself. I could relate to the insanity and serenity but not to the idea that I had to rely on another power. In terms of my life story it didn't make sense, after the enormous amount of independent survival it didn't make sense to have to turn around and ask something to take care of me."

A number of the women commented on the notion that AA was male-dominated. Donna, a 40 year old woman who had a dependence on alcohol explained:

"I'd heard of AA but I'd not known anyone who'd been to it. I'd seen it on the television and it didn't seem to fit who I was - mainly men who drank all the time and behaved in antisocial ways and I was never antisocial. I don't like groups and wouldn't like to go up and tell someone that I'm an alcoholic. I would feel vulnerable and judged even though they're the same."

The final theme expressed by many of the subjects was that 12 step groups often became very negative and depressing because they dwelt on the stories of substance use and did not impart positive skills-enhancing messages as previously expressed by Deidre.

8.1 Introduction

While 6% of the subjects were adamant that they would never be attracted to any kind of specialist alcohol and other drug treatment service, the remainder made suggestions for improvement. These fell into the broad categories of telephone counselling and out-patient services with flexible hours, which were gender sensitive, professional and skills oriented with a non-confrontational style and that adopted a holistic approach to health. Education of medical practitioners was also seen as important.

8.2 Out-Patient Services & Hours of Operation

The majority of women in the sample endorsed the availability of out-patient services that were open during the evening and week-ends. As Janine pointed out: "there should be more programs and groups offered after 9-5 Monday to Friday, and because there is nothing available outside business hours people are pushed into AA which they might not have wanted to do originally." Sally commented on the need for:

> "professional counselling by a professional on an outpatient basis. I needed someone to listen to me and also to say this is normal and you're doing really well. To say have you looked at such and such skills and maybe some exercise sort of thing."

Those women in the study further marginalised by mental illness and unemployment emphasised the need for a "drop-in" style of centre where they could feel safe and relaxed and have time to develop a rapport with staff before being expected to tell their story and ask for assistance. Telephone counselling was also a popular option as it is non-stigmatising and could encourage them into a therapeutic relationship or a more intensive treatment program once they felt safe. As Donna commented: "A telephone counselling service would be good - someone who knows the facts not just a consoling person, a professional person who's up to date with the latest information."

8.3 *Women-Only Services*

Although the subjects were not specifically questioned on the value of women-only services, 16% mentioned them as something that would be absolutely crucial for their recruitment into a treatment service. As Alison said:

> "If there had been a women's service.... That's my biggest beef I'm not a strict feminist but I won't go to a male gynaecologist any more, there are areas where I don't think there is a good rapport with males. I could never talk to a man, and I think also for things like drugs and things that get you into trouble. If there had been more women's services without being under the label of lesbian separatist, I would certainly have taken that option and saved myself a lot of pain. For women it should be someone who is a professional with no stigma. One of the problems is the money. Most women can't afford to see a psychologist - it's not covered by Medicare and you do 10 sessions and that's it, it's not long enough for serious problems."

Lorna summed her feelings up by saying:

> "..women's services, it's important to have somewhere where women feel safe and can have female therapists. It should have a relaxed atmosphere and have a drop-in component. It should offer assistance for a range of issues, not just the alcohol problem alone."

8.4 *Holistic Approach*

A service with a holistic approach to health was frequently suggested by the subjects. The inclusion of gentle exercise to reinforce feelings of good health, integration of mental health and alcohol and other drug services, social skills, assertiveness training and conflict resolution skills, massage, meditation, and parenting skills classes to be available. As Donna noted:

> "I missed having a nurturing mother, so I had no role models for how to be a daughter or a mother, and I always had to be saying 'is this what I should be doing?, is this right?' and never feeling adequate. After going to [an expensive private 28 day residential program for eating disorders] I think who can afford that sort of treatment and does it work anyway, this going back into your childhood in group therapy and after 6 weeks I thought 'what good does it do?' They did no individual counselling and taught me no skills. I needed something

skills-based, to teach me how to get on with people and improve my self-esteem. All these treatments are out of reach to the normal person, even seeing a psychologist is expensive, especially to people with alcohol and other drug problems. There are detoxes that take Medicare cover but they only send you to AA after that."

