

***“You don’t even wash your face,
let alone anything else”***

**Exploring Understandings of the Relationship between
Alcohol Misuse, Sexual Health Risk and General Health
Outcomes among Scottish Women Offenders**

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Executive Summary

Background

Alcohol misuse or heavy consumption in general is associated with a number of poorer general and sexual health outcomes (including risky sexual behaviour and sexually transmitted infections). Women involved with the criminal justice system have been identified as a highly vulnerable population in terms of health; in addition, alcohol misuse has been found to be significant problem among female offenders, often coexisting with abuse of illicit substances. Despite this, little is currently known about this population's understanding, or the salience of, the relationship between health and problem drinking. As meeting the health needs of women offenders is likely to be a complex and expensive exercise, it is important that policy makers and practitioners are aware of the extent and nature of these problems and the best way to invest funds and resources. To explore these issues, interviews were conducted with 19 women (reporting previous involvement in the criminal justice system and problematic alcohol and/or drug use) who were attending a community-based rehabilitation centre. Overall, the aim was to provide a more holistic understanding of health and sexual health and their relationship to alcohol (and other substance use) in this vulnerable population.

Key Findings

Initiating Alcohol and Drug Use

- Analysis revealed that women perceived their alcohol and drug use as a process underpinned by the increasing experience of disconnection from the self and others, and recovery from addiction as a reversal of this process. Alcohol and drug use in the initial stages was fuelled by the experience of social and emotional isolation with which the use of licit and illicit substances was viewed as an effective means of coping. Substance use was perceived as a way of achieving psychological disconnection from aversive emotions associated with the experience of traumatic events experienced in both childhood and adulthood (i.e. loss and victimisation often occurring in the context of emotionally cold or rejecting relationships). Paradoxically, substance use was also viewed as a way of connecting with others, providing a means of gaining acceptance or intimacy within the relational setting. First drug of choice (i.e. alcohol or illicit drugs) was dependent on availability and normative use within social circles. This noted the initiation of drug use was different from alcohol use in the respect that drug use was often initiated to achieve a sense of connection with a drug using partner.

Continuing Alcohol and Drug Use

- Over the longer term, use became increasingly driven by the physical and psychological need for the drug itself as well as the perceived need to cope with the negative social consequences of drug use. Periods of sobriety led to experiences of extreme emotional distress which were aversive and increased

the likelihood of a return to substance use. A complicating factor was the persistence for many women of negative life events which was a further disincentive to stop using or drinking.

- Given that substance use provided only a temporary solution to emotional distress, attempts to desist were often unsuccessful as the underlying problem remained. In attempt to cope more effectively, women chose to substitute one drug with another. Choice of substitute drug was largely attributed to availability. However, a contributing factor was negative perceptions of the previous drug and a fear of reliving the negative consequences of using that drug. Crucially, whilst substitution of alcohol with illicit drugs (typically heroin) was seen as a progression in the seriousness of use, substitution of illicit drugs with alcohol was not viewed this way. Indeed, alcohol was seen as having other advantages, being viewed as more socially acceptable and convenient, better value for money and importantly, less likely to lead to dependence than illicit drugs.
- With growing dependence came increasing disconnection from the self and others as the drug gained centrality in women's lives. This was especially notable among heavy drinkers who reported increasing self-isolation.
- Prolonged use culminated in the experience of total disconnection or 'hitting bottom' described as a period during which life ceased to have meaning or value. Reaching this low was viewed as necessary stage in the process triggering conscious recognition that desistance from use was required for survival. Recovery was described as an experience of reconnection wherein the 'real' self re-emerged and relationships with others were rebuilt.

Perceptions of Physical Health Risks

- In the initial stages of use, women felt personally invulnerable to negative health effects of both drugs and alcohol. While in some cases an awareness of the possible long-term consequences of using or drinking was apparent, women did not view these risks as personally relevant. Rather, the positive benefits of use (in terms of alleviating emotional distress and connecting with others) outweighed concerns regarding possible risks to health.
- Whilst some women attributed continued use of substances (in the face of sometimes very serious health threats) to lack of control over their use, others clearly felt that the costs of coping with the extreme emotional consequences of sobriety were a powerful disincentive to desisting. Instead, alcohol and drugs were used as self-medication, i.e. pain management, as health deteriorated.
- Medical help only tended to be sought as a last resort or where health conditions were seen as impeding the ability to procure substances (more likely in drug users). For heavy drinkers who tended to self-isolate, help-seeking was especially problematic, as imposed self-isolation brought feelings of security and comfort and contact with others was seen as threatening.

- Physical deterioration represented only part of women's motivation to desist. A key factor appeared to be a growing awareness of the damage done to relationships because of substance use and a wish to repair or renew some of those relationships. This was prompted by a perceived shift in the understanding of a valued relationship. The possibility of gaining, or indeed losing, a relationship that women had come to realise as valuable appeared to be the key factor in decisions to desist.
- Recovering physical health was perceived as secondary to achieving mental wellbeing. Increased mental wellbeing in turn facilitated a growing awareness of the value of care of the physical self as the increasing importance of valuing the self was extrapolated to valuing the body.

Understandings of Sexual Health and Risk

- The role of alcohol in sexual behaviour and sexual risk behaviour was complex. While participants cited the causal role of alcohol use in risk behaviours (i.e. condom non-use and having sexual intercourse with a number of partners), it was clear that alcohol was also used instrumentally in this context; to facilitate sexual behaviour and, sometimes, sexual risk behaviour. In this sample, reported condom use with non-commercial sex partners was inconsistent.
- Calculations of risk in relations to sexual behaviour were based primarily on the perceived 'safety' of a sexual partner, and absence of overt signs of ill health. For women who had worked as prostitutes, perceptions of risk were informed by their sex work in a variety of ways, leading to a decreased likelihood of risk reduction practices in personal relationships. It was notable that accurate knowledge about STIs was very low in this sample.
- As for physical health, women rarely sought sexual health care and such care was mostly opportunistic. Barriers to seeking care included lack of knowledge and the chaotic lifestyle associated with substance use. In the context of seeking testing for HIV and Hepatitis C, a significant barrier was the perception that this process involved disclosure of past behaviour to a health professional.

Recommendations

- The ready availability of low cost alcohol and the culturally acceptable nature of alcohol consumption appear to be associated with initiation of alcohol use in this vulnerable group. As such, the Scottish Government's recent emphasis on addressing the low cost and high availability of alcohol as a route to societal change with regards alcohol misuse would appear to be well founded.
- According to the findings, continued heavy drinking appears to lead to increasing self-isolation; as such, points of contact with health services are few. Thus, healthcare professionals need to be proactive in offering healthcare opportunistically to these women. In addition, when women do attend healthcare settings, every effort should be made to identify them as problem drinkers and to

involve Community Health and Care Partnerships in an effort to meet their multiple needs.

- Findings suggest that women perceived that their ability to care for their physical health was compromised by poor mental health. Therefore, efforts to promote physical health are unlikely to be successful in the absence of support for mental health needs over the long term. Indeed, given the interrelated nature of factors underpinning health and substance use risks in this population, no one factor e.g. physical health, sexual health or mental health should be addressed in isolation. A holistic approach is required. Overall, findings are consistent with policies to increase the integration of all services. Efforts to divert women from the criminal justice system to substance abuse treatment in community settings where such a holistic approach is possible (within a safe and non-threatening environment) should be emphasised.
- In the process of initiating, continuing and desisting use, physical health is not prioritised among this population. Therefore, health promotion efforts focussing on the negative health effects of alcohol and other substances may not be the best strategy to aid desistence. Given the focus and primary importance of establishing and maintaining relationships as a reason for initiating drug use and re-establishing relationships as a reason for desistence, health promotion efforts may more usefully targeted at the social and relational consequences of alcohol and other substance use.
- Results suggest that risk factors for this population in terms of sexual health do not differ dramatically from other populations, in terms of factors that increase risk (such as risk perceptions and knowledge and the instrumental use of alcohol to facilitate sex). However, the degree to which alcohol is used instrumentally in this population may be higher than in other populations. While this point is certainly speculative, the data does illustrate that there was an association between high levels of sexual victimisation among participants and difficulties with and aversion to sexual intercourse. Discouraging alcohol use in the context of sexual behaviour in this population may require addressing, in the first instance, the sexual difficulties associated with earlier sexual victimisation. Interventions are needed to promote risk reduction practices such as condom negotiation skills. Interventions are also required to improve self-efficacy and promote skills which would allow women to feel secure in both refusing unwanted sexual encounters and communicating their sexual needs to non-commercial partners without the use of alcohol. Finally, given the high rate of reported sexual difficulties among these women, there is may be a need for psychosexual therapeutic intervention with this population.
- In the context of seeking testing for HIV and Hepatitis C, a significant barrier was the perception that this process involved disclosure of past behaviour to a health professional. This was perceived as both unrealistic and threatening in the context of these women's lives. Significant outreach work may be necessary in order to reduce the perceived aversiveness of this process and increase uptake of testing. Training women in this population (who are in recovery and who have undergone testing) as peer educators may be especially useful in allaying fears.

Introduction

Alcohol misuse is a significant problem among female offenders (Fazel et al, 2007; Gelsthorpe et al., 2007). Alcohol misuse or heavy consumption in general is associated with a number of poorer health outcomes (e.g. increased risk for violence, unintentional injuries, hypertension, liver disease and a number of cancers; English et al., 1998) and increased risk of mortality for both men and women (White et al., 2002). In relation to sexual health, one of the most consistent findings is a correlation between heavy or problem drinking, risky sexual behaviour and sexually transmitted infections (STIs) (Cook et al., 2006). While there is a relative paucity of studies of sexual health among women involved in the criminal justice system, with the majority of studies originating from the US (e.g. Staton-Tindall et al., 2007), it has been found that incarcerated women have high rates of STIs, including, increasingly, HIV (Harrison & Beck, 2005). In Scotland there are high rates of STIs among socially excluded groups including prisoners and addressing this issue has been identified as a priority (Scottish Executive, 2005).

Historically, research on the relationship between alcohol use and alcohol related problems (including morbidity and mortality) has focused on men (Nolen-Hoeksema & Hilt, 2006). The current trend for increased alcohol consumption among women, especially younger women and some older women (HEBS, 2000) has resulted in growing recognition of the need for research which investigates the link between alcohol consumption and all aspects of physical and mental health in women. Research on gender differences in the health impact of alcohol is equivocal, with some studies suggesting that women suffer greater harm at lower levels of consumption than do men (e.g. Filimore et al., 1997) with others reporting that women experience lower levels of alcohol-related harm compared with men (Plant et al., 2000). However, what is not equivocal is the alarming rise, in Scotland, of female deaths associated with alcoholic liver disease in just over 20 years (a rise of 424% between 1980 and 1993; NHS, 2005).

In the context of health, women offenders represent a specifically vulnerable group, with multiple, complex problems (e.g. Gelsthorpe et al, 2007). In relation to use of substances, a recent study in England and Wales (Plugge, 2006) found that the percentage of women prisoners who drank alcohol to excess was almost double that of the general population of adult women (42% vs. 22%) and, compared with 12% of the general population who reported using an illicit drug in the past 12 months, 75% of women prisoners had used such drugs in the 6 months prior to imprisonment. Compared with the general population, women offenders are at high risk of sexual violence, and are more likely to have suffered childhood sexual abuse (which itself is linked to alcohol and other substance abuse e.g. Wilsnack et al., 1997; Schuck & Spatz-Widom, 2001). They have high rates of physical health problems associated a number of factors; poverty, (WHO/Europe, 2007) disconnection from health and preventative services as a result of deprived and marginalised backgrounds (Covington, 2007) and health problems

associated with substance use (e.g. Messina & Grella, 2006) and arising from violence, sexual abuse and involvement in prostitution (Covington, 2007). Women offenders also suffer disproportionately from mental health disorders when compared both to the general population and to the male prisoner population (Bastick, 2005). A recent study found that 90% of women in prison in England and Wales suffer from a diagnosable mental health disorder and/or substance abuse problem (WHO/Europe, 2007). Alcohol and/or drug dependency among women offenders is frequently associated with concurrent psychological morbidity (e.g. post traumatic stress disorder, other anxiety disorders, dissociation and depression) (Covington, 2007). While Scotland has a lower proportion of women prisoners than many Western European countries, including England (SCCCJ, 2006), evidence suggests that the situation of Scottish women offenders is similar, in terms of health, to the research cited above. The 2003-4 Annual Report of the Chief Inspector of Prisons for Scotland reported that 75% of women held at Cornton Vale prison (the main facility for holding women in Scotland and the only Scottish female-only facility) had a history of abuse and very poor physical health, 80% had mental health problems and most had serious problems with drug and alcohol abuse (SCCCJ, 2006).

While sexual ill health (e.g. STIs including HIV) may be associated with a number of factors in this population (e.g. involvement in the sex industry, violence in the domestic situation), the high rates of problematic alcohol use and the correlation between problem drinking and heightened sexual risk suggest that alcohol use may be a significant factor in sexual risk behaviour¹ among women offenders (it should also be noted that alcohol misuse often coexists with abuse of illicit substances; Zador et al., 1995). However, the existence of a correlation between problem drinking and risky sexual behaviour does not provide information on the underlying causal relationships between the two factors (Cooper, 2006). The specific issues associated with women offenders notwithstanding, the link between alcohol use and risky sex is complex. Whether alcohol impacts on sexual behaviour is a function of a number of factors including alcohol related expectancies in relation to sexual behaviour (e.g. a belief that alcohol will decrease the chances of practicing safe sex, such as using a condom e.g. LaBrie et al., 2002) and the use of alcohol as a reverse causal explanation for risky sex (i.e. drinking as a strategic decision in order to fulfil a desired sexual outcome; Cooper, 2006). However, to focus solely on the relationship between alcohol use and risky sexual behaviour does not take into account the larger meanings that alcohol may have in women's lives and the cognitive factors which are associated with initiation and continuation of alcohol use.

Research has demonstrated that women's use of alcohol is embedded in the context of their daily lives, culture, social contexts and norms (e.g. Barnes-Powell, 1997; MacAskill

¹ Sexual risk behaviour is defined in many studies as failure to use condoms. For the purposes of this study, sexual risk behaviour is defined more widely as behaviour that puts an individual at risk of an unwanted sexual outcomes – STIs including HIV, unwanted pregnancy, and involvement in coercive sexual intercourse which may be damaging both physically and mentally.

et al., 2001; Guise & Gill, 2007). For example, Barnes-Powell's four year ethnographic study of young working class women's drinking patterns found that alcohol use had positive and symbolic meanings, allowing an escape from daily life and feelings of empowerment (Barnes-Powell, 1997). Guise & Gill's (2007) study of binge drinking among young women at a Scottish university also found that drinking was positively constructed by the women as a social, enjoyable activity that decreased inhibitions and facilitated social interaction. Utilising a different paradigm, socio-cognitive research has also highlighted the importance of the expectations that an individual has about the outcomes of drinking alcohol in understanding alcohol use and the development of alcohol use disorders. Alcohol outcome expectancies are 'the immediate effects of alcohol anticipated by an individual' (Demmel & Hagan, 2004, p. 126) and include expectations about the impact of alcohol on, for example, assertiveness, mood management, sexual enhancement and tension reduction (Hasking and Oei, 2002; Demmel & Hagan, 2004). Also, an individual's ability to cope with stress and the coping strategies utilised are important in patterns of alcohol use, especially heavier drinking and problem drinking (e.g. Yeenstra et al., 2007; Hasking & Oei, 2002; Carpenter & Hasin, 1998).

While numerous studies have been carried out on non-clinical, and, less frequently, clinical populations (i.e. those diagnosed with an alcohol use disorder), the exact nature of the relationship between expectancies, coping and patterns of use remain equivocal (e.g. Demmel & Hagan, 2004; Yeenstra & Oei, 2002). Nevertheless, the above research suggests that alcohol use, whether problematic or non-problematic, is crucially underpinned by a wide variety of meanings and beliefs. To investigate the link between risky sex and problem drinking in isolation would therefore yield much less informative data than research which sought to elicit the contribution of alcohol to sexual risk within the larger context of women's lives.

Aims

While the main focus of the proposed study is on sexual risk and sexual health, the impact of problem drinking (and use of other substances) on general physical health is an equally important issue. Few studies explicitly address the issue of beliefs about the possible negative health outcomes of alcohol use and the impact of such beliefs on patterns of use. Guise & Gill (2007) found that women in their study did not construe their binge drinking as problematic. This had the implication that the health threats associated with problem drinking would not be salient to these young women. In Scotland, raising awareness of the risks of alcohol consumption has been most challenging in relation to heavy drinkers (NHS Health Scotland, 2002). Indeed, there is evidence that there is an inverse relationship between alcohol consumption and negative expectancies of poor health outcomes (LaBrie et al., 2006). However, little is known about this population's understanding, or the salience of, the relationship between

negative health outcomes and problem drinking. This research presents an opportunity to explore these issues. It will allow a focus not only on sexual, but on general health, thus providing a more holistic understanding of understandings of health and their relationship to alcohol (and other substance use) in this vulnerable population. With this in mind, the research questions were as follows;

- a) Explore the meaning of alcohol use in the context of women's daily lives (both positive and negative)
- (b) Explore the perceived relationship between alcohol misuse and sexual health and sexual risk taking
- (c) Explore perceptions of alcohol misuse on general health outcomes and the salience of these outcomes to women's lives and decisions to modify/stop alcohol consumption
- (4) Explore understandings of concomitant illicit substance use on all of the above.

Methodology

Participants

Participants were 20 adult women (aged between 23 and 50 years old (mean=35.8 years) with a history of involvement with the criminal justice system (13 of whom had previously served a prison sentence or had been remanded in custody). All participants were drawn from a specialist community-based rehabilitation centre which offers diversion from prosecution and/or alternatives to custody for females who have previous involvement with the criminal justice system and who may have a substance misuse problem. The service provides a safe environment for vulnerable women in which programmes of care and support are provided which are aimed at addressing the root causes of substance use and offending behaviour in order to affect behavioural change. Prospective participants were either resident in this centre (N=11), or lived in the community attending the day service provided by the project (N=9). However, one participant had been diagnosed with a medical condition which was focal in her account of her previous substance use and general health. As such, her narrative was considered too readily identifiable and for reasons of confidentiality was removed from the data set.

Procedure

Prior to data collection, meetings were held with senior staff members at the rehabilitation centre to discuss procedural and practical issues associated with running the research project. Agreement was reached that participants would be recruited in one of two ways (a) via a key-worker or (b) directly by the researcher (JW). Initially, key-

workers, using a standardised script provided by the research team, approached prospective participants and provided a verbal description of the research project to assess interest. Written information about the project, including contact details for the researchers was also given to each prospective participant at this point. Individuals who wished to participate informed their key worker, who then communicated this information to the researchers. Nine participants were recruited in this way. However, while it was initially intended that all women would be recruited via this method, staff shortages in the rehabilitation centre meant that this approach was not practical in terms of use of staff time and research project deadlines. Instead, (JW) was invited by centre staff to present a short explanation of the study and confidentiality agreement to assess interest among groups of women who had just completed group activities on centre premises. After JW gave an explanation about the research, women were given written information about the study and encouraged to take time to think about whether they wanted to be involved. They were advised that, if they decided to take part, that they could arrange an appointment with JW through their key-worker or directly with the researcher herself. Eleven women were recruited in this manner.

Interviews (of approximately 90 minutes to two hours duration) were conducted on the premises of the organisation and (with, the participants' permission) audio recorded. Before commencing, a full explanation of the nature of the research and the confidentiality agreement were provided and written consent obtained. Participants were reassured of their right to refuse to answer any question which they felt might cause them distress and were also informed of their prerogative to terminate proceedings at any stage, without explanation, if they so chose. In addition, women were reassured that non-participation in the study would not compromise their relationship with the organisation or staff members in any way. All women were provided with sources of appropriate support and information pertaining to sexual health. A £10 voucher was given to participants as an acknowledgment of their participation.

For descriptive purposes, participants were also asked to complete three short questionnaires immediately following the interview. The CAGE questionnaire (Ewing, 1984) was used as a screening tool to formally establish the prevalence of problematic alcohol use within the sample. A measure of subjective dependence to illicit drugs was recorded via The Severity of Dependence Scale (SDS) (Gossop et al., 1995). This is a commonly used measure of the extent of subjective dependence, with possible scores ranging from 0 to 15; the more severe the dependence, the higher the score. Further items were included to record sexual health history including history of STIs, experience of unplanned pregnancy, HIV and Hepatitis C testing history. Combined with information from qualitative interviews, this data yielded important information about the women who participated in the study in terms of their substance use and sexual health.

Alcohol and Drug Use

Of the 19 participants involved in the study, 12 reported concurrent use of drugs and alcohol (six reported a period of heavy alcohol use followed by illicit drugs and six a

period of drug use followed by alcohol use). Two women reported exclusive use of alcohol and five self-identified as users of heroin with occasional use of alcohol. 74% of participants had a CAGE score of >2 indicating the presence of problematic alcohol use or dependence. For women in the current sample, mean SDS scores were 9.6 (range=5-14). This is roughly comparable to other populations of problematic users (e.g. Brooke et al., 2002). Following discussion with staff at a community service, it was clear that, given the chaotic and complex nature of their clients' lives, distinguishing 'problem' drinking from 'social' drinking is problematic, as alcohol is utilised for multiple reasons in this client group and anecdotal evidence suggested that alcohol can be used problematically in clients who would deem themselves social drinkers. Thus, confining participation to self-identified problem drinkers was deemed overly restrictive. Equally, co-morbidity of alcohol and drug use is common in this population. Thus, excluding women who used substances other than alcohol meant not only that data would lack ecological validity; but also that the opportunity would be lost to explore the complexity of any relationship between use of alcohol and illicit substances.

Health

Women reported a disproportionate number of serious health problems which were often felt to be associated with drug and/or alcohol use. These included liver and kidney disorders (n=7), deep vein thrombosis (n=5), abscesses (n=4), septicemia (n=3), respiratory ailments (n=3), epilepsy (n=2), cardiac symptoms (n=2) and arthritis (n=1). Mental health problems were also common within the group with a significant number of women reporting depression (n=9), and a smaller proportion indicating diagnoses of anxiety (n=2), paranoid schizophrenia (n=1) and personality disorder (n=1). This corresponds to the findings of previous studies which have indicated high levels of serious health problems within similar populations (e.g. Covington, 2007; Gelsthorpe et al., 2007; Messina & Grella, 2006; WHO/Europe, 2007).

Sexual Health

Of the 19 women involved in the study, 17 women self-identified a heterosexual and two as bisexual. Nine women reported a current sexual relationship. Almost two thirds of the sample reported sexual victimisation in childhood, adulthood (or both) and 42% (n=8) of the sample reported past involvement in prostitution. In the past year, five participants had been screened for sexually transmitted diseases, five had undergone testing for HIV and six had been tested for Hepatitis C, whilst a further four women were awaiting screening. With the exception of one individual, it was reported by participants that all tests had been carried out at the rehabilitation centre the women attended. Prior to referral, nine women reported ever having been tested for sexually transmitted infections (STIs) (n=8), HIV (n=6) and Hepatitis C (n=9). Testing typically occurred during pregnancy, whilst in prison or (less often) at specialised drop-in centre for women involved in prostitution. By contrast, reports of proactive, independent help-seeking with regards sexual health were few (n=3). Five women reported a history of STI; two of these participants had been diagnosed with Chlamydia, two with pubic lice, one with *Trichomonas vaginalis* and one with gonorrhoea. Though only one woman reported a

diagnosis of Hepatitis C on the questionnaire measure, interview data indicated that nine women had actually been diagnosed with Hepatitis. The reason for this disparity is presumed to be that women did not perceive this disease as a sexually transmitted infection, being more likely to presume their infection was due to unsafe practices whilst using drugs.

Analysis

Verbatim transcripts were analysed using Interpretive Phenomenological Analysis (IPA) (Smith, 1996). Interview technique associated with IPA involves asking open-ended questions based on the topics of interest, with prompts and probes used as necessary to facilitate understanding. Interrogation of the topics of interest is derived inductively from participants' responses; it is the task of the interviewer to follow the participant's narrative and to utilise prompts and probes to clarify issues arising/topics of specific interest to the project.

The choice of IPA was made on both theoretical and pragmatic grounds. This approach allows a detailed exploration of the participant's views and experiences of the topic under investigation, without the imposition of *a priori* assumptions by the researcher. Individual transcripts are coded to identify emergent themes. Recurrent themes are then identified within and across transcripts; such themes reflect a shared understanding among participants of the phenomena under investigation. IPA has been widely utilised within health related research and sexual health research (e.g. Duncan et al, 2000), in work examining the meanings associated with alcohol use (de Visser & Smith, 2007) and in research which has investigated understandings of the links between alcohol and risky sex among adolescents (Coleman & Cater, 2005). It has also been used successfully with populations of vulnerable women including female drug users involved in prostitution (Smith & Marshall, 2007) and women with histories of victimisation, mental health problems and substance use (e.g. Nehls & Sallman, 2005). However, unlike grounded theory, IPA does not require that data be collected more than once, an important consideration with participants who have chaotic lifestyles for whom follow up research would be extremely problematic.

Results

Analysis revealed that women perceived their alcohol and drug use as a process underpinned by the increasing experience of disconnection from the self and others and recovery from addiction as a reversal of this process. Alcohol and drug use in the initial stages of use was fuelled by the experience of social and emotional isolation with which the use of licit and illicit substances was viewed as an effective means of coping. Over the longer term use became increasingly driven by the physical and psychological need for the drug itself, as well as the perceived need to cope with the consequences of drug use. With this came increasing disconnection from the self and others as the drug

gained growing centrality in women's lives. This culminated in the experience of total disconnection or 'hitting bottom' described as a period during which life ceased to have meaning or value. Reaching this low was viewed as necessary stage in the process triggering recognition that desistance from use was required for survival. Recovery was described as an experience of reconnection wherein the 'real' self re-emerged and relationships with others were rebuilt. Understandings of the general health risks associated with using drugs and alcohol and attitudes towards help-seeking appeared to undergo changes in line with the perceived level of connectedness associated with each stage of the process shifting from a lack of awareness of risk in initial stages, to increasing disconnection from physical health concerns followed by a re-emergence of concerns with physical health during recovery. Conversely, understandings of sexual risk and health did not appear to be linked to the process of addiction and recovery to the same degree as physical health concerns. Instead women's risk-taking behaviour in this respect appeared more closely linked to low levels of awareness and beliefs about risk management by partner choice.

Findings are presented to reflect the process of disconnection and reconnection described by the women interviewed. For the sake of clarity, and to illustrate changes in attitudes and perceptions at each of the phases described, results are arranged according to stage of use (i.e. initiating, continuing and desisting from alcohol and drug use and recovery). Reasons for changes in use (i.e. substitution of alcohol for illicit drugs or vice versa) are discussed as a sub-section of continuing use as women's perceptions in this respect reveal potentially important information regarding understandings of risks associated with drug type. As perceptions of general health risks were found to shift with increasing disconnection at each stage of use (and again in line with reconnection during recovery), these findings will be reported according to stage of use throughout the body of the text. As understandings of sexual health and risk did not appear to demonstrate this pattern they are presented and discussed as a separate section.

Initiating Alcohol and Drug Use: Feeling Disconnected

Of the participants included in the sample, roughly three quarters described themselves as problem drinkers. For six of these women problem drinking followed a more prolonged period of heroin use whilst a further six participants indicated that problematic alcohol use preceded their use of heroin. Choice of first drug used (whether alcohol or illicit substances) depended largely on exposure to other users (either within the peer group or when problematic use occurred later in life, the women's friends or more typically their partner). This had the dual effect of increasing the availability of drugs or alcohol whilst also encouraging a positive view of the substance used as not only socially acceptable within the immediate social context but also as an effective way of 'fitting in' within the group (this is discussed further as a motivation for drug and alcohol use below). Two participants reported problematic alcohol use only whilst a further four women reported problematic use of illicit drugs. Though these women described using

alcohol in their early life, this and alcohol use during adulthood was considered as occasional and non-problematic in nature. All four of these women reported that their exclusive use of illicit drugs was linked to exposure to alcoholic parents or partners who had behaved violently towards them. Such experiences produced negative perceptions of alcohol use which discouraged consumption, whilst an absence of such experiences when in the company of users of illicit drugs failed to produce comparable barriers to consumption.

Analysis revealed two major interrelated themes regarding reasons for initiating alcohol or drug use, these were: (a) psychological disconnection and (b) connecting with others. These themes underpinned initiation of use regardless of the type of drug used (i.e. illicit drugs or alcohol) or, in cases where the use of more than one drug was considered problematic, the order of use. The results presented here reflect this, with examples to illustrate instances in which reasons for initiation of use differed by type of drug.

Psychological disconnection

For the women interviewed the primary function of initiating (and continuing to use) alcohol and/or drugs was to achieve psychological disconnection from distressing thoughts and emotions. This was the case regardless of the order of use or the type of drug used.

Typically, participants referred to 'blinking' 'forgetting' or 'blocking out feelings' suggesting that the aim of drinking or using was dissociate from psychological experience. Many women traced the source of the distress from which they sought to disconnect to the experience of loss and/or physical, sexual or emotional abuse which they felt acted as a trigger for alcohol and/or drug consumption. In many cases, participants reported such events as occurring early in life producing negative emotions which remained unresolved in adulthood. Like many other women, Rhona felt unable to discuss her experience of sexual victimisation with others, instead drinking excessively as part of a variety of avoidant coping strategies intended to 'block out' her experience.

The rape was a big factor in that [drinking], that was part of why I started. I would have just taken my life otherwise. It took me three year to tell anyone... that's why I started taking downers and hash and drink to block it out and that and then I self-harmed as well. I tend to self-harm now and again, but aye, I was drinking litres and litres of wine and super lagers. (Rhona)

In a similar vein, Pauline's account revealed a perceived link between childhood sexual abuse and the early onset of alcohol use as a way of suppressing the negative emotions associated with the experience.

About 12 I started drinking, yeah. I was really quite drink dependent as well by the time I was 14, really bad. I would always be drinking Thunderbirds, Merrydown cider, didn't even like the taste of it, half the time I'd just force it doon ma gullet to get it in me. 14, I

was quite bad on the drink and speed at the time....at 14 I had a suicide attempt. Serious, and at 15 as well so I was quite a messed up lassie, so I was. Really messed up. I don't know it was various other things that happened to me when I was younger as well that I carry a lot of anger about with me for..I'm starting to deal with it just now. When I was about 4 or that, the guy from the next close used to abuse me at the top of the close and things and I think that's a big part of it as well. I've blocked it out a lot but I'm starting to think that's why [I drank]. I didn't realise at the time that there was a lot of anger in me. (Pauline)

In instances where problematic use of alcohol or drugs had begun later in life, such events were identified as occurring in the contemporary environment. A number of women discussed the experience of multiple bereavements which led to the advent of their alcohol or drug use. Following a period of non-use, Ellie explained the onset of her heroin use arising, in part, as a means of coping with cumulative grief arising from the deaths of multiple family members.

I first started using after the death of my brother, well there had been a few deaths actually, my auntie, my granny, my mother's partner. Not that they meant that much to me as my brother but they do mean something. Just not as much as him, if you see what I mean. Still, they all add up don't they? Even if you're not that close to them it still has effect on you when they happens so close together like that. (Ellie)

Equally Fiona, whose alcohol use followed a period of recovery from heroin use, identified the experience of bereavement as key in the onset of problematic drinking.

I: What about drinking then? Have you ever?

P: Aye when my sister died I drank. Excessively, terribly...I think ah drunk just to take the pain away. (Fiona)

For a number of women traumatic events occurred within the context of emotionally cold or rejecting relationships. This appeared to have the effect of intensifying negative emotion associated with other traumatic experiences. Though Celia associated her use of alcohol and drugs with the experience of childhood sexual abuse, it was evident that her relationship with her mother exacerbated her distress.

P: ...the root of the problem, why I was drinking, taking the drugs ...was me being abused as a kid. Physically, mentally, everything...

I: You said first of all though that you drank to oblivion? Why that type of drinking?

P: To forget about my home life, what I'd done. I did what I wanted and came haim when I wanted. My ma didn't even bother about me. ...I got nae praise, I would get no rewarded

for the bad behaviour or the good behaviour, I was getting nothing at all apart from the physical doings. (Celia)

Having a child was also reported by some participants a trigger for use. A number of participants described feeling overwhelmed and exhausted by the experience and turned to drugs or alcohol to provide relief. Pauline, who felt she had suffered from post-natal depression after the birth of her first child reported using speed as a pick-me-up.

...after I had him I was really...I didn't know at the time but I was suffering from post-natal depression, so I heavy started to use speed to give me that 'oompf' sorta thing. (Pauline)

Women's perceptions of being unable to cope after the birth of a child were often exacerbated in circumstances in which they received little support. This was the case for Shona who linked her sense isolation after the birth of her second child to the onset of problem drinking.