8.5 *Education of Medical Practitioners*

The women in the study also had suggestions for improved education of medical practitioners and psychiatrists about their prescribing habits and assessment procedures. Janine spoke of her experience:

"better education of GPs and psychiatrists and more networking between professions. I had asked them to write across the top of my chart at the doctors not to prescribe me tranquillisers, and when I went to see him after my husband left, he offered me Valium and I said 'no, then I'd have two problems instead of one.'"

Vanessa was also disturbed by her experiences with the medical profession:

"No, the doctor didn't discuss any treatment options, he just put me on Tryptanol which I think was wrong. But I was not able to look after my own treatment then, like I can now. He once wanted me to go and see a psychiatrist but I wouldn't because I thought he'd give me more Tryptanol. Now I realise I was suffering from amphetamine withdrawal and should have had a different type of treatment altogether."

8.6 *Additional Suggestions*

The role of workplace programs was mentioned by a number of subjects who lamented the lack of such services and the need for working woman with alcohol and other drug problems to have them detected and be assisted in a confidential manner. Nicola had two further comments:

"Those ads that are on the television are quite good [she was referring to a harm reduction campaign called Speedwise Speedsafe] but they need to also be aimed at single mothers and unemployed people. Dope (cannabis) should be more available because it's easier to score speed than pot and that is so wrong."

8.7 *Suggestions for Alcohol and Other Drug Interventions*

As only a small percentage of women in the sample would not consider treatment under any conditions, there appears to be a great deal of scope for improving recruitment and retention rates for specialist and generalist alcohol and other drug treatment services. While many of the women had some notion of available treatment resources, there were significant gaps in their knowledge. The importance of outreach activities by existing services through media coverage in women's magazines and presentations at a variety of women's groups was emphasised by the women in the sample.

The most strongly endorsed option was a non-residential service which offered a telephone counselling and an informal 'drop-in' component which provided access to childcare, and that was also available during the evening and on week-ends. The 'drop-in' component was particularly important to women with serious mental illness and the need for sensitivity of such services to their needs was emphasised. As the sample had very strong objections to 12-step self-help groups, such a service should provide an on-going women-only and/or mixed-sex support group. Such a group would provide the positive aspects of on-going social support from peers but also have access to professional counsellors to contribute skills development techniques such as social skills and assertiveness training, which so many of the women regarded as important to their recovery.

The role of on-going support was also raised in the context of length of treatment. While many of the group benefited from self-help manuals and other forms of brief interventions such as medical practitioner's advice to quit, others mentioned that they felt the need for more than substance-specific therapy and would have valued a longer-term therapeutic relationship to deal with related issues in their lives such as sexual violence and parenting skills.

Many of the women called for a women-only service. While this may not be economically viable in all communities, gender-sensitive components such as the option of a female counsellor and access to women-only groups for

the management of sexuality and relationship issues would be an appropriate option for traditional mixed-sex services. The desire for professional staff who employ a non-confrontational therapeutic style was also emphasised by the women in the sample. This emphasis on professionalism appears to arise from their concerns about stigmatisation and labelling and a belief that this is a particular feature of peer group "counselling" such as Alcoholics Anonymous.

A further concern related to self-help groups such as AA, was the choice of outcome goal. More than half the sample did not wish to become abstinent but to continue the use of alcohol and/or cannabis on a social basis. The preference among women for controlled or social drinking outcomes has been reported in the treatment literature by Miller and Joyce (1979), Helzer, Robins, Taylor, Carey, Miller, Combs-Orme and Farmer (1985), Sanchez-Craig, Leigh, Spivak and Lei (1989), and Sobell, Sobell and Toneatto (1991), but not by others such as Bromet and Moos (1979) and Orford and Keddie (1986). The importance of offering women a goal of social drinking, provided there were none of the accepted contra-indications, would be an important feature of an accessible treatment service for women.