Didn't take any drink till I had my second child. I went to a new scheme (where I said to you I stayed) and then my partner got the jail and I met the neighbours and I was off drugs and finding life hard. Just started drinking to kinda blank it out thinking that's better than going back to drugs, but it wasnae it was worse. (Shona)

Unsurprisingly, a number of women reported experiencing mental health problems, such as chronic depression. Consistent with previous reports of emotional trauma, including loss, as a major factor in initiating drug and alcohol use, such losses were often seen as a precipitating factor in mental illness. Lack of support in coping with mental health problems exacerbated substance use, seemingly because of the increased feelings of isolation. As in Isobel's account;

My life had been took afe me you see, my job. That was the only identity I had in my marriage, that's all I had. I lifted that bottle up, that took everything away from me [crying] and my ex-husband, I even said to him to go to ALANON to understand the alcoholic because he never, ever, with my psychiatric problems, my mental illness, er, if I tried to speak to him about it he'd just tell me to fucking phone the psychiatric nurse [crying] that there was nothing he could do, but in actual fact he put me there. (Isobel)

Women often associated the distress that underpinned their alcohol and drug use with negative events that they had experienced. Closer inspection of accounts revealed that this distress could be understood in part as being linked to the impact such events had on women's sense of self. Indeed, women frequently talked about feelings of worthlessness, self-hatred and emptiness and their use of alcohol and drugs as attempts to distance themselves from these feelings in order to facilitate a positive change in self-concept. Liz explained how her tendency to focus on the negative aspects of her life

and her inability to change what had happened led to her to feelings of self-hatred and drinking as a means of changing her identity.

P: I didnae like, I didnae like the way I naturally feel....just, just, just...I dunno. It's just like, och....I was depressed a lot . I just kinda felt...I hated myself. I hated who I was. I was just trying to change who I was. I didn't appreciate, I always thought of all the bad things that had happened and what I couldnae dae. I didnae sit and look at what I had achieved and what I was able to do. I just wasnae thinking right I suppose (Liz)

Isobel discussed using alcohol for similar reasons.

The emptiness...I had no identity and I canny emphasise that enough. The bottle did what I couldnae do for myself, or so I thought. And what it did was just stripped me. (Isobel)

For some women, negative feelings about the self appeared to be linked to difficulties experienced disclosing thoughts and feelings with others. This was linked to the individual's belief that they were somehow undeserving of help, as was apparent in Fiona's account.

P: It's been all different things, my dad died when I was a wean [child]...we came haim and my mum was just greeting [crying], I just knew then. And then they talked to us after that. And then I kept not talking, my ma took me over to the doctors...it must just have been I didnae want to talk. I didnae greet [cry] or anything I must just have been holding everything in. And I'm still dead deep. I hold mair [more] in than I talk about.

I: Do you know why?

P: I don't know, I just think it's my problems so why should anyone else have to deal with them....I used to hate myself (Fiona)

Ideas about disclosing feelings to others as unacceptable also discouraged help-seeking. In this way the use of alcohol and drugs became seen as the only viable alternative. Vicky's sense that being 'free' about her feelings could be considered shameful led to difficulty expressing emotions and alcohol use as a means of disconnecting from emotional experience without the need to disclose to others.

See when you're at school and there's so much going on behind closed doors and you canny express your feelings, that's how you end up doing all these things like myself. Coz it's not acceptable to open up and be free about your feelings. A lot of people do have problems and that's how we use. Because it's hard for them to express their feelings and things like that and tell people. For me at the time it was and I would say for a lot of people I knew. Women in my peer group (Vicky)

The belief that problems should be kept concealed from others was widespread among the women interviewed. As well as the perceived unacceptability of discussing problems openly, this belief appeared to be underpinned by a more deep-seated mistrust of others. Some accounts suggested this to be a further outcome of the negative life experiences women reported. For example, Isobel explained how her experiences in childhood and as an adult had led to the understanding that to trust other people would leave her vulnerable to harm.

P: I never trusted anybody

I: How come?

P: Coz you keep everything indoors, I kept everyone at a distance

I: Why?

P: Fear of being hurt again

I: Who had hurt you not to trust anyone?

P: Instances in my childhood and in my marriage...that was my way of coping with things, to do things for people but to keep them at arms length coz I always thought, what are they after? What do they want from me? So if I couldnae help myself, I wasnae letting anyone into my life outside my family coz they would take the pish right out me [take advantage of me]. (Isobel)

Though women's difficulties with emotional expression and trust appeared to some extent to underpin their emotional isolation, it was also apparent that they felt that even if they did seek comfort and support from those close to them, help would be unlikely to be forthcoming. For example, though Sarah's views about looking after herself were to some extent positive (in that she understood this way of coping as reflecting strength and independence) it was also apparent that she did not expect understanding from those she might have approached for support.

P: I'm wan [one] to do my ain caring

I: How come you feel like that?

P: I don't know, I'm just strong, strong, willpower...tae...probably coz I'm too independent and I don't look for...like to ask people for help. It's my problems, I make my bed so I should lie in it. I've always been like that but my ma was a bit like that and my da. He's very deep. So it could come from him. I don't tell my family nothing. They don't understand addiction or anything like that, neither they do...I wouldn't talk to them coz they wouldn't have the first clue what I was talking about (Sarah)

Thus, in line with their beliefs about help-seeking and the availability of support, women chose to deal with their emotions in an isolated manner i.e. through the use of drugs or alcohol as a means of psychological disconnection. Though successful to some extent, women appeared aware that the solution was an imperfect one. Ruth discussed her use of drugs in this manner;

Just the pain and the hurt and the experience I've went through, know what I mean? Coz as I've said I'm no great talking about my ain experiences. I can talk all day about yours but I don't talk about mines. So I built everything up and then I took drugs and I thought I'd found an answer but I didnae. (Ruth)

Whilst Sarah acknowledged that despite using alcohol over a prolonged period to cope with experiences of loss, this means of coping was not an entirely successful means of suppressing her grief.

It's always been the same [i.e. reasons for using alcohol]. Just loss and things. Drinking to block it out but even when I did drink I still gret [cried], so....aye. (Sarah)

Connecting with others

Though psychological disconnection appeared to be the primary aim of drug and alcohol use, women also viewed such behaviour as a way in which they could potentially achieve connectedness with others. As was apparent in previous extracts, women's reports suggested that they frequently felt isolated. Many women reported experimenting with drugs in the early stages of use as a means of being accepted. Drug use was seen as a social facilitator enhancing the individual's social performance whilst also providing a way of 'fitting in' by adopting normative group behaviour, as in Sally's account;

....coz ma pals were doing it and so that's why I done it an' all. I went about with people that were a lot older than me and they were like, are you wanting and that and it was just to fit in. Fit in and be normal. Confidence and all, it gave me more confidence so it did. (Sally)

Similar reasons were given for the initiation of alcohol use. Sheena observed;

..it was just basically started afe drinking at the weekend with people. And then it was getting bad. But you know what it's like when you're younger, you do things just to be in with the crowd...when I was drinking I felt more better about myself, within myself. Felt more confident when speaking to people than being straight. (Sheena)

Though this type of consumption was typical for many women in their early life, a view of alcohol and drug use as a means of connecting with others remained a reason for drinking in later life. Liz discussed how her sense of isolation coupled with the belief that

alcohol use would provide her with the confidence and the context to meet others was linked to the onset of her alcohol use in adulthood.

It made me feel more confident, it made me feel more in control and it made me feel part of...you know, everybody that was round about me was drinking. Everybody. Like ma neighbours, people that I knew so it was more a social thing as well so it made me feel part of a group. And I don't really have any of my family speak to me. My boyfriend's in jail so I didnae really have anybody and so it just gave me the excuse that I needed to just go out and socialise with other people (Liz).

It appeared from accounts that through using alcohol and drugs socially as a way to fit in, women became more aware of the other benefits of using or drinking as a means of enhancing their sense of self and suppressing distress. For example, Sarah indicated that though gaining acceptance was the primary purpose of initiating drug use, this led to the realisation that other advantages of this nature could be gained.

It started with like, using drugs because of the crowd I was going with was using drugs. And I think it was just to be accepted by them coz I realised that it made you feel good at the start, it made you feel confident and it made me feel different from what I felt before , so I felt good about it at first... and it made me forget so it did. And I didnae feel as hurt, in pain as much. I was hurting. And then when they obviously found out about it after a period of time, I don't know, I got attention... (Sarah)

The use of alcohol or drugs as a way of connecting with others appeared to be linked to not only to circumstances which produced a sense of isolation but to women's negative view of themselves as inadequate, flawed or 'empty'. Alcohol and drug use was viewed as a way of filling this void, thus facilitating connection with others. Pauline's account was typical in this respect;

P: Confidence it gave me a lot of confidence so it did. Sitting with certain people and fitting in. A lot of confidence like, alcohol gave me the most confidence.

I: Why did you feel you needed to be more confident?

P: Coz I felt a total wreck without it, I just felt incomplete all other times. Just incomplete.

I: In what way?

P: Just as if there was a big sorta void in ma life as if there were a big, something missing an I fult it with alcohol. Just felt as if, maybe it goes back to my wee daughter that's adopted. I don't know. I've never got over that (Pauline)

Though both alcohol and drugs were used by women as a means of connecting with others, a major variation in this theme was noted with regards to the function of alcohol

and drugs in this respect. Achieving connectedness as a reason for initiating drug use took on especial significance for non-users who were part of a couple wherein their partner's drug use emerged after the relationship had begun. Women who reported such circumstances tended to experience their partner's drug use as decreasing intimacy within the relationship. Donna described how the disparity between her partner's lifestyle as a heroin user and hers as a non-user; his secretiveness and increasing absences, led to a growing sense of loneliness and exclusion. In turn, the desire to regain the intimacy and companionship of earlier stages of their relationship was key in her decision to initiate use.

P: He started a year into the relationship, started getting all funny wi' us. Hiding, using foil and thinking I was daft. I knew what it all was but he never, ever gave it to me. Never. But eventually it came out he was taking it anyway and I just got fed up watching him all the time....say I wanted to go to the pictures or something and you can't get him, or making dinner, and you just look and he's sitting UUHHHH pure gouched out his face. You just feel as if it's a pure retard sitting here. Honestly!...he was going out a lot and that was making me feel even worse coz I was in the hoose. Whereas if he'd have taken me...But I knew what he was going to do and that was the reason he wouldn't take me so in a way I just wanted to go back to the old... the way things were. The first year of our relationship I wanted that back.

I: And what was that like?

P: Just great, we done everything together, we'd go out and have dinner, all normal things...and I was like that, I wanted to be there, so...

I: So you end up...

P: Just to be with him and to be around other people coz I felt isolated. (Donna)

For women with partners who used alcohol, this type of reasoning regarding initiation of use was not apparent. Though such relationships tended to encourage and support drinking, the desire to achieve connectedness through alcohol use did not appear to be a major motivation. Instead being part of a drinking couple provided a ready context for alcohol use in terms of increasing the availability of alcohol, indeed men who were also users often supplied alcohol to their partners. Such relationships also provided a justification for drinking. For example, Andrea's account suggested her partner's alcohol consumption produced a sense of entitlement that validated her own drinking.

I found it much easier for me to have an excuse to be drinking – well, if you're drinking, I'm drinking. You know what I mean? He'd be sitting like that pure drunk man, then I'd get a drink. I want one and aw. (Andrea)

Participants discussed negative life experiences and social circumstances which appeared to affect their perceived ability to connect with others. Experiences of emotionally cold parenting, loss and victimisation early in life were reported as resulting in a sense of the self as vulnerable, mistrust of others and the experience of intense emotional distress (whilst similar events in adulthood produced comparable outcomes and/or reinforced those resulting from earlier trauma). Negative views of the self and others appeared to lead to difficulties expressing thoughts and feelings in interactions with other individuals. Alcohol and/or drug use was understood as a means of coping with distress which precluded exposing one's vulnerabilities to others. However, this coping strategy appeared to create further distance between the individual and those within their social context. Indeed, women described themselves as feeling isolated and as lacking the confidence to engage with others despite an enduring need for intimacy. Indeed, using drink or use drugs as a way of connecting with others (both intimately and socially) appeared underpinned by women's view of themselves as otherwise 'empty' or inadequate within the relational setting. In this way, women's relationships with others provided the context for use, were linked to positive perceptions of drinking or drug use and also ensured that a supply of alcohol and drugs was readily accessible. Thus, alcohol and drug use appeared to serve a dual purpose for women in the early stages of use providing a way of disconnecting from painful thoughts and emotions whilst connecting with others in a way which was deemed 'safe' for the individual in terms of avoiding further harm.

Initiating Drug and Alcohol Use: Failure to Consider Risk

Accounts indicated that in the early stages of use, women failed to fully consider potentially negative consequences to their physical health. In general, women ascribed this to being young (and therefore naïve) at the time when use was initiated. However, accounts appeared to suggest that rather than a total lack of awareness, failure to consider risk was more adequately explained by a tendency to minimise the potentially harmful effects, as in Sheena's account;

When I was young I was so naïve, its not like you're thinking when you're drinking or smoking heroin that you are going to catch some sorta disease or you're affecting the organs inside you. You don't think a bit of powder or a drink could dae all that! I didnae think taking drink, bottle of cider, would hurt your insides when really it does. Long term it can affect it... (Sheena)

This was confirmed in other accounts, such as Vicky's, which suggested that though some awareness of the long-term health risks associated with excessive alcohol use may have existed when use was initiated, women failed to view them as personally relevant. As with other participants, Vicky felt she had only become fully aware of the potential consequences of use retrospectively, through direct observation of the ill-effects of problematic drinking among others users.

I didnae ever think that I'd be... it's only with being in here and through knowing people who have been on alcohol and seeing the harm that they've done to their bodies. I think everybody knows that you can damage your liver but no I just didn't think of it that way at all. (Vicky)

This noted, in a small number of cases, women appeared fully aware of their vulnerability to the effects of excessive alcohol use but went on to use anyway. Pauline noted;

Coz of the paracetamol attempts on my life when I was 14 and 15 I was always told I could never be a drinker in later life coz of my liver. Sclerosis of the liver and things is what they says to me. And they're right. (Pauline)

Women's perceptions of health risks associated with drug use appeared to be associated almost exclusively with injecting and perceptions of the lifestyle associated with being a 'junkie'. As such, non-intravenous drug use was viewed a relatively harmless in terms of negative health outcomes. Kim had this to say;

I was only smoking, I didnae think it was a big thing. I thought of a junkie as someone who uses needles. So I didnae know much about it and I thought, what the hell can you catch afe of smoking something? This was years ago, you didnae hear much about it back then. All you knew is that a junkie was somebody that jagged themselves. Quite naïve wasn't it? (Kim)

Though many women discussed initial concerns about becoming a 'junkie', these concerns appeared to be weighted more heavily towards the social implications of this lifestyle than the health risks. Pauline discussed how prior to injecting she had associated being a 'junkie' with the deterioration of life circumstances. Though fearing such an outcome she went on to inject anyway, linking this decision with insufficient concern for her own welfare.

I wasnae concerned about myself at the time to be honest with you. Just the fact of having...I don't know...going down. Coz I always thought, it's a bad drug. At the time you think JUNKIE. And that was always a word that was alarming to me.... Just no life, your life away. Life ruined. Things in my life, my life wasnae too great at the time but I could still kiss that goodbye. (Pauline)

Where concerns about health risks were present these were outweighed by the perception that the benefits of use would outweigh the risks. Though Shona feared that injecting might lead to contracting HIV her view of injecting as normative and her desire to be accepted by others in her group meant she chose to inject regardless of her concerns.

Catching the virus aye, I was scared of that. Just the whole thing with injecting and then it came to the stage that everybody was injecting and I felt the odd one out coz I wasn't doing it. I just felt there was...missing..I don't know, I wasnae missing anything. I just wanted to be like everybody else. Just like talking about the 60's, everybody on acid, like my generation, everybody junkies. I'd still dae anything, you still take your chances...(Shona)

This kind of reasoning was also noted among women who reported problematic alcohol use. Isobel discussed how her sense of personal invulnerability to the harmful effects of alcohol combined with a positive perception of drinking as relieving her 'symptoms' i.e. emotional distress and depression, led to alcohol use despite an awareness of the risks involved.

P: You think, no way that will ever happen to me.

I: Any idea why that...

P: Any idea why? Well, I thought that was my friend [alcohol] and that was relieving my symptoms. (Isobel)

In the initial stages of drug and alcohol use women did not appear to consider the potential risks to their health. Instead, many felt they had come to more fully recognise the damage they might be doing to their bodies after the fact. Minimisation of risk, perceptions of the self as invulnerable to harm and a desire to drink or use which outweighed any concerns which might have been present in the initial stages meant that, in general, the potential ill-effects of using alcohol or drugs did not enter into decisions to initiate use.

Continuing Alcohol and Drug Use: Increasing Disconnection

Alcohol and drug use was typically perceived as being initiated to serve a dual purpose (i.e. achieving psychological disconnection and connecting with others). Distressing events (such as loss and re-victimisation) which were experienced after use was initiated continued to make disconnection a primary goal of drinking and using illicit drugs. Indeed, participants reported what appeared to be a disproportionate number of negative life events which were felt to maintain use, as in Sarah's account;

It was when I lost, my niece committed suicide, then ma aunt died a couple of months after that. Then my sister died, then my brother died. And oh! In the past few years there's been thirteen deaths erm, and to start with that, my partner left me for another girl with 2 kids...so it was one loss after another. (Sarah)

Other traumatic experiences appeared to occur as a direct consequence of use itself. Often women discussed the breakdown of relationships with non-using partners and family members, and losing custody of their children as a consequence of use which they felt had maintained drinking or drug use or increased the severity of use over time. Such experiences often intensified existing distress but also in many cases decreased perceptions of existing support. For Sarah, losing custody of her child as a consequence of her alcohol use triggered more excessive drinking. This was then maintained by the loss of her mother and her failure to address unresolved distress connected to previous victimisation. Lack of support and understanding from her sibling during this period appeared to exacerbate her distress further, leaving her with no outlet for her grief and feeling 'lonely, depressed and angry.'

P: I got my weans [children] taken off me. So they're with ma sister just now. At the beginning I drank every day, every single day, aye. Whereas it should have been the opposite way. I should have pulled myself together but if ma sister had gave me the help I needed back then maybe I wouldn't have done that...

I: What more could she have done?

P: Talked to me mair! And tried to understand where I was coming fae [from] and what I was hurting about. And after that I lost my mammy, 18 months ago and that made it worse. And years ago I used to get doings afe of the guy I was with. It was like terrible doings. I wake up and I get hit with a claw hammer and dragged me oot of my bed by the hair on my heid. Hit over the back with a brush pole that snapped in two...I was just lonely, depressed and angry (Sarah)

In other instances, women discussed their continued use of alcohol or drugs as a way of coping with the guilt and shame they associated with their actions whilst intoxicated. Vicky, who had been sexually unfaithful to her partner whilst drunk, viewed alcohol use as both a cause and a consequence of her behaviour. Here she explained her continued use of alcohol (and later drugs) as a way of distancing herself from feelings of guilt but also as a means of punishing herself for her actions by 'keeping herself unhappy.'

There was so much guilt in me. Lot of guilt, know what I mean? Loadsa guilt. And I was just walking about loaded. Keeping yourself unhappy. It led to me taking drugs eventually because I wasnae happy within myself with all the secrets and lies. (Vicky)

Indeed, the idea of alcohol-use as a form of self-punishment for past actions was common to a number of accounts. Celia explained how drinking for her also became a means of self-harm as penance for her previous behaviour.

I think punishing my body as well for the things I've done. Like no self-harming on the outside but on the inside. (Celia)

Thus, women's lifestyles and circumstances continued to make psychological disconnection from distressing thoughts and emotions an important goal of use. As women became more physically and psychologically dependent on the drug they were using however, other concerns began to fall away, as in Andrea's account.

It got the stage in the end and all that I was just, me and him [partner] were just getting up out our beds (and I smoke and he doesnae) I'd light up a fag and just pour a straight vodka and after I got it down me that was me set for the day. I felt as if I hadn't a care in the world. I missed appointments, I was never getting to the doctors and things. I was like that, ach, that can wait. Ach! Who cares, man? I hadnae a care in the world. Bills are building up, building up and I'm just no caring. And your personal appearance that goes and all, man. Like see with me, outside I wear jeans once and then change everything, by that time I was getting to the stage of wearing them days...(Andrea)

Conversely, periods of sobriety were experienced as bringing into sharp focus thoughts and emotions that had previously been suppressed. This was evident in Shona's account;

...when you're on the drugs or the alcohol, life just passes you by. You're sitting steaming or you're full o' it and it just passes by you but when you're straight you'll just sit and think about it and you'll analyse it and you'll try and..hingme.. the problem, it's in your mind and it's in your head and it's kinda hard to deal with that when you're not used to those pressures (Shona)

Indeed, women were aware that the disconnectedness they achieved from drinking or drug use was temporary in nature, lasting only as long as the effects of the drug itself. The desire to avoid psychological distress resurfacing encouraged women to maintain consistent use. Ellie explained how continuing need to suppress distressing thoughts and emotions created an unremitting cycle of drug use.

I always tend to overanalyse things, go over things. Over and over in my head, the drugs take that away. It stops you from doing it and I think if you're like that and you know what drugs will do that for you, its like a wee cycle thing, like a pattern, you get into coz you know that you won't be able not to do it unless you keep using (Ellie)

Equally, the avoidant nature of drug and alcohol use as a strategy to cope with psychological distress meant that the issues women sought to distance themselves from remained unresolved, thus maintaining use. Ruth's account was typical in this respect.

...it was things that had happened to me before I was 16 and when I was 16 that led me into drugs, know what I mean? And it kept me taking drugs coz I never spoke about it (Ruth)

Physical addiction also followed prolonged periods of use leading to increasing importance of consumption as a means of controlling the physical pain of withdrawal. Shona observed;

I was throwing up when I was ill with the drink, but. When I woke up in the morning, soon as I had my second eye open I was running to the toilet, spewing and running out the other end. Spewing out that way and the rest out that way and sitting with a bottle in the other hand trying to get the pain away (Shona)

The growing emphasis placed on disconnecting from both physical and psychological pain led to increasing centrality of drug or alcohol use in women's lives. As this occurred, accounts suggested that women became gradually less and less concerned with connecting with others through their drug or alcohol use. Though some women continued to enjoy the companionship that went along with using drugs or alcohol with others, it was clear that the focal point had shifted from earlier concerns (regarding acceptance and 'fitting in') to a focus on the drug itself. For example, though Andrea continued to enjoy the company of her drinking companions it was clear that the main function of these associations was to ensure a steady supply of alcohol was available, or as she put it 'that was the only good thing about it.'

P: We went from wan [one] house to the next to the next to the next, it wasnae...it was like if somebody fell asleep, they could just fall asleep where they are then wake up and start drinking again. Straight away, that's just how it went for us, know what I mean.

I: Was that a good thing for you?

P: At the time aye, because you know when you fall asleep and wake up you know that there's going to be a drink there for you. And see if you're going home you might not have a drink to wake up to. You're like that oh god, when I wake up I'm going to have to get up and get a carry-out, I've got to come away back up here. In a way that was a good thing. That was the only good thing about it! Coz you knew because there were that many people there'd be a drink there for you. But sometimes you'd think, they're gonna drink all that drink so you'd actually try and keep yourself awake to make sure you were, you had plenty of alcohol in you. (Andrea)

The decreasing importance of connecting with others as a function of drug use was particularly notable for women in relationships with another drug user. Fiona noted the gradual deterioration of her partnership over time as drug use became more the central concern.

When I first met him, he was like a boyfriend, but after 2 or 3 year he was mair interested in taking drugs than talking to me, so it was mair like drug partners. The two of us would get full of it together, and go to sleep and then get up and get full of it again and then go

back to sleep then up and get full of it. That's it. Waste of time. Waste of life. But it happens. (Fiona)

Though some women maintained social contact with others through their use (albeit as a way of ensuring a steady supply of drugs or alcohol), this was not the case for all those interviewed. Indeed, in a number of cases a consequence of prolonged use was increasing self-isolation. This was specifically associated with alcohol use (perhaps as gaining access to alcohol was less likely to require co-operation or communication with others) and was typically found in the accounts of women for whom social isolation had been an issue prior to use.

I was just staying in my house when I was on the drink, every day and every night. I'd be up to the shop with my jacket with me and back to the house. At least you go to your chemist or somewhere when you're on methadone but alcoholics are not on it. (Shona)

For some of these women, venturing into the outside world and 'facing others' became an experience to be endured, one which they often chose to cope with by using alcohol, as in Liz's account;

After that as I say it was just to get me started, get ma day going, get me moving. Coz I couldnae really go out, even to the shops without a couple of cans in me coz I used to be dead paranoid so that would calm me down enough so I could face things, so I could face people. (Liz)

In fact, a number of women reflected that the confidence they had felt that alcohol had given them in the initial stages of use had not in fact provided them with way of connecting with others as they had hoped, but had created instead, false experiences and connections in the interpersonal setting. Shona commented;

...oan drugs or drink it's all false. Its false confidence, its false love, its false everything. Everything is false, you're a false person, you put a mask oan to suit everybody (Shona)

Indeed, the social self presented to the world through the medium of alcohol use was thought of as a 'wall' or a 'mask' which provided a defence against potential threat within relationships, but presumably did little to achieve the intimacy that women desired by ensuring that the 'real' self remained hidden. Pauline saw her alcohol use as enabling her to create a protective barrier between her and others who might mean her harm;

It was keeping a front on, it's like putting a wall up which means that people can't hurt you. Coz you are that worried that you'll get hurt coz, trust me, I did. I was putting a wall up to people and if I put a wall up it means that if you dae something to hurt that person it doesn't matter coz it's no really me anyway. It's someone else. (Pauline)

For Liz (and many others), the tendency to conceal the self and emotions to avoid further harm was a coping strategy which predated but was enhanced by use. However, it was clear that an unintended consequence of using or drinking for these purposes was a gradual loss of identity.

It was killing me but not in the physical sense. It was just killing who I was. I didnae know who I was. I had no idea who Liz was. And see if you'd said to me, who is Liz? I wouldnae have had a clue. I'm still trying to learn who I am. I have always masked how I felt so I don't really think I ever knew who I was ... (Liz)

Creating a false persona through alcohol and drug use appeared to affect women's capacity for self-reflection. This combined with continued disconnection from others was perceived as impacting upon their ability to affect behavioural change as Isobel noted;

I just hadnae changed. I was still trying to please others and put that false face on and that's why I kept drinking, I hadnae looked at me to change (Isobel)

Thus, women described what appeared to be increasing feelings of disconnection from the self and others as a cause and a consequence of their use. This was felt to culminate in the experience of 'hitting bottom', or 'reaching the gutter' wherein individuals were felt to reach the lowest point of their addiction, reaching critical levels of disconnection where any sense of value for life or the self was lost. Shona's account was typical in this respect.

I was in the gutter, couldnae get myself out of the gutter, I was getting worse and worse and deeper into trouble...as low as you can go, you'd do anything for drink and drugs, you don't know where you life's at – you're right down in the ground, doon the kerb, erm, you canny get any lower than you are. Lost in your addiction. Lost ma dignity for maself, lost my self-esteem. Going about dirty, no caring. Not got your heart in anything, your heart and soul...you're just totally full of it all the time. Don't know what normal is, don't know what a life is. Don't know how it is to get up and get washed and get yourself organised, all your days just sitting in your jammies [pyjamas] full of it, full of it, full of it. Know what I mean? Not eating nothing, no money, going through all the withdrawals and pain, couldnae handle it any mair. Felt suicidal. (Shona)

As in Shona's account above, women typically described feeling suicidal when they reached this stage in use. At this juncture, alcohol and drug use took on a new meaning for some women, providing a means of gradual self-destruction. Kim talked about her desire to 'drink herself to death.'

At the time I was at a very, very low point in my life. I was scunnered [upset/annoyed] with myself. I couldnae find a way out. I think I was slowly trying to commit suicide but within myself without actually going out and harming myself - like physically, putting a razor to my wrists or something....I wasnae eating for a start, I was on a liquid diet

constant. I wasnae eating, I wasnae taking care of myself, I was just wanting to sit and drink and drink and drink and drink until I passed out and just hope to fuck I wouldnae wake up....Basically wanting to sit and drink myself to death (Kim)

Analysis suggested that over time, the function of women's drug and alcohol use changed as an increasing emphasis was placed on achieving psychological disconnection. This shift appeared to occur in line with traumatic experiences which occurred after the onset of drug and alcohol use (often as a consequence of the lifestyles women adopted). Relationships with non-users who might have provided support were lost, whilst those with other users continued to support use. Using alcohol and drugs as a means of disconnecting from physical and emotional pain ironically became the source of increasing disconnection from the self and others leading in many cases to further emotional and (in some cases) self-isolation. Eventually women reached what appeared to be a state of total disconnection associated with complete immersion in drug and alcohol use as a means of self-destruction.

Continuing Use: Change in Type of Drug Used

The majority of women interviewed had used a variety of drugs including alcohol. In general, women viewed their reasons for continued use of alcohol or drugs were very similar i.e. to achieve disconnection. Changes in use sometimes occurred after a short period of abstinence and were typically triggered by negative life events or continuing difficulties coping with unresolved distress without the use of alcohol or drugs. As drug and alcohol use provided only a temporary solution (doing little to address the actual source of distress) attempts to desist in use were often unsuccessful as the underlying problem remained. In such circumstances, women chose to substitute one drug with another.

At the time I was drinking I didnae want to go back to drugs but then I still had to fill up that emptiness inside, like some part of me is missing. And when I take a drink, that part is full. I don't know if that makes sense. (Sarah)

Rather than representing a calculated decision, the drug women chose as a substitute appeared largely circumstantial, owing much to what was available to the individual in her immediate social environment. Women whose partners or friends were drug users tended to substitute with illicit drugs, whilst those who were involved with individuals who used alcohol tended to drink. For instance, looking at Kim's account, it was apparent that the relative availability of alcohol and heroin within her social circle led her choice of drug at different points. With regards to her use of heroin she commented;

Erm, because it was there. I was roon [round] about somebody that was taking and I didnae know much about it so I was like, fuck it. Aye I'll try it. Gies it and I'll gie a drag, (Kim)

Whilst her subsequent use of alcohol was also influenced by its availability at a time when she felt the need to use:

...when I came afe the crack for a while I found myself drinking a lot more coz I was kinda in a circle of pals that were always drinking and it just carried on fae there (Kim)

In accounts where substitution occurred without a period of total abstinence, (i.e. where use of drugs (typically alcohol and methadone) co-occurred) availability was also a major factor in choice of drug. Andrea described her reasons for substituting methadone for alcohol in terms of the relative convenience of the supply of each substance.

I wouldn't say that I was that much of a big drinker but what had happened was, roughly about this time last year I was in here for drugs and I got afe a drugs and I was on methadone. And I just I didn't, I couldn't be bothered going to the chemist to pick up my methadone and coz he [partner] was sitting drinking I was like that, I'll get a days grace. Instead I'll just have a couple of drinks with him and then wan [one] day went to the next, then the next and then I started feeling rough every morning and then I needed that curer to get me going and that was it. I just never went back to the chemist to get my methadone, just went straight onto drink. (Andrea)

This noted, substitution was also motivated by negative perceptions of the drug previously used based on the consequences this use had had for women in terms of their behaviour, relationships and life circumstances. Fear of reliving these consequences often led women to forswear a return to using their previous drug of choice. For example, Donna's decision to use alcohol as a means of coping was linked to the sense that the use of illicit drugs no longer represented a viable option;

I'm being serious here and my mum and that know this and all, I'd rather do myself in than go back to heroin and all that. No just for myself, I couldnae put my family through it. Even though I never hurted them or anything, I never stole coz I was fortunate, my partner at the time had a lot money so I never had to do anything for it, it was just always there but I would never go back to it. (Donna)

For women who had previously been users of alcohol, negative perceptions of the self as being out of control whilst drinking often underpinned decisions made regarding substitution, again this was often linked to the sense that their relationships would be further damaged by such behaviour if drinking was to continue. Behaving in a socially unacceptable manner, being unfaithful sexually whilst drunk, or becoming violent were discussed as reasons why a return to drinking was unconscionable, as in Celia's account:

I'm feart [afraid] an' all that I hurt somebody, maybe kill somebody, that's how aggressive I was getting and I could see quite easily I could dae it. And I don't know

where the strength was coming from coz I wasnae eating, I wasnae or nothing. I was just on the ceiling. With the alcohol just recently and that's what made me say, oh come on now here, wait a minute....(Celia)

Vicky's sense that she was unable to control herself when drinking and the shame she felt in relation to her behaviour eventually became a reason to stop drinking.

I: Why did you stop drinking?

P: Coz of the things I done on it. The reason I stopped drinking alcohol was because...I canny just drink to be sociable, I've tried it but I can't...any times I went on one of his works night out I would get steaming and make an embarrassment of myself. (Vicky)

Like other women however, the underlying issues which motivated Vicky's alcohol use in the first instance remained, and when negative events were experienced later in life, this led to the onset of her heroin use.