The stigma associated with the label alcoholic has been recognised as a barrier to treatment for men and women (reviewed in Acker, 1993; Cunningham, Sobell, Sobell, Agrawal and Toneatto, 1993). For women, however, the social stigma associated with dependence on alcohol and other drugs is magnified, as it is more strongly linked with moral laxity and deficient maternal instincts (e.g. Blume, 1991). The request for telephone counselling and more informal and ongoing support in an out-patient setting, with professional staff bound by confidentiality constraints appears to be an attempt by these women to facilitate a less confronting and stigmatising treatment model. While the SMC group appeared to have similar levels of dependence and patterns of consumption to the treatment group, there were other reasons that they did not require residential treatment. These include more social resources and less traumatic and chaotic backgrounds. These suggestions, therefore, do not preclude the

necessity for residential services for those women whose psycho-social and medical profiles suggest that they require them.

The additional points raised were cost and a holistic approach to patient care. Many of the women commented on their inability to pay for expensive private treatment. This was not only confined to women on low incomes who had spent their resources acquiring their drug of choice. It also included women who were not working outside the home, and those who left their spouse in order to make the necessary changes in their life and had very limited resources for themselves and their children. The importance of a holistic approach included the need to address issues such as sexual violence in long-term counselling, and also massage, gentle exercise and naturopathy in a treatment program to increase a general sense of well-being and the regaining of strength and control.

For the small percentage of women who would not seek specialist treatment for alcohol and other drug dependence under any foreseeable conditions, comments were made on the importance of educating general medical practitioners and obstetricians and gynaecologists. The failure of medical practitioners to detect and intervene in significant alcohol and other drug problems among this group of women and their continued reliance on prescribing hypno-sedatives and anti-depressants to deal with life stress, require on-going and increased vigilance by medical under-graduate institutions and those providing continuing education programs for medical practitioners. The more focused targeting of public health campaigns was also mentioned to include young women, mothers and the unemployed.

The need for wider deployment of industry-based employee assistance programs targeting substance misuse problems was also raised. The difficulty of attracting women into such programs has been examined by Cahill, Volicer and Neuberger (1982). They found that specialist programs to educated employers and employees on the needs of female employees with drinking problems resulted in an increase of female referrals and a decrease in the proportion of female clients with prior disciplinary action.

8.8 Summary

In conclusion, the women in the self-managed change group highlighted a number of important factors for the reduction in alcohol and other drug problems for women in the community. These included improved outreach by existing services, improved training of medical practitioners to detect and intervene for alcohol and other drug problems among women, and more widely focused public health campaigns.

There were a number of suggestions for ways in which treatment services and interventions *per se* might be improved. Contrary to the prevailing notion of demonstrating motivation for treatment by proving you only want to 'do it for yourself', the salience of concern for others, particularly spouses and children, should be utilised where appropriate by therapists to engage women in treatment as part of a motivational interview (e.g. Miller and Rollnick, 1991). The importance of early interventions for adolescent girls, particularly those with substance dependent or psychologically unavailable parents, has also been emphasised by this group of women.

The importance of the additional options of a non-residential service which offered a telephone counselling and an informal 'drop-in' component that was also available during the evening and on week-ends was highlighted. Additional components that were considered important included: the option of a non-abstinent outcome; professional therapists; and non-confrontational models which also offered non-stigmatising peer support groups. The provision of a gender-sensitive service, the option of a female counsellor, childcare facilities and a holistic approach which made available long-term counselling for issues such as sexual violence, were also considered integral to an overall policy for reducing the harms associated with alcohol and other drug misuse among women.

APPENDIX ONE GENDER ANALYSIS IN STUDIES OF SELF-MANAGED CHANGE

AUTHORS/ YEAR	METHOD/ SAMPLING	CRITERIA FOR INCLUSION	TOTAL N/ ♀ N	GENDER ANALYSIS	FINDINGS
Saunders & Kershaw (1979)	A community study of the prevalence of alcohol-related problems and processes significant to recovery	To be classified as 'definitely alcoholic' had to score 2+ on the SMAST, to self-identify as having alcohol problems in the past and an unspecified "cluster of alcohol-related disabilities". Abstinence not a criterion	3,600 persons screened, 19 were classified as past 'definitely alcoholics' of whom 13 were now abstinent or drinking within safe limits. 7 of these 13 had received treatment/1 female in final category of currently recovered without treatment	Gender differences were not mentioned in the text but sufficient information was provided for this author to make a comparison	Spontaneous remission occurs more commonly among the less dependent, the processes involved concerned significant life events such as marriage and job change. For the only woman it was seeing others drunk when sober
Tuchfeld, 1981	A qualitative study in which subjects were recruited from newspapers, radio and television advertisements	Sustained resolution of alcohol problems for one year and having received no formal intervention including Alcoholics Anonymous. Abstinence not a criterion. Collateral interviews with spouse	162 people returned the questionnaire of which 51 were found to have resolved without treatment/16 females	Nil	Factors associated with resolution were physical health, learning more about alcoholism, religious conversion, influence of family and friends, financial problems, alcohol-related death of a significant other, legal problems and "extraordinary events" which included pregnancy

AUTHORS/ YEAR	METHOD/ SAMPLING	CRITERIA FOR INCLUSION	TOTAL N/ ♀ N	GENDER ANALYSIS	FINDINGS
Waldorf, 1983 This data is also reported in Biernacki, 1986	A qualitative study of ex-opiate addicts, half of whom recovered without treatment. Sampling method was chain referral	At least one year of daily opiate use, >5 of a list of 10 withdrawal symptoms and 2 years without daily use - abstinence not a criterion. Treatment was defined as >3 days in a treatment program and >21 days in a detoxification or jail program	201 total of whom 101 were recovered without treatment/ 30 females	The numbers of women in the samples were reported but no gender analysis were reported	The five most important reasons were: time to do other things, fear of the lifestyle consequences, fear of loss of significant other, fear of returning to prison, and concern for health. They described religious or ideological conversion, environmental influences, substitution and drifting to the mainstream as salient factors
Graeven & Graeven, 1983	A longitudinal community survey of adolescents over 10 years. A chain referral sampling method was used	Heroin addicts were defined as those who had self and other perceived dependence and a pattern of daily use	76 of those identified as addicted were interviewed of whom 22 had no treatment/10 females	Nil	Factors apparently associated with recovery without treatment included close family relationships especially with the mother, having friends, having spent time in prison but not belonging to a deviant group

AUTHORS/ YEAR	METHOD/ SAMPLING	CRITERIA FOR INCLUSION	TOTAL N/ ♀ N	GENDER ANALYSIS	FINDINGS
Ludwig, 1985	A sub-study of a cross-sectional study of alcoholics. Subjects were recruited via newspaper advertisements and the researchers clinical practice	Subjects who responded to the advertisements were screened on the basis of 12 months abstinence without the assistance of AA or formal treatment	29/2 females	Nil	The factors facilitating spontaneous recovery include fear for the future consequences, physical illness, physical aversion, change in lifestyle and a spiritual experience

AUTHORS/ YEAR	METHOD/ SAMPLING	CRITERIA FOR INCLUSION	TOTAL N/ ♀ N	GENDER ANALYSIS	FINDINGS
Sobell, Sobell & Toneatto, 1991	A longitudinal study of natural recovery with a 5 year follow-up period. Sampling was via advertisements in newspapers, television and radio	Subjects who responded to the advertisements were screened using the following criteria: recovered for more than 3 years, score >5 on the MAST, zero BAL at time of interview, collateral information supplied, no history of treatment including >2 Alcoholics Anonymous meetings but may have attended detoxification. Abstinence not a criterion	In the two resolved without treatment groups there were 92 subjects/ 17 females	Analysis of gender differences was only performed for group membership	Content analyses not yet published