...I was unhappy before I had my son and I thought I'll have a kid and I'll be happy. But I wasnae happy with me and that just wasnae right coz I was on anti-depressants and sedatives [...] ma husband got cancer and all that so there'd been a lot of trauma and that [...] I started taking drugs when he was very young, I'm talking about months old. I didn't think he'd know and it just progressed longer and longer and then my husband just had enough and just walked oot. That's when ma low point was. And even when he left I couldnae see ma son for a while, so that made me right deep intae it and I had to be out of it all the time to cope with my son, to cope with no having him...(Vicky)

Though women often saw substitution of illicit drugs (typically heroin) as a progression in terms of the seriousness of use, a change in use from drug use to drinking was not viewed in this manner. Indeed, for those women who had previously had a problem with drug use, alcohol was seen as having a number of advantages over illicit drugs. Andrea discussed the relative benefits of alcohol and drugs, noting her preference for alcohol in terms of convenience and value for money.

I would say I preferred the alcohol to the drugs. The only worse thing about the drugs is if there's a dry up or you've got to go to different hooses to score, to find oot who's got the best gear. And who's got this an' who's got that. It's all that running aboot that puts you afe. Coz alcohol is legal you wouldn't get an issue, you can buy it and that's it and if the polis come to your door you're no hiding it or anything like that, know what I mean? So...it's easier to get the drink than to get the drugs these days man... With drugs and all, once you've had it you're sitting like that, oh god I've got to get money for the next hit. But the drink you seem to get a longer effect with drink, I think. (Andrea)

The sense that alcohol use was somehow more socially acceptable than drug use was also an appealing aspect of drinking for a number of women as in Pauline's account;

I've got this daft thing in my head where it's alright to be a drinker so I wouldnae bother if people knew I maybe drink. (Pauline)

To some extent then, alcohol use was easier to live with, inviting less stigma and discrimination with which the use of illegal drugs was associated. Sarah's decision to substitute heroin with alcohol was (with her child's social welfare in mind) was led by this reasoning.

I used drugs for, I'd say, wait till I think now, about 20 years or more and then I stopped, I dunno, I stopped taking when ma wee girl started school and...I thought I'm not having her going to school and people saying your mum's a junkie and blah, blah, blah. So I'd take a drink now and again and leave it and then I started going about this guy and he was a heavy drinker and I went from a couple of drinks and built up till it was constant drinking. (Sarah)

It is notable that Sarah's initial (though mistaken) understanding that she would be able to limit her use to 'a drink now and again' also appeared to underpin her decision to use alcohol as a substitute. Indeed, alcohol was typically viewed as more manageable than illicit drugs by women who had substituted one for the other. Kim (who had used both crack and heroin before a period of problematic drinking) explained how she had initially approached alcohol use in the belief that having 'conquered' two previous addictions, she was strong enough to avoid a third.

P: I came afe the heroin, came afe the crack and you're looking for something else to occupy you, you're looking for another...because you've sacked they two you think you're immune to any other kind of habit, do you know what I mean? You don't think that you're...you don't think that you're going to get addicted. You think you're immune to addiction but it doesn't work like that.

I: Why do you think that is?

P: Coz you've conquered wan [one], you think you've conquered wan [one], you've come off it and you think, oh fuck, I won't get another habit man. I've just come off it so I can come afe a..it's an ego trip innit? Kind of like an ego trip. Ach,awaaaay! I won't get a habit, it's no going to happen to me. I can control it, it controls you! (Kim)

Substitution of an illicit drug for alcohol (or vice versa) was typically triggered by the experience of negative life events. Drug type was to some extent dependent on what was accessible to the individual in their immediate social context. However, such decisions were further facilitated by women's reluctance to return to using their previous drug of choice (due to negative associations between using or drinking and the consequences of such use for the individual's life and relationships). This noted, women who had replaced illicit drugs with alcohol appeared to hold positive perceptions of

alcohol as a substitute drug, viewing alcohol use as more convenient and socially acceptable than use of illicit drugs and, perhaps most importantly, as less likely to lead to dependence.

Continuing Alcohol and Drug Use: Perceptions of Physical Health

Women approached drug and alcohol use with little consideration of the potential health risks associated with use. Until obvious signs of physical ill-health did emerge, women continued to minimise risk and view themselves as personally invulnerable to harm, as in Sally's account;

I think its coz you just don't think, it's never gonna happen to you. You hear it happen to other people but you think it'll never happen to me. I'll be 'right. (Sally)

Typically, focus was on managing the immediate ill-effects of drug or alcohol use whilst potential long-term consequences were rarely considered. Sarah had this to say;

Well, apart from no wanting to be sick and shaking and things like that , sweating... It's no as if I was going, oh no, I'm gonna have liver failure or whatever, sclerosis, never thought of that. Never crossed my mind (Sarah)

As use progressed over time however, signs that alcohol or drugs were beginning to cause damage to the body began to emerge. Though women were no longer able to view themselves as invulnerable, health problems that did not cause immediate difficulties in terms of unpleasant or painful symptoms (even if serious in nature) were typically ignored. As Sally said 'you don't think about things like that if it's no affecting you at the time'. Indeed, according to this participant's account the perception of damage to her liver as transient appeared additional justification for bout of alcohol and Valium use;

I: Is there anything else that's worrying you just now?

P: Well, just mair ma liver. I got telt that's the only thing that can repair itself oot of all your organs. So I went on a wee bender there and it did swell up and I don't know if that's what caused it, obviously, it probably is coz it's went back doon noo coz I've stopped.

I: Did you think I'm not well here? Did that enter your head at all?

P: See you don't think about things like that if it's no affecting you at the time. (Sally)

In fact a return to health after a period of illness was often taken as a cue to re-start use. Andrea who suffered from frequent, severe kidney infections which required hospitalisation had this to say;

...as soon as the infection cleared up anyway, the doctor didn't have to say to me. I was like I'm feeling brand new, I can go haim. And then I'd go haim and just start, start from phase one again [drinking]. (Andrea)

Women explained such behaviour in terms of their physical and psychological dependence on drugs or alcohol which they felt removed individual agency in decisions to use. Sarah, who had used drugs even whilst in hospital, felt she had little control over this behaviour due to what she saw as an addictive personality. However, it appeared from her account that despite a perceived lack of agency, she still viewed drug use in this context as functional, providing a means of mood management.

P: When I was using drugs I had bacterial endocarditis, septacemia, nine abscesses in my lungs, pneumonia, suffering from malnutrition, sores all over my skin. I was really seriously ill and I was in hospital for 3 months and it was touch and go and yes, I still carried on. Actually the week I left the hospital I got somebody to bring me stuff up and I had it in the hospital. And I was trying to tell myself, that's my last one. I've got a few days to go and that'll take the urge away and I'd be safe. But the day I got back out of hospital and I got home, I went home and scored.

I: I suppose what some folk might think would be how can you go through all that and it not have any impact on your actions? What would you say to them?

P: I think I've got an addictive personality or gene or whatever, it's just so powerful that it just controls you. It's like a magnet drawing you so it is. It's not just physical, it's an emotional thing as well because whatever you're feeling, if you feel sad or happy or whatever, it'll ease it and make you able to cope better. (Sarah)

In line with the increasing disconnection women experienced more generally as a consequence of their continued use, individuals also appeared to begin to lose touch with their physical self. Sarah explained how as alcohol use became more central in her life concerns about her physical wellbeing gradually fell away.

Thoughts like that just disappear. I mean you loss interest in the way you look, the way you dress, you hygiene, eating, everything just...life doesnae really matter as long as you keep drinking (Sarah)

This was apparent regardless of whether illicit drugs or alcohol were being used in a problematic manner. The pharmacological effects of drugs and alcohol also had the effect of dulling physical sensation making it easier still to disregard symptoms of ill-health, as Kim explained;

I had septicaemia, you know? I was getting sore necks and I was getting headaches and I was rapidly losing weight and people about me were saying, you look ill, you should go to the doctors, you need to go to hospital and I could see it myself but I was like, och, you know. It'll pass. It'll pass. Coz for a start you don't really feel much pain, I mean you don't feel any pain and if I was feeling my neck you know you'd really think I'd be like that, well, there must be something wrong! But when you look back, you won't, you don't really think that you don't look at it that way. All you really care about is getting you next fix.....(Kim)

Though a number of women felt that they lacked control in their decision to continue using, it was apparent that many had weighed up the relative costs and benefits of desistance and had made a conscious decision to continue upon their chosen course despite their failing health. Andrea's account was typical in this respect. Though aware that her alcohol use was damaging her health, previous experience of sobriety and its negative emotional consequences encouraged continued use as a means of avoiding a further resurgence of distress.

I: Do you ever worry about your physical health?

P: When I was drinking or taking drugs no. Never. When I was taking drugs it didn't matter and when I was drinking it was exactly the same, it didn't matter. Although I've had problems before, know what I mean? But it never crossed...it never occurred to me. It's just I noticed every morning when I was waking up, it was like, God! Sore! Know my side and my back and I was going to the toilet. Smell of the urine, horrible smell coming afe of ma urine and that. And I'd think I'd taken infections or a chill or something, that's what I would always think.

I: So you didn't sort of link it up, drinking and health problems?

P: No, no. I knew it was alcohol that was dain it to me but just, it never stopped me fae drinking. He [partner] was like that to me, you need to watch what you're dain.. But I was like, damn it! That was the attitude I had. And what I've found is and aw, see for about 3 week we were afe it and as I says he was on antabuse and all of that and what I found was I got awful, awful depressed and erm, that was when all the feelings came back about losing my brother, you know? And how I never saw my son, I havenae really saw anybody who was really close to me like before. (Andrea)

Though spells in prison had the effect of preventing drug and alcohol use among women for (at least a short time), this also did not lead to desistance in most cases. Rather women's experience taught them that even a temporary cessation of use would lead to the re-emergence of unwanted thoughts and feelings which produced a strong motivation to use as soon as a supply became available. Alice (who had found herself in these circumstances previously) saw this as a self-sustaining cycle in which

considerations of physical health had no place or as she put it was *'the last thing you think about.'*

Using just stops the feelings completely. It's when you stop using that the feelings start flooding back, so you're in the jail and you don't get drugs and that's when they start coming back again and then you come out into society and then its so hard that you just start using again. Just circle. Going round in a circle. It never seems to stop, there's nothing that stops you, especially your health. Your health is the last thing you think about. It's just stupid...it becomes an addiction and you're no caring as long as you've got the drugs or whatever in your body. (Alice)

Unwilling to face the emotional consequences of desistence, women were forced to find other ways of coping with ill-health arising in association with their continued drug and alcohol use. Under such circumstances many women reported using alcohol and other drugs to relieve symptoms despite the underlying awareness that this was likely to make health problems worse. Self-medication (typically with alcohol) was especially likely among women who were using methadone. This was linked to the understanding that pain relief medication would not be made available to them, leaving them to deal with their symptoms in some other way. Fiona explained how this, her lack of faith in 'across-the-counter' pain medication and a strong desire to avoid a return to illicit drug use led to the choice of alcohol for the purposes of pain relief.

P:sometimes my stomach gets dead, dead sore so I'll have a wee drink to take the pain away but then I know it no gonna coz its....my liver is fucked. Know what I mean? It's just mental.

I: So you'll drink as a pain killer basically?

P: Aye, coz when you're on meth there's hardly any pain killers you can take, Coz they all come up as opiates and it fucking murder. And I've tried paracetamols but they don't take the pain away, they just make you feel worse.

I: So is booze the only thing that's left?

P: Either that or back to scoring drugs again (Fiona)

Medical help tended to be sought only for what women considered to be serious health problems. Where illicit drugs were used, this was sometimes linked to the perception that illness might cause disruption to women's mobility and therefore their use. Sally described seeking help only for what she saw as serious or potentially debilitating problems due to the perceived impact on her ability to 'score.'

P: If I couldn't get up and go and do the things that I done every day and that, then I would go to the doctor. Like I had a urine infection wan [one] time and I couldnae get afe

the couch for about 3 days. And I had to go to the doctor, I was shocked it was a urine infection coz I'd been sick an all that, so I was. And I had a pain in my side and somebody said to me, that could be fluid in your lungs and that gave me a fright and that's why I went to him. I went straight into hospital...

I: So what types of things were you worried about not being able to do?

*P: Like getting up to go to score, or being able to go out to get work and get money.
(Sally)*

By contrast, women who were problematic users of alcohol (and therefore had access to much more convenient source of supply) were not motivated to seek help for these reasons. Instead, it appeared that their tendency to self-isolate further removed them from the likelihood of seeking help. Whilst discussing her tendency to miss or delay doctor's appointments, Rhona explained that one effect of excessive drinking was to make any kind of activity seem effortful.

*You get to a certain stage on the drink that you're that comfortable and relaxed and everything you just don't want to move and that. You're just fuck it, I'm no going anywhere. It's an effort to even get up and go get your jacket on to go for mair drink.
(Rhona)*

Indeed, it was clear that when women were forced to seek help this, for some, represented a major undertaking. This was apparent in Andrea's account of a trip to her doctor's surgery which indicated that fear of humiliation and disapproval in the public setting made interactions in this context appear overwhelming.

I kept making appointments and kept making appointments and missing them until wan day I was like no, I need tae to go. So I got up, got the curer and a packet of polo mints, thinking, oh nobody can smell this afe me! That's the first thing that goes through your mind, that they'll be like that, looking at you, you know? And see the mair you try to make yourself look straight, the worse you look! And then you fuck up (excuse the language) and the mair you fuck up the worse it is. And it's like I'm no drunk but you're doing the stupidest things. You're going like that, oh god by the way I've had it with this! Sitting there feeling a wee bit half cut and you're like that, better no be a big line just to gie you a prescription. And the mair you're trying to be aware of it, trying to stay straight, act like you're supposed to be the worse you feel! You're like, OOoo! My god. (Andrea)

Though women lacked the motivation to seek medical attention as a consequence of their drug or alcohol use, the tendency to avoid help-seeking was for some participants also linked to a sense of being unworthy of medical attention. This often reflected a more general view of the self as worthless in the eyes of others, a perception which Alice linked to experiences in her past which had taught her to view her life as having little value.

I think most people would go to their doctor if something is bothering them but me, I just wouldn't. I just don't like bothering people with things like that. Don't like bothering them. If you think about a lot of what I've been through, I don't know...No-one seems to care about me. So if they don't care about me I don't care about myself. I just care about other people. That sounds pure stupid but I'm not caring, my life isn't that important (Alice)

Participants' regard for their health appeared to mirror the course of their use. As women 'hit bottom,' it appeared that they had no concern for their physical wellbeing or appearance (or as Shona put it, "You don't even wash your face, let alone anything else..."). Feeling trapped and suicidal, some women appeared to almost welcome signs of ill-health as signalling an end might be in sight. This seemed to be the case for Kim, who commented:

Never any reason to go [to the doctor] I was looking for a way out anyway so, even if I did notice any symptoms of anything I would dingy them, know what I mean? I push them away to the back of my mind and just go and get another bottle, that's how I dealt with pain (Kim)

Women rarely considered the negative health outcomes of drinking and drug use until obvious symptoms began to emerge. However, unless such health problems caused immediate problems in terms of interrupting daily life (and therefore were considered too serious to ignore) help was not sought and women instead chose to use alcohol or drugs as a means of self-medication. Increasing social and self-isolation characteristic of the lifestyle adopted by heavy drinkers also severely limited the likelihood of women seeking medical assistance. Indeed, even when health problems were life-threatening women reported that this did not result in desistance. Though women cited lack of control resulting from physical dependence as underpinning such decisions, it was evident that some consideration of the costs and benefits of desistance were involved (with continued use being viewed as more advantageous in terms of avoiding the re-emergence of unwanted thoughts and feelings). Thus, a sense of mental wellbeing (or at least the avoidance of psychological distress) was more highly valued among women than their physical health.

Factors associated with Desistance & Recovery: Reconnecting to the Self and Others

'Hitting bottom' was considered by women to represent the lowest point in the cycle of addiction in terms of their social, physical and psychological welfare. However, reaching this stage was felt to be a necessary first step in the process of recovery, preceding conscious decisions to change patterns of use. For example, Shona, like other women, felt that despite losing a great deal through her drug and alcohol use she lacked the motivation and self-control to cease use before it was her 'time to stop.'