AUTHORS/ YEAR	METHOD/ SAMPLING	CRITERIA FOR INCLUSION	TOTAL N/ ♀ N	GENDER ANALYSIS	FINDINGS
Klingemann, 1991,1992	A qualitative study of problem alcohol and heroin users recruited via newspapers and radio announcements	Subjects who responded to the advertisements were screened for a significant improvement in alcohol (<30g/day) or heroin (<2/month) consumption which had been achieved without any or minimal treatment or self-help groups for > 1 year. Abstinence was not a criterion	60 subjects of whom 2/3 had some treatment or self-help experience/30 females in the sample	Nil	Identified a motivation phase, decision implementation phase and a struggle for maintenance. The coping mechanisms described included diversion, self-monitoring and distancing
Leung, Kinzie, Boehnlein & Shore, 1993	A 19 year longitudinal study of a native American village. Half the village was interviewed but information on sampling technique not provided	The DSM-IIIR criteria for alcohol abuse and dependency. Abstinence was not a criterion	131 were interviewed, 46 from the initial sample, and 46 who were remitted alcoholics/ 21 female	Gender analysis of prevalence and drinking styles reported but not of reasons or processes in stopping drinking	Treatment was not a major factor in reduced drinking rates. Improvement in economic, social and cultural circumstances were cited. For individuals a recognition of the social and financial problems associated with alcohol dependence

APPENDIX TWO **NON-TREATMENT INTERVIEW SCHEDULE**

City ______________________________

Age (yrs) ______________________________

Current relationship situation ______________________________

Current circumstances (children, accommodation etc)

____

____

____

____

Family background (culture, language, religion, who you lives with, most salient memories of family life)

____

____

____

____

____

____

Education/Employment (years of schooling, work experience, post school education)

___

___

___

___

Any significant relationships and obstetric history

___

___

___

___

Drug use history (who introduced, age first used, used what, how - transitions in use, why, feelings at that time)

___

___

___

When did you begin to use a lot (what started off heavy use, relationships, using how much, how often, how long)?

When did you begin to feel that your drug use was becoming a problem and why?

Short Dependence Scale - when you where using just before you decided to quit

Did you ever think you drug use was out of control?
Never Sometimes Often Always

Did the prospect of missing a short make you feel anxious or worried?
Never Sometimes Often Always

Did you worry about your drug use?
Never Sometimes Often Always

Did you wish you could stop? *Never Sometimes Often Always*

How difficult would you find it to stop or go without?
Not difficult Quite difficult Very difficult Impossibly difficult

Did you ever have to do things you'd rather not do to pay for your drug use e.g crime, sex work etc and did you spent any time in prison or have any convictions as a result?

What was your health like at the time of your using e.g. HIV/Hep A-C, psych admissions, suicide attempts, self mutilation, eating disorders etc?

Have any of these problems continued?

Have you ever experienced physical or sexual assault or unwanted sexual contact throughout your life? what kind, by whom?

____

Have you ever experienced domestic violence? where you or the perpetrator intoxicated at the time?

____

____

____

Did ever report any of these assaults (family or police, if yes what happened, if no why not?)

____

____

Did you talk to anyone about your drug use concerns?

____

____

____

Where people telling you to do something about your substance use?

What treatment options did you know about?

What had you heard about them (positive and negative)? why did you decide not to go to one?

Did you think people look down more on women or men (counter-balance gender order) who have alcohol and other drug problems?

Had you heard about self-help groups like NA/AA etc - what had you heard about them and why did you decide not to attend?

Did you experience a physical withdrawal? what were the symptoms and how did you detox yourself?

What did you do/use to help you get clean e.g. changed drug type, moved away from using friends etc

How long have been clean/sober now?

What were the things that worked for you in getting/staying clean?

What do you use now e.g. smoke cigarettes, social drinking or dope smoking?

___

___

What do you do to ensure your use doesn't escalate again? e.g. what are the warning signs and what action do you take?

___

What ways do you think treatment services could be improved that would have made you feel comfortable to go there?

___

___

___

Is there anything we haven't discussed that you think is important or do you have any questions for me?

___

___

___

Many thanks for your time

APPENDIX THREE

A SUMMARY OF SUBJECT'S MOTIVATION AND STRATEGIES FOR CHANGE

Subject No	Pseudonym/ age	Drug of Choice	Motivation/Strategy for Change
1	Caitlin 26	heroin	existential crisis [no longer a nice middle-class girl]/ substituted with heavy alcohol and cannabis use for some months but has now cut right down and also given up smoking cigarettes, changed social circle and developed a closer relationship with her family
2	Rose 21	alcohol	existential crises [not feeling like a real person], sex work and sexual assaults by strangers/ used heroin briefly during withdrawal, still went to pubs to play pool but drank water, went to the beach a lot and visited family in another state. Now can have alcohol in the house after 6 months and not drink
3	Joy 23	amphetamines	her husband, who had been using very heavily, was in hospital as a result of an accident so she could no longer use with him, she also had been very sick after 5 day binges, they were also homeless and unemployed/got involved in work and enjoyed having a clear head
4	Antonia 30	alcohol	concerned about her health and weight/avoided friends in nightclubs and didn't go back for a couple of years, got involved in alternative medicine and exercise
5	Cassie 21	amphetamines	concerned about her health [found ecstasy particularly dependence-producing] and finances/ planned to do activities each day such as going to the park, avoided using friends, now has also given up cigarettes
6	Yvonne 22	amphetamines	got sick of lifestyle and concerned for her health and weight/moved interstate, used alcohol and cannabis during withdrawal which became a problem as her boyfriend became an alcoholic and she had to leave him, returned to Sydney and got into exercise and avoided friends who used

Subject No	Pseudonym/ age	Drug of Choice	Motivation/Strategy for Change
7	Ester 22	poly drugs	concerned about health and the relationship between her drug use and bulimia/ went overseas, avoided drugs and mixed with healthy people, did 'spiritual things' such as meditation
8	Alison 37	cocaine	concerned about danger of being caught as she got more desperate to obtain the drug and being dependent/ valium during withdrawal, avoided people who used and left unsupportive husband to move to another country
9	Fiona 51	hypno-sedatives	withdrawal symptoms when the prescription ran out/ read self-help books that were available in bookshops and followed tapering regime described
10	Lorna 23	alcohol	unemployment, family pressure and health effects/ relied on family and friends for support
11	Victoria 33	amphetamines	existential crises of seeing herself in a mirror and health concerns/ got clean from speed using exercise and alcohol but has since given up alcohol and cigarettes
12	Annette 34	cannabis	concerned about ending up like her father and wanted to be clean to confront him about her childhood/ homoeopathy and avoided relationships with men who used alcohol or other drugs excessively
13	Faith 36	alcohol	concerned about ending up like her mother and sexual regrets/ gave up for periods of a month with a female relative and when that person when back to drinking she just continued not drinking until she learned how not to drink excessively - she initially made rules about only 2 drinks at any one occasion but learned that if she made rules, when she broke them she experienced the abstinence violation effect, so now she just monitors how she feels and drinks a lot of tea, exercise, dropped friends who drank heavily, reminded herself how good she felt
14	Sylvia 35	alcohol	bleeding gastric ulcer and other health effects/ strict diet that involved fasting, broke up with boyfriend, changed friends