I don't think anything stops you, not your health, not anything. My kids have been taken away, my mum had to take my kids, that's my loss. Big loss to me. That still doesnae make me stop. If you canny stop for your kids, you'll never stop, you think you'll never stop until it's your time to stop. Its too controlling, too powerful, naebody can beat it. Unless it's your time up. (Shona)

'Time to stop' (i.e. hitting bottom) appeared to be crucial in engendering an awareness among women that they had reached a crisis point whereat choosing to desist or continue using or drinking represented a choice between life and death. In this way the deterioration of the physical self provided the most obvious, visible wake-up call that action must be taken. Pauline described her recognition of the physical damage she had done to her body through alcohol and drug use as creating an awareness of imminent self-destruction and an accompanying urgency to change.

I hit ma bottom, I couldn't go any lower. I hit ma bottom at so many levels ma body wasn't taking any mair. I was gonna be dead soon....feeling sick, underweight, very malnourished. Veins collapsed in, insides eating way at me because of the alcohol. My body was really, really messed up. You could feel it inside, the drink - a burning feeling. I just knew I was on a timer. I knew I was on a stop clock and it was going down very, very fast...that's when I knew I had to stop... (Pauline)

For other women, physical damage to their bodies at this stage literally prevented use from continuing. For example though Sally's health problems were the underlying reason for her desistence, it was evident that this represented a forced choice.

P: I think its coz I've no got any veins and I got blood clots in baith legs and I was injecting...I had to get this thingy put in, a central line, in the hospital coz they couldnae get a vein when they gave me blood transfusions and I think that's it, coz I've got no veins, that's what stopped me taking it.

I: So what is it specifically about having no veins?

P: I'd have to smoke it and I don't like smoking, It's not the same. It just doesnae gie you the same effect. I knew if I was going to buy a bag I would end up wasting my money coz I wouldnae get it in. (Sally)

For some women a spell in prison was required to trigger thoughts of desistence, this was often linked to enforced abstinence and the experience of severe withdrawal. Andrea described how being on remand (i.e. "doing a weekender") provided the additional push that she required to engender change;

I: I'm trying to understand then, why didn't you stop before...? Why was it at that particular point, know what I mean?

P: Coz I'd been feeling so rough coz I'd done a weekender and all and I was feeling pure, pure rough – I had the bile and spewing up all the time and shakes and all that. DTs and all that. I was like 'ah, ah ah.' (Andrea)

Recognition of physical deterioration represented only part of women's motivation to desist from use. Indeed, in most cases, women placed greater importance on their desire to rebuild relationships damaged through drug and alcohol use as facilitators of desistance. For example, though health was a consideration for Kim, this concern appeared to be underpinned by her desire to be healthy enough to be able to provide adequate care for her daughter.

I knew I was seriously damaging myself but I didn't give a fuck, I was wanting a way out. Came to the day when I thought I canny dae this any mair, man. I've got a 5 year old that needs me, what kind of shitty mum am I going to be?...I just decided I want to change, I'd done too much to my body. (Kim)

Thus, recognition of failing health (sometimes triggered by the experience of prolonged withdrawal in the prison setting) and fear of losing valued relationships appeared to provide the initial impetus to change. However, women's accounts suggested a long history of (often serious) health problems and (in some cases) repeated imprisonment had not previously led to desistance, whilst the breakdown of relationships was also a common consequence of using. Given that such experiences had failed to influence behaviour in the past it appeared that additional factors must come into play to facilitate change. For example, without an 'ultimatum' being issued regarding access to her son, Vicky felt desistance would have been unlikely;

I've got ma son and so I don't want to make a mess, if I do I won't get to see him till he's 16 and that's a long time to wait to see him, that's a big ultimatum to me. I felt to be honest with you, that if that hadnae happened it would have taken a lot for me to be convinced to stop using but because I want my son, I want a good life again...(Vicky)

For Pauline, the negative health outcomes of use appeared to spur change at the outset. However, it appeared to be a shift in her perception of her relationship with her daughter that provided a key motivating factor in her decision to stop drinking. Though Pauline had been aware that this attachment was threatened in the past as a result of her drinking behaviour, this had not led to desistance (perhaps because of the previous perception that the mother/daughter relationship held little value to her daughter). Changes in this perception combined now with the threat of losing this relationship appeared to provide sufficient impetus for change on this occasion.

P: I lost my family as well, my daughter is getting too old for it. She's getting to the stage where she's getting ready to disown me.

I: Would it have had any impact if she'd said something to you before? Did she?

P: Aye, but I didn't think that she cared about me coz she just recently started telling me she loves me. She's never said that to me before, so I think if I'd have thought I had a chance with her I would have given up... (Pauline)

Indeed, the perception of being valued by others was of great importance to many women in terms of their recovery. Typically, women reported high levels of social and emotional isolation and difficulties expressing negative thoughts and emotions about past traumas. The existence of relationships perceived as positive and loving appeared to support desistance through influencing women's sense of self and their ability to connect with others. For example, Ruth discussed how her relationship with her partner underpinned desistance by encouraging self-acceptance, increasing self-esteem and providing her with an alternative means of coping with distress (in that this bond provided her with a trusted confidant). As this attachment removed the primary purposes of drug use (i.e. psychological disconnection and connecting with others) Ruth felt that she no longer needed drugs.

P: I've got a good partner, know what I mean? I've got a solid partner and, like when I met him I was a total wreck. I had nae self-esteem, I'd nothing. Erm and I couldnae believe that he wanted to stay with me and I gave him a life of hell but he stuck it oot! And he's still wi' me the day. So he made me believe in myself again and made me realise that these things that happened werenae my fault. Coz for years I punished myself but how can I be responsible for what men do to me? So, I realise now that I'm no responsible and they're the wans with the problem not me. Noo I know that I'm a lot better, my self-esteem is away up there again and I like myself. But before I met my partner I was the total opposite, know what I mean? I hated myself, I hated life I thought I was nae good for nothing but then he made me believe in myself again and fae then I've just felt better and better and better.

I: What was it he did that made you feel different?

P: Erm, he loved me! He loved me! And I didn't think anybody would have...I couldnae understand...We were close friends and I telt him everything. He was in the jail and I was writing to him and I was kinda opening up bit by bit....He's oot the jail eventually though so I've got that to look forward to and that's why I'm no using drugs any mair. I'm like that, nah, don't need them know what I mean? (Ruth)

Indeed, being able to connect and identify with others and express previously suppressed emotions was seen as key to recovery among most of the women interviewed in that this decreased the sense of disconnectedness which women typically identified as underpinning drug and alcohol use. Vicky's contact with staff and other users (at the rehabilitation centre and at meetings she attended) appeared to serve this purpose, making her feel able (perhaps for the first time) to share the feelings that she had previously avoided through drinking and drug use.

I think being here I don't feel as lonely, plus I've got to, at meetings, we've all got to share at NC every week. Someone comes along and gives their share and you can identify coz you feel the same. It's no ever, oh I've never done that. It's always you identify with them. I identify with them so it's having someone that understands. That knows.....I've got to experience my feelings now. I think it's like just the way I was brought up, you don't express your emotions, you just get on with it. I think maybe I used substances to block my feelings out. I think that's what the bottom line is. (Vicky)

Similarly, Alice acknowledges the importance of poor mental health in initiating substance use and the importance of addressing mental health problems as the first and most essential step in facilitating long-term changes in use.

Mental health is a big issue for some people. It's a big issue. I do think you need to target mental health before you target anything else. The mental health honestly is the thing that keeps things going so you have to deal with mental health problems first off and then you might be able to cope with everything else after it. Coz it's my mental health that's put me where I am I, know what I mean? I've kept everything locked up in there and that's why I use. So I need to deal with that first and then deal with everything after that. (Alice)

It was evident, as Alice continued, that critical in this process was being able to understand and resolve emotions connected to the traumatic experiences which were felt to be at the root of drug use and drinking, and to find an alternative method of coping with these events;

I: What needs to change for you to get rid of your drug using?

P: Dealing with the issues that I've got that are underneath it. The rape and things like that. I need to learn to deal with that as a person without drugs (Alice)

The existence of a positive attachment in women's lives also appeared to impact on perceptions of the risks associated with drug and alcohol use. Feeling connected and valued by others appeared to lead to a greater value being placed on the self. This in turn appeared to lead to greater focus on physical health. This was evident as Ruth continued:

I watch what I'm dain now whereas when I was on drugs I didnae. I didnae care, if I hurt myself or I was ill, I'd just think, oh it doesnae matter, it doesnae matter. Now if I feel any way no well at all, I go to the doctors noo, know what I mean? Coz I never went to the doctors before for years. I'd just phone them up for a repeat prescription once a month and that was it. (Ruth)

Indeed, looking after physical health became more of a priority in women's lives in the context of these relationships. Kim understood being healthy as essential to re-building her relationship with her daughter.

I: How much does your health figure in wanting to stop drinking

P: Very important, if you've nae health you're nae life. If my health is fucked, I'm fucked. Won't be able to run about with my daughter (Kim)

Recovery was also associated with reconnection to the self. Women frequently talked about their 'real' self re-emerging (or emerging for the first time) during this period and the importance of self-exploration, as in Shona's account;

I'd be the wee shy wan in the corner but noo I'm like, aye I'll do it and I'm away up here! And I'm like, why am I dain this? And they're like, that is you, that's the real person. The person on drugs isnae you, so it's weird to find yourself again. Find out who you are, what kinda person you are, what kinda things you like. (Shona)

Indeed, achieving self-knowledge and understanding was seen as key in the process of self-acceptance, which was felt to underpin long-term change. Vicky discussed the importance of this but noted also the difficulty of achieving such a goal given the sense of regret and self-blame associated with her previous lifestyle.

P: When I first came in [to the centre] I was just crying all the time coz I couldnae get over the guilt and the shame what I put my son through, even just being a user - all that. But erm, I had to work on me first before I could accept what I'd done and think well, I've done that I can move on. I'm always going to regret what I've done but it is okay to move on. And that's what I've always needed to know because that's why I kept doing things. Because with the alcohol I drank more because I'd done stupid things, and then I went onto drugs coz I wasnae happy. Just realising all the guilt and shame but it's all right to move on and learn from what you've done.

I: You said there you need to know its 'okay' to move on, I wondered why you said it like that?

P: I suppose it is punishing yourself to some extent. I used to think the guilt and shame I couldnae move on coz of the things I had done but that's the only way I can, if I accept I've done that. I've accepted what I've done. I'm no saying its good things I've done, far from it, but I've got to accept what I've done and that's in the past. It has to be from now. (Vicky)

Indeed, attempts to change behaviour without a central focus on self-knowledge and development were linked to difficulties desisting from use. Celia noted how her tendency

to focus on the needs of others as a motivation for abstinence (rather than a focus on her own needs) had tended to result in relapse.

I was doing all the things for everybody else but no for Celia. So I think that's how I kept relapsing all the time (Celia)

Women interviewed often reported relapsing in the past but remained hopeful that they would be successful in their attempts to change their behaviour over the long term. Typically however, women viewed recovery as an ongoing challenge as Pauline explained;

Naebody can say never. That's something they'll always say to you in here, to everybody in recovery. You can be in recovery 5, 10 or so years and still relapse and though I don't think I will, you can never say never. (Pauline)

Though many women felt confident they would be able to maintain recovery, it was clear that perceptions of alcohol use as manageable persisted for some, as appeared to be the case for Shona;

P: I don't want to stop completely but I think I'm going to have to. Don't think I can touch another drink again. I'd like to be able to see if I could. But I could start it all off again, know what I mean?

I: And what do you think your chances are?

P: I think I can control it but people say that that's my addiction kidding me on.

I: And what do you think when people say that?

P: Don't know, I just keep thinking, ach, I'll just have a wee drink that night and I'll be able to put it down and just get on with my day the next day. (Shona)

Analysis revealed that women's experience of recovery was one of gradual reconnection with the self and others. This included not only the re-emergence of self-identity but also a reconnection with the physical self which brought about a greater focus on health concerns. Though physical deterioration sometimes acted as a trigger for the conscious decision to desist, women clearly felt that the most important factor in recovery was to achieve mental wellbeing. This involved achieving a sense of self worth and identity and learning to cope with the emotional and psychological issues without the use of substances. Improvement in physical health, it was felt, would follow from this, as a result of the ability to care for one's self and one's body.

Understandings of Sex whilst Using or Drinking

Attitudes towards sex

In general, women felt that using alcohol and/or drugs affected their attitude towards, and desire for, sex. A large proportion of the women interviewed had at some point been users of heroin. Use of this drug was typically associated with an almost complete loss of interest in sex, as in Rhona's account;

You just don't feel like having sex when you're on the drink or drugs, your sex drive – it kills your sex drive. Your sex drive goes oot the windae [window]. It does for a lot of people. (Rhona)

Though there was general agreement on this point, women's understandings of the influence of alcohol use on attitudes towards sex showed some variation. In some accounts, alcohol use was associated with a greatly decreased sex drive. For Kim maintaining a steady supply of alcohol became her central concern whilst sexual thoughts and feelings lost meaning;

I just loss all interest , I'm mair interested in where I'm getting the money for my next bottle than fucking sex or, know what I mean? Goes oot the windae for me (Kim)

Other reports, however, suggested that, for a number of women, alcohol increased interest and desire for sex. For example, though Donna still placed some value on physical intimacy with her partner whilst using heroin, she felt her interest in sex during this time dwindled. This she contrasted to a later period of alcohol use during which she felt that sexual feelings had returned;

Och, on the heroin I didn't have a sex life, just couldnae be bothered, rather sit with a bit of foil that have sex. Erm, I wasnae interested in sex. Coz it's no just that, he was no interested either, so it was the two of us. As long as he was there and I was getting a wee cuddle that was fair enough by me. But the drink was completely different, even though I wasnae having it [sex], I was wanting it. I used to sit and think about it! (Donna)

Overall however, women reported gaining little pleasure from sex. In some cases this was linked to having a partner who also drank heavily and the sexual difficulties this appeared to lead to. Celia's explained her lack of sexual interest in her partners as linked to the impact heavy drinking had on their sexual attractiveness.

I never really, had a sex drive, right? See coz if you're going to bed with somebody that's reeking of drink or they'd be sweating or...it's no very attractive. Or they'd fall asleep on you or they'd be up all night, sitting drinking all night and then they'd wake you up early in the morning and its just when you've weans to look after, or work to go to and they're being selfish. So I was just like that, nothing at all. (Celia)

Indeed, even when women were motivated to have sex, sexual difficulties linked to their partner's alcohol use meant that sex was rarely enjoyed. Andrea discussed her frustration in this respect.

Like my partner, he drinks, falls asleep. Well he doesnae fall asleep, he's [konked out] Aye! Exactly! Wakes up has a nap and the bump, back again. Me I, when I was drinking – life and soul of the party, all joking and carrying oan and all that, noising everybody up and that no?... He'd take brewers droop or something, know what I mean? [laughs] And it'd be like aye right. Or he'd ejaculate too early and I'd be like, fucking hell! What did I fucking even get in ma bed for? And this was all a big deal at the time. I'd be thinking right I've got to try and wear nice undies, make it all nice and all that. And I'm like fucking did that for that? A fucking poxy three minutes? Is that it? I was like, ahhh! (Andrea)

Low interest in sex, combined with low levels of enjoyment, meant that many women viewed having sex as a chore or duty within the relationship as Liz explained;

When you're taking heroin, it takes you libido away. It takes your sex drive away...when I'm drinking or on drugs because you canny really feel anything and you don't really enjoy it so you're really dain it coz you have to or to make somebody happy, you're no doing it for yourself. (Liz)

Though a number of women linked sexual difficulties to their own (or their partner's) drug or alcohol use, some accounts suggested that low interest in sex had other origins. Shona felt her 'drugs came first' (and thus may have influenced her attitude to sex); however her account also suggested that she viewed her lack of interest in sex as being due to some flaw within herself.

P: I wasnae a very sexual person, I hated sex. Didnae enjoy it, errrm....my drugs came first, errrm sex didn't get a look in, I hated it. Even if I did have it and that wasnae very often, I didnae get an urge for sex I didnae want it. Even if I was on cocaine -people get horny on cocaine and want sex- but I didnae. I was - don't come near me, don't even come near me! I don't like it, I'm just no into sex at all and it doesn't bother me. I don't get anything out it.

I: What is it you don't like?

P: I find it boring! I think it's absolutely crap, I'd rather go to sleep. Get afe me, hurry up! Oh no. I just, I've never had an orgasm wi' it from the start. Like everybody talks about these things 'orgasms' and I'm like, what is it? ...Everybody thinks there's something wrang wi' me and I think sometimes there's something wrang with me, how do I no like sex? (Shona)

It was apparent from other women's accounts that low enjoyment and interest in sex was viewed (to some extent at least) as being linked to previous experiences of sexual

victimisation. For example, though Celia perceived the quality of her sexual experience as being affected by her partners' sexual difficulties (which she understood as being caused by excessive alcohol use), she also viewed early experiences of sexual abuse as affecting her ability to enjoy sex;

I: So you didn't enjoy sex in your relationships full stop?

P: No. I think it's to do with what happened to me when I was younger and it was to do with the drink and...maybe that did with the drink as well and I don't really realise it even though it was. Half the time men can't even perform when they're drinking. Some are just...over, their sex drive just goes right over. I think though what happened when I was young, I'm not able to trust, or relax and enjoy sex the way I should I think that still holds me back. (Celia)

While the above suggest a link between drug use and (to some extent heavy drinking) and both a decrease in sexual activity and interest in such activity, the role of alcohol in sexual behaviour was more complex than this. Alcohol was also used instrumentally by some women to both facilitate and improve the experience of sex (It is noteworthy that sex was usually construed as intercourse by participants). Fiona associated alcohol use (and to a lesser extent the use of stimulants) as enhancing sexual enjoyment through reducing inhibitions regarding sex;

When you're drunk you don't really care, you can have a laugh. I've got mad photies [photos] and I shouldn't even have mad photies! But you have a laugh. You're mair open to trying other things and having a laugh aye, I'd say that about drink. But no with the drugs though I suppose with uppers it's the same (Fiona)

Some women reported that they sometimes used alcohol as a way of preparing for sex, seeing drinking as a way of gaining the confidence to have sex. For example, Sarah talked about using alcohol as a way of relaxing and easing self-doubt prior to sex. This appeared especially important to her in the early stages of sexual relationships as a way of avoiding social awkwardness. That her partners also tended to be drinkers appeared to provide a social context where the use of alcohol for these ends was acceptable.

P: ...if I've just no long been in a relationship and we were still...early doors. If you'd had a drink you were more confident and mair at ease and mair relaxed especially if you were going to bed! Gave you Dutch courage.

I: So what do you feel like you would have been like without it in that sort of situation?

P: Shy. Aye, shy and...um...shy and quiet.

I: What, erm...would that have been a bad thing then...erm, no.....or what did you think would happen if you were shy and quiet?

P: I don't know I think that coz the two of us were drinking, errrr...it was never, I've never been in a sorta relationship where it's been me drinking and the other person no drinking. It's always been the two of us that's been drinking or using or whatever, it just seems to break the ice and make it easy instead of it starting with a bit of awkwardness. [laughs] (Sarah)

Similarly, Shona used alcohol in the hope it would increase her sexual confidence. This she hoped would allow her to enjoy sex, something which she did not feel capable of without drinking. However, rather than enhanced enjoyment or loss of inhibition (in a more general sense) being the primary aim of drinking in this context, Shona's real concern appeared to be proving to herself that she was capable of enjoyment and thus sexually 'normal;'

P: Drink gave me confidence. And that's why I drank as well to get mair confidence for sex for instance.

I: But see what I mean, why even bother drinking to have confidence to have sex when you're not going to enjoy it anyway? What was the reason for having sex then?

P: To see if I could enjoy it with more confidence to act like that, coz otherwise I was really shy and I've no confidence at all. But I was like that, well if I take a drink I'll have more confidence and I can be more open. I didn't see another way to dae it....And plus it's no very good for a relationship when you're like that. Erm... you just keep on thinking that you're different and why do I no like sex and how can I give myself the confidence to get in there and be open instead of turning the light afe, I'll get in first, half your clothes on, half afe. It's horrible. (Shona)

The belief that alcohol use would somehow make sex easier or more enjoyable meant that drinking became part of some women's routine preparations prior to sex, as in Pauline's account;

If I was going to have sex I would get full of it to dae it, When you hear it out loud it sounds crazy doesn't it?... No that it was gonna be just anyone, obviously it would be somebody that I knew if it was gonna happen. But imagine getting full of it to make the night go like [clicks fingers] because you know that night you're gonna have sex, know what I mean? Makes you less uptight. It's like one of those preplanned things you know what I mean? Like shaving your legs for the night, know what I mean? I'd be sitting with my bottle of vodka. Oh whit? (Pauline)

In summary, while drug use was generally associated with a complete loss of interest in sexual activity, the role of alcohol was more complex. For some women, excessive alcohol use meant that all interest in sexual activity ceased. However for others, the relationship was more complicated. Some women acknowledged the role of alcohol in

facilitating sexual activity and experimentation. Indeed, some women used alcohol instrumentally, believing that it would give them the confidence to enjoy sex more. For some, enjoyment meant the ability to experiment, however for others, who lacked sexual confidence and who gained little enjoyment from sex, alcohol provided a means to overcome these difficulties.

Alcohol Use and Perceptions of Sexual Risk

Alcohol use and perceptions of 'promiscuity'

Though women saw alcohol as having a positive function with regards to their sex lives, they also acknowledged that using alcohol to induce the confidence to have sex or improve sexual experience had the additional consequence of affecting their judgement in sexual situations; this was viewed as influencing risk-taking behaviours. Most women reported inconsistent condom use when they were not 'working' (i.e. selling sex). Thus, an increase in 'promiscuous' behaviour (i.e. having sex with a number of partners either serially or concurrently) was often associated with increased risk. Like many other women, Pauline felt drinking not only led to greater promiscuity but also impaired reasoning and decision making with regard to her choice of sexual partner;

P: With alcohol, no with alcohol you're more promiscuous, so you are.

I: By promiscuous what you meaning?

P: Just mair tartish basically. [laughs] You are though, it's a known fact. You know what I mean, you're mair brazen with a drink in you. Like I would never have thought of bedding that guy and I did. And I was keen to get him intae bed one of the times, I don't know why. (Pauline)

However, from the accounts of many of the women, it appeared that the link between 'promiscuity' and alcohol use was more complex than Pauline suggested. Liz, for example, suggested that attributing 'promiscuous' behaviour to alcohol was disingenuous at best, as it was likely that behaviour would not alter in the absence of alcohol;

I know people say that they do become more promiscuous with drinking but a lot of the time they're just as promiscuous without the drink. So they canny blame the drink or the drugs. And as far as people saying drugs, there are only certain drugs that can make you do that. A lot of drugs actually take your sex drive away so there's usually a reason why you're doing it, you know? I mean I know girls who have sex because of their insecurities and just to feel wanted not coz they want tae. But if they're gonna do that when they've been drinking and taking drugs, they're going to do that when they're straight and sober. (Liz)

While Liz is expressing an opinion, some evidence to support her claim can be found in the accounts of both Vicky and Andrea. Vicky clearly makes the link between wanting to have sex to feel loved and accepted and the manner in which being drunk facilitated 'risky decisions' which allowed her to have sex to fulfil these desires;

I: You're saying you took a lot of risks, how did that come about when you were drinking, like with guys and so on?

P: That was even with my partner, it was just coz I was drunk. I wanted to be accepted all the time.

I: What do you mean by that?

P: Just guys to like me but they're all really just after the same thing aren't they? But you think coz they're showing you a bit of attention you're getting accepted... I just wanted to be loved even though I was with my partner, I was always wanting that extra bit, something else. (Vicky)

Interestingly, Andrea, in the quote below, explicitly dismisses alcohol as a causal factor in her sexual risk behaviour. Instead, she reflects on the role of alcohol in facilitating risk behaviour that she acknowledged that she wanted to engage in (i.e. having unprotected sex with a man who was not her current partner).

P: I says, I'm no blaming the drink obviously I should have kept myself straight enough, especially if you werenae there. You know what I mean? To know what I was dain and when I was dain it and everything else, but I wasnae.

I: Why do you think you didn't by the way? Why do you think you didn't at the time sorta keep straight?

P: I just kept thinking coz we'd been arguing, it was kind of ah, fuck him anyway. I don't care if I fuck this up. But inside I'm really thinking, I hope he's alright. But then you get to the stage that you just don't give a fuck, you're like fuck I'm going to get pissed and that's it. (Andrea)

Finally, Pauline, who had earlier suggested that alcohol was causal in risk (i.e. alcohol 'made' her promiscuous) notes the role of worsening alcohol abuse on perceptions of risk, where risk is acknowledged but possible harm is rendered meaningless by the spiralling despair associated with continuing use;

I didnae really care about ma life, I'd no expectations for anything, I didnae really care what happened to me. If somebody had given me an STD, somebody gave me AIDS, I wouldnae really care. But, looking back it went though ma head. Oh he's [sexual partner] likely to gie me something but I don't care about it. That's the way I felt at the time...I

was running about fighting and all at the time as well. The reasons I was fighting I know noo by looking back was I didnae care what happened to me. I didnae care if I got stabbed. (Pauline)

Alcohol use and condom use

As stated above, most women reported inconsistent condom use with non-commercial partners. Inconsistency of use was linked to a number of factors, including dislike of condoms and scepticism about their efficacy;

I: So talking along those lines, what do you think to using condoms?

P: They're crap! Crap! As in crap! As in they still don't protect you coz they burst.

I: Do you still use them?

P: Me and my husband no, we never. But if I go doon toon I use them then. Definitely. (Heidi)

Heidi's reference to 'doon toon' refers to selling sex commercially. Women who were involved in selling sex felt they used condoms consistently (as this was deemed a high risk situation) even when under the influence of illicit drugs. It is worth noting, however, that some accounts suggested that this may not be the case, as drug use caused memory lapses which made self reports of consistent condom use in commercial situations problematic;

P: I woke up 3 days later and I'd been in the toon working and everything and I didnae know I'd been oot working coz I was that mad with it I didnae know what I was doing.

I: And how did you feel about that when you realised?

P: It was just like part of my life had gone.

I: But if you couldn't remember working

P: Anything could have happened to me.

I: Were you worried you might have caught something.

P: No, no really coz ma pal who I used to go with, the two of us worked always together and if somebody stopped and they wanted me, I'd say can she come wi' us but she'll get out when we get wherever we're going. And if they said no, I didnae go with them. So she was always there with me, and even though I was full of it, you know what you're doing. Although you forget like maybe the next morning when you get up you do know what you're doing at the time I think anyway.

I: So did you get checked out after that.

P: No, coz I didn't need to coz my pal had been there anyway. (Sally)

Another factor associated with non-condom use was beliefs about what was and was not risky in the context of sexual behaviour. Ruth, in her account, clearly felt that she was at low risk because of the long term and monogamous nature of her relationship and her avoidance of 'promiscuity';

I never slept about know what I mean? It's just been my partner and that's it and before I went with my current partner I was 3 year on my ain. So like sex was never a big thing in my life so I don't worry about sexually transmitted diseases or that. I've never put myself in the position where I should worry. Like I've never been out two nights in a row and slept with different guys in a row and any time he's been in jail I've never slept with another guy...Coz you know who you're wi' then, alright you never know everything about anybody. It's impossible to know everything. I mean I've been with my partner for years and I know there's things I still don't know about him. (Ruth)

However, the low risk that many of the women associated with non commercial partners appeared to be a function, not simply of monogamy, but arising from the belief that their partners were 'safe' because they were known and trusted. These beliefs were fairly consistent across accounts. Perceptions of unprotected sex in a relationship as low risk appeared to be linked to the sense of security women felt when with their partner. For Kim, feeling 'safe' enough to have unprotected sex was underpinned by a sense that her partner could be trusted, which in turn was linked to sharing the same social circle.

P: At the time its just a safety element, you feel safe wi' them, so you're no exactly thinking that you're going to be in danger coz you know them and you feel safe with them and obviously you need to feel safe with them to sleep with them anyway! But erm, the fact you do know them makes you feel that wee bit safer that you don't think of, oh my god I might get such and such. You don't think that know what I mean?

I: when you say you know them, what would you need to know about them?

P: Well, the person I'd slept with them I'd known for a good few year know what I mean? I was pally with them, I knew who they'd been with, well obviously no everybody but round about when I was there, people that I knew and hung about with and shit like that (Kim)

In addition, accounts suggested that in relationships, condom non-use was not only a result of trust between partners, but a proactive strategy to please a partner and achieve closeness with that partner;

P: ...one night he didnae like them, could he no use one and I said aye.

I: What made you decide that?

P: Because I trusted him. I'd been with him that long and all and as I says I had him up on a pedestal and I suppose it's to please him, please your partner. You want them to be happy so if he thought he'd enjoy it more without I was alright with that. I never really thought about it, just seemed right at the time. I mean we were really close, like tight. I was totally in love with him and I knew he wanted weans (Ellie)

Perceptions of risk and experiences of prostitution

A proportion of the women interviewed reported that they had been involved in prostitution in the past as a way of funding (mainly drug) use. Selling sex was viewed as especially high risk in terms of sexual health. However, involvement in prostitution appeared to skew understandings of risk in personal sexual relationships. Sally, for example, while continuing the theme of the importance of trust in personal relationships, also contrasts this relationship with the high risk nature of commercial sex. This contrast served to further minimise perceptions of risk in her personal relationships;

I: Do you think you might have taken any risks then as far as sex is concerned that might have put you in harms way?

P: Aye, aye definitely. With working in the streets

I: What do you consider risky?

P; I could have caught anything, I could have got murdered. Anything could have happened to me, touch wood I'm wan of the lucky wans [ones] that it didnae.

I: But you feel you're not taking risks in your relationship?

P: No we know one another and if he was gonna do something by now he would have tolt me. I says to him about that wan guy so...

P: I don't worry about it noo. I did used to worry about it.

I: What made you worry about it before?

P: Coz I worked the streets but coz I'm just going with him I don't need to worry about it. Coz I trust him. (Sally)

Furthermore, for women who had sold sex, the dislike of condoms discussed earlier was compounded by the association of condom use with commercial sex work, as in Pauline's account:

I: So using condoms wasn't really something you thought about?

P: Just when I was working and all that, I think that's maybe why I didnae as well because I associated them with that. That sounds crazy. (Pauline)

While participants usually spoke of sexual risk in terms of the perceived 'riskiness' or 'safety' of a sexual partner, women who had sold sex tended to view themselves, and not their partners, as 'high risk' in terms of having been infected or infecting others with sexually transmissible infections;

I'd worked while I was wi' him [partner], I wasnae thinking o' oh, you're thingy [high risk] and I might catch, I was thinking of ma guilty conscience, I'm thinking of that condom that had split on me. (Pauline)

It was apparent as Pauline continued, that this view of self as 'high risk' appeared to influence attitudes and behaviours towards risk reduction in the context of sexual behaviour. Though this participant felt alcohol use affected her sexual decision-making to some extent, she also linked condom non-use to her belief that she may already be infected with a sexually transmitted disease; thus practicing safe sex was case of 'too little, too late'.

I: How much did alcohol affect you using condoms, if at all?

P: I don't know. I don't know. It's...I think I was always....see in some ways I kinda already telt myself that och, I might already have a disease because of the amount of things that have already happened. Even though I hadnae been tested and I didnae know at that point so, och that wouldnae have made a difference, because of the way things had worked out with [sex] working and things like that. I think that was a lot to do with it. That was the way I thought at the time. But not using the common sense to think, well even if I have, be careful! (Pauline)

Similarly, Andrea's willingness to accept her partner on trust (with no information about his sexual background) appeared to be linked to downward comparisons made by her between her perception of him as a 'nice guy' (i.e. presumed to have a 'respectable' and low risk sexual history) and herself as high risk.

No it never crossed my mind for one minute, coz he was so nice. I'd heard so much about him, know what I mean? He didnae seem the type of guy like just tae jump in and out of bed with anything and I was like that wait until he finds out about my past, you know and when I said it to him he was like you finished now? And he's like that so, what

you've done is in the past I didnae even know you at that time. And what I've done in the past has got nothing to dae with you. So we've been together 6 year next year. (Andrea)

Perceptions of risk and drug use

Sharing needles whilst injecting was also seen as very high risk behaviour in terms of contracting blood borne viruses (e.g. Hepatitis B, Hepatitis C, HIV), which could also be transmitted sexually. Women who hadn't injected therefore tended to see themselves as very low risk or risk free due to their lack of involvement in injecting (and also in prostitution);

P: All I've had in here [in the centre] is the hepatitis jag [vaccination for Hepatitis B]. Its actually part of this programme [of treatment].

I: Would you have had it otherwise?

P: Nope.

I: How come?

P: I don't know, coz I didnae think it was for me.

I: How come? Coz I don't know your background or anything?

P: A lot of things like that, see I don't inject, I don't work the streets, like muck about or anything like that. I've stuck to the wan guy. I smoke drugs and I shoplift so I don't see myself being very high risk so I don't see that as particularly applying to me. (Alice)

A strong association between injecting behaviours and risk also appeared to underpin the idea that if a sexual partner was thought to have avoided intravenous use of drugs they might be considered to present a low risk in terms of carrying and transmitting HIV through sexual contact. Kim explained here how her decision to have unprotected sex was based on the belief that her partners, as a non-intravenous drug users, were unlikely to be infected.