Subject No	Pseudonym/ age	Drug of Choice	Motivation/Strategy for Change
15	Karen 35	cocaine	chronic nose bleeds, financial problems, disliked people she had to associate with/ met a non-using man and moved to Australia, self-help books and naturopathy
16	Donna 40	alcohol	felt guilty and unhappy and wanted to feel proud of herself/ lots of fizzy drinks and non-alcoholic beer whenever she's socialising, meditation
17	Margaret 30	amphetamines (diet pills)	health effects and doctor shopping/ substituted with coffee and cigarettes, naturopathy, left the sex industry, self-help books, changed friends, moved to another suburb
18	Maggie 25	poly drugs	existential crisis [turned into someone she didn't like], severe sexual assault by stranger/ moved to Australia, exercise and study
19	Lynette 38	alcohol	severe mental illness/ take medication to control schizophrenia, employment, succeeding in tertiary study, sober friends, fussy about sexual partners and can now control drinking to the extent of having bought a bottle but didn't have a drink
20	Lillian 37	cannabis	causing conflict in relationships, memory problems, paranoia/ fasted, tai chi, co-counselling, renewed interest in music, moved to a sober household and changed friends
21	Sally 22	heroin	difficult relationship with boyfriend who was HIV+, lifestyle and sex work, work problems; made a number of attempts and had been heavily into alcohol and cannabis as a young teenager/ had to go into hiding to escape boyfriend, changed friends, improved education and obtained a vocational diploma to feel like she had some choices, reminds herself of the negatives as she still craves after 2 years and lives with a sexual partner who is a counsellor in a therapeutic community

Subject No	Pseudonym/ age	Drug of Choice	Motivation/Strategy for Change
22	Peta 30	alcohol	health effects and multiple problems from intoxication [criminal charges and sexual assaults], got married, stopped drinking during first pregnancy then re-commenced and after binge at 32 weeks pregnant decided she had to stop completely/ changed social life, avoids alcohol completely (even in christmas cakes) and smokes cannabis on rare occasions of going to parties
23	Colleen 46	hypno-sedatives	motivated by wish to die/ after realising she wasn't going to die after withdrawal was completed she avoided chemist shops and doctors and reminded herself if she took any more she'd have to go through withdrawal again
24	Tara 47	alcohol	pregnancy and lactation/ breast feed two babies which took 4 years in total and by then had time to reflect on how out of control she had been and had lost the taste for alcohol
25	Amelia 43	alcohol	concern for her children's safety when driving while intoxicated/ got divorced, meditation and conflict-resolution skills, drinks socially but monitors how she's feeling and switches to soda water
26	Janine 53	alcohol	had been dependent on barbiturates 20 years ago and then 4 year later on alcohol, scared by rapid development of dependence symptoms over 6 months of first alcohol use [had previously been scared of alcohol because her father and first husband were alcoholics]/ read self-help books, generalist counselling for bi-polar affective disorder, did courses in welfare and counselling, has also managed a gambling problem without formal assistance
27	Vanessa 54	amphetamines (diet pills)	when she moved to Australia she was unable to get amphetamines prescribed/ was prescribed anti-depressants for 12 months and withdrawal from those she described as "horrific", read self-help books, husbands support was absolutely central to her recovery

Subject No	Pseudonym/ age	Drug of Choice	Motivation/Strategy for Change
28	Janet 43	alcohol	health effects and impact on her career, weight gain, sexual regrets/ prolonged her traditional January abstinence period of 10 years duration, smoked cigarettes heavily for the first year, drinks lots of soda water and exercises
29	Nicola 29	amphetamines	pregnancy/ broke-up with boyfriend who used, moved to another area, changed friends and involved herself in her work
30	Deidre 47	alcohol	became aggressive, existential crisis of ending up like her mother when she had an episode of amnesia when driving [strong fear of going mad]/ husbands support was very important but it took him a while to realise she couldn't drink at all, dropped friends who drank heavily, reduced social life, drinks soft drinks at parties that look like alcohol, now even during crises drinking never occurs to her
31	Belinda 28	heroin	after several half-hearted attempts in the past a successful sexual relationship and pregnancy were the final motivators/ support from partner, moved interstate, exercise, avoided people who use, avoided cues to using like certain music, substituted with alcohol for the first 6 months but also gave that up when pregnant
32	Edith 77	alcohol	existential crisis [feared she'd lost her identity and dignity]/ got a job, acknowledged deep down that she couldn't drink and so people drinking didn't bother her as she was so disgusted with herself - after 30 years of sobriety she commented that "the remorse is going but the disgust is still there"

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