I knew they hadnae used intravenous, know what I mean? I didnae think I was gonna get AIDS afe them anyway, I don't share and I was only jaggig for a short period of time, know what I mean? And I was always dead careful about it coz things like that do scare me, but no – they werenae intravenous. (Kim)

In summary, women typically understood unprotected sex with multiple partners (i.e. sleeping around' or being 'promiscuous') or sex with an individual whose sexual history was unknown as high risk, whilst unprotected sex with a long term or known partner was viewed as low risk (and therefore as not requiring safe sexual practices such as condom use). Alcohol, but not other drugs, was implicated as a factor in risky sex. The most

important factor in decision making processes in this context, however, was women's own perceptions of risk. Similarly, alcohol, while being cited as a causal factor in risky sex, was also used a facilitator for potentially risk sex.

Individual Factors Associated with Sexual Risk: Communication Skills and Knowledge

Difficulty talking about sex

Many women interviewed found it difficult to be open and trusting in sexual relationships and reported experiencing problems talking about their sexual needs with partners. Ruth linked this to previous experiences of sexual victimisation which she felt had affected her ability to trust men fully when in a sexual relationship.

I didnae talk much at all, know what I mean? It was just kinda of a ...,it [sex] just happened and you just kinda got on with it. I never really had a partner that I sat down and spoke to anyway until I met him so....I just never, I never trusted any of them to talk to any of them, sexual-wise coz I'd so many hang-ups about men. (Ruth)

This difficulty in communicating with sexual partners also appeared to affect women's ability to negotiate condom use. For women who had been involved in prostitution, there was a further barrier to communication; for Pauline, this was associated with a lack of confidence in behaving appropriately in a sexual situation with a personal partner, given that her experiences selling sex were negative and she lacked experience in having sex in a personal context. This meant that she feared behaving inappropriately and any possible subsequent rejection;

I always remember wanting to use contraception but I was embarrassed of asking...everything I'd known sexually I learned on the streets working when I was 16 so I was still actually quite naïve about sex. I was really....still naïve coz any experience I had sexually wasnae a nice one. So, I don't know, I didn't really know how to deal with it or how to broach the subject with them. I didn't have the confidence in myself to think it's alright to ask that. You need to be confident and I've not been confident enough to think, this is acceptable, it's alright for me, he's no gonna laugh at me. Know what I mean! Ask! Know what I mean? It's fine. I was already scared about doing the actual act itself coz there was always that thing because I'd been out on the streets, like will I say...he doesnae like me if I say this and that. (Pauline)

Lack of knowledge and awareness

As discussed above, women's understandings of risk appeared to strongly influence their sexual decision-making. However, these understandings of risk were underpinned by a lack of accurate knowledge and awareness about sexual health and risk. Indeed, there was a strong sense in accounts that women felt ignorant about sex and sexual

health. A number of women linked their lack of knowledge to chaotic and unstable lifestyles wherein traditional sources of information and support were typically absent. Donna, who felt she knew little about these issues, had this to say;

P: I've never had a bond with like ma mum for ma mum to sit down and tell me [about sex] and I was never at school, I was always dogging it [playing truant]. My mam never sat down and told me anything, god, I started my periods and she just went, oh go away and got my auntie. (Donna)

As Donna continued, it was clear that this situation had led to her viewing signs of sexual infection as stigmatising and therefore too embarrassing to discuss. Any information she did possess was gleaned from listening to other people and this information was of doubtful provenance;

I: How do you think that has affected you?

P: I get embarrassed coz I don't know, see discharges and everything, I thought you were black [dirty] because that happened. I never got told anything basically and what I do know I don't even know if it's right because I'm just sitting listening to people in company talking. (Donna)

Indeed, direct conversation about personal concerns or experiences about sex and sexual ill health was typically viewed as non-normative or taboo within women's social circles and was as such avoided, as in Sheena's account.

I: What about other STD's?

P: People don't talk about it. People don't walk about saying, I've got gonorrhoea [laughs] It's just no done [laughs] people would think (Sheena)

For many women, access to information about sexual risk and sexual health appeared to occur for the first time in adulthood as a result of pregnancy (or more typically) spending time in prison or a community-based rehabilitation project. In addition to the other barriers to knowledge discussed above, lack of knowledge and awareness was also linked to drug and alcohol use, as this participant in her thirties, explains;

P: To be honest I never really knew anything about it. STDs or anything. I'd never heard of it. All I knew about was AIDS, that's all I'd heard about. Chlamydia and that's it. Didn't know any other at all till I came in here and heard about it..., came in 8 weeks ago....some people know what to look for but I don't think I do. Like when I was younger I didn't even know what Chlamydia was until I got older and heard that it was common. I got told that in here. But other than that I wouldn't even know when to go to my doctor to get checked out. It would be good to learn these things coz you're no learning when you're out of it on drugs or drink or that. You don't want to. You're not even here. (Shona)

Lack of accurate information about issues associated with sexual infection also presented difficulties for the women in assessing their health status, as lack of knowledge about symptoms (or the lack thereof) presented difficulties in this context;

I had to go doon the toon to work [sell sex] and the Durex burst one time...just a couple of months ago and it kinda worried me. If I've got anything. I've nae discharge or anything like that but I'm still worried. I wouldnae know what to look for. (Heidi)

Similarly, Suzanne feels that an absence of feeling ill means that she is not infected with a transmissible disease;

P: I still have to get other tests to make full sure, I said I was okay for them to be done so I'm waiting for them. But everything is fine. I don't feel ill, so everything is fine.

I: Do you feel, think you'd feel ill if you had something?

P: Maybe feel sick or something? (Suzanne)

Another important issue associated with women's lack of accurate knowledge was apparent in beliefs about the controllability of risk via careful partner choice. The accounts of a number of women appeared to suggest the belief that, in some cases, risk could be judged by the physical appearance of one's sexual partner. This was apparent in Vicky's account (although she also attributes lack of risk awareness to drug use);

P: I wasnae thinking about risks, he seemed brand new, he didn't seem ill or anything. So I thought I'd be fine.

I: What were you looking for, you said he seemed 'brand new'?

P: He didnae seem ill, like yellow or that, like you know when people have got the Hep and that you think they have yellow faces and just dead ill and...I don't know. I honestly don't know what I was looking for. I think I was just oblivious to everything because I was that into the drugs. (Vicky)

Following on from the quote above it was apparent that, for some women with a history of drug use, the most salient risk in terms of infection was Hepatitis C. While Vicky was discussing risk of Hepatitis C in terms of sexual transmission, the relative ease of transmissibility via other routes (compared with HIV) meant that Hepatitis C was perceived as a major risk, with risk of HIV being seen as 'a thing of the past';

P: You don't hear about HIV as much. [...] But you don't really hear about it with drugs as much [...] it is a worry obviously. But HIV is mair a thing of the past as such, no a thing of the past but, its no as many people whose sharing needles coz there's so many

places you can get needles and that nowadays. [...] With HIV there's no really an excuse nowadays. No really that there is with Hep [...] but there's so many ways you can get it. People think that using clean needles is alright but then there's things like tweezers! They don't realise things like that! (Pauline)

As Pauline continued, it was apparent that another factor in the salience of this risk was the perceived prevalence in the peer group. Importantly, this also served to minimise any consideration of STIs;

P: When I'm with people who use drugs, they will talk about Hep all the time, never HIV. [...] you don't hear of people with HIV going about, but you hear about people with Hep going about. I don't know why. I don't know whether it's your addiction runs you down in that way. [...] But you hear every second lassie in here has got Hep, honestly, you'd be surprised.

[...]

I: I just wondered how much people think about other STDs?

P: No, I don't think that people think that much of them.... (Pauline)

In summary, participants reported a lack of accurate knowledge about sexual risk, sexual health and sexual ill health. This lack of knowledge was associated with a number of factors, including lack of information early in life and a normative sanction against discussing concerns about these issues. Women also reported experiencing difficulties communicating with sexual partners. One health risk that did appear salient to women with a history of drug use was Hepatitis C; however this also served to minimise concerns about STIs in general.

Failure to Seek Help for Concerns Relating to Sexual Health

While there were a number of factors which mitigated against accurate risk perception and the ability to carry out adequate risk reduction practices in the context of sexual behaviour, women did experience anxieties about their sexual health. However, seeking professional help in the context of sexual health was difficult for participants. Any sexual health care sought was often opportunistic. Cervical smear tests were often perceived as a context in which other concerns could be raised;

I: You've mentioned before that you've thought about this [STIs], it has always been at the back of your mind?

P: Aye, back of my head and every now and again it would come into my thoughts but it wasnae as if it was totally right there in ma head all the time, know what I mean? ...So when she was doing the smear and that I asked if she'd do the sexually transmitted disease.

I: Was it only now you started worrying about it?

P: Aye, well it has always been in the back of my mind but, erm, coz I wasnae going for ma smears or anything like that I couldnae get tested for anything else. It was just niggling away at me but I never got it done. (Sarah)

However, women did not always volunteer for such procedures;

I: Did you have regular smears before?

P: [...] see when I came in here [rehabilitation centre], I said I havenae had one [cervical smear test] for a long, long time and she [nurse] said aye, you have [had a cervical smear test in the community]. My memory is so bad with drugs, I've lost a lot of memory.

I: But you managed to keep those appointments?

P: No, she [health professional in community] used to grab me! [laughs] When I used to go up collect my methadone and she'd be like come here, you need a smear. And I'd be like, oh no, I had to bump intae you. We used to run away from her and she'd catch us. But if it wasn't for her I wouldnae have had it done. (Shona)

Indeed, Shona's narrative is an example of a more generalised tendency not to be proactive about seeking sexual and reproductive health care, with the result that, even when services are available, there often had to be an explicit offer of such services in order to engage women. An additional issue, for Shona and other women in the sample, was that memory problems associated with substance abuse meant that difficulties were experienced remembering to make appointments, keep appointments and retain health related information.

As mentioned in Sarah's narrative above, there was often long delays between onset of anxieties and help seeking. One factor which contributed to this delay was denial that the participant had put herself at risk. For Andrea (who had had unprotected sexual intercourse outwith her regular relationship), denial was facilitated by alcohol use. In addition, such use was also a barrier not only to making appointments with health professionals, but in keeping those appointments;

I: What did you do about (if anything) like the fact you hadn't used a condom?

[...]

P: I was like, nah, nah, nah, nah. I'll be fine, I'll be fine, I'll be fine. Touch wood. Touch wood. And touch wood, I was. But it coulda been the other way, you know what I mean.

I: I wondered whether you'd gone and got checked out or anything

P: Basically about 8 or 9 weeks later I was like, I better go and get a wee check up. [laughs]

I: How come you waited that long?

P: Just coz, I was on the drink constantly.

I: Were you worried about whether you had anything or passed it on?

P: No.

I: Did you have sex in that 8 weeks?

P: Aye, me and my partner and he did protect himself at first coz we didn't know about... said till you go get checked we're using protection and I was like no problem, no problem but I just kept missing appointments. (Andrea)

In addition, there were a number of barriers associated with seeking testing for HIV or Hepatitis²³. In the extract below, Shona reflects on the stigma associated with being diagnosed HIV positive and the perceived hopelessness associated with such a diagnosis. In addition, her statement that thinking seriously about risk is only possible when women are clean and sober “*only time you care about it is afterwards*” was a consistent theme among participants;

P: I think they're scared of it [HIV/AIDS]. We've been brought up to see it as dirty and to be scared of it.

I: What do you mean?

P: You're a dirty person if you've got it.

I: Can you just tell me what you mean by dirty in case I'm misunderstanding you.

² When women refer to 'Hep' or 'Hepatitis,' this is Hepatitis C.

³ While transmission of HIV and Hepatitis can occur via various routes, it has been included in this section for the sake of clarity.

P: You've got it through being either a slut or being a junkie. Naebody ever thinks, she might have loved the person she got it fae, he never told her or whatever. Erm, or an accident with blood. If I ever got it. Oh, touch hairy wood! If I had the virus or anything – I hope I never need to say that – they'd all say junkie, that's how she's got it. Slut.

I: So do you think there's still a big stigma?

P; Aye very - and that's how nobody wants to know if they've got it..and like I say, why everybody who does get it wants to end their life, just keep dain drugs. And dain everything they shouldn't dae until you die. Or just dae a big dose o' drugs and that's it. That's what I would do. I would end it. There's a lot of users that ken they have AIDS but they don't speak about it. But that doesn't stop us fae taking chances because when you're withdrawing and the drugs come in, you don't care, you'll dae anything. Only time you care about it is afterwards.(Shona)

In addition, women were aware that testing for HIV and other infections involved more than simply presenting for a blood test. Participants spoke of the perceived need to discuss issues relating to risk with health professionals both prior to and after testing. While some women wanted to take a test and get the result, they felt unable to engage in the *process* of testing because of the chaotic nature of their lifestyles while using substances. An additional issue was that such discussion would reinforce the negative feelings women already had about the risks they had taken. This made undergoing such testing even more challenging for women who were already in a very vulnerable position and also mitigated against full disclosure;

P: I'm trying to not to overwhelm myself with things like HIV, AIDS and Hep so I'll deal with the Hep one first.

I: So how do you feel about going to speak to them?

P: I don't want to speak to them as such right, at first, I just want to get the thing done. I don't want to sit and talk to the, I don't want all this, (wah wah wah) counselling. I just want to go in and get the test. Good luck to them trying to get blood out me, probably need to take the blood out maself!

I: What is it that puts you off about counselling?

P: I don't know coz doing things like that brings everything heavy...when you're hearing all the things you've done bad, you don't need to hear that. Coz they need to address it kinda thing I would imagine. I don't why, I don't want to hear about my mistakes it's horrible to have to sit and [...]

I: Is that what you imagine it will be like?

P: Aye a bit. I think it will be but I'm not answering them anyway. I just want to get the test done.

I: What sorts of stuff do you not want them to bring up?

P: I don't know just the way they'll be kinda like...have you [been] vulnerable this time, have you been vulnerable that time? You already feel stupid for the mistakes you've made and hearing them just, it endorses that feeling you know what I mean? (Pauline)

However, while seeking help was associated with a host of difficulties for participants, receiving negative test results could have a positive impact. For some, this provided an impetus for future safer sexual practices (i.e. using condoms);

P: If I was to meet somebody just now if things don't work out with me and this person, er... I would definitely have safe sex.

I: What's changed?

P: Coz I've had the all clear and I don't want to go through that again.

I: Anything else [That's the reason] how has that affected you then getting the all clear? What difference has that made?

P; Erm, Its made me realise how stupid I was to be honest with you that I took those chances and could have had underlying sexual diseases at the time and kinda passed it on tae other people and could have ended up making me infertile and all that carry on. (Sarah).

In summary, there were a number of barriers to help seeking in the context of sexual health. Substance abuse was associated with delay in help seeking and, even when women were aware that health care was available, often uptake of care was opportunistic and required proactive offers of help from health care professionals. Testing for HIV or Hepatitis C was associated with a number of barriers; the *process* of testing was often seen as aversive to women whose lives were chaotic due to substance abuse and/or were already suffering feelings of guilt about their past risk behaviour.

Discussion

Previous research has highlighted that alcohol misuse is a significant problem among female offenders (Fazel et al, 2007; Gelsthorpe et al., 2007). Such use is also associated with a number of poorer general health outcomes, (English et al., 1998) increased risk of mortality for both men and women (White et al., 2002) and increased vulnerability to negative sexual health outcomes (Cook et al., 2006). Studies have also indicated that alcohol (and other substance use) can best be understood as embedded within the context of people's lives (Barnes-Powell, 1997; MacAskill et al, 2001). The current research aimed to explore women offenders' understandings of the relationship between alcohol and other substance use and health (including sexual health). However, in order to do this, it was deemed necessary to explore these understandings within the wider context of women's experiences of initiating, continuing and considering desistance from substance use. Thus, the data obtained offers an appropriately contextualised account of women's perceptions of health and health risk in relation to drug and alcohol use trajectories.

Data from this study supports previous research that links problematic substance use with childhood abuse (Wilsnack et al., 1997; Schuck & Spatz-Widom, 2001) and negative life events throughout the lifespan (Johnston et al, 1997; El-bassel, 2006). In addition, women reported a consistent lack of perceived positive relationships. Indeed, women described few experiences of empowering, supportive or empathic interactions with others. Instead, accounts focused on violations in relationships (which were linked to diminished self-worth, distress and difficulty expressing emotions). This resulted in a sense of emotional isolation, underpinned by the belief that others in the immediate environment were unable or unwilling to validate and respond to the individual's emotional experience. Thus, drug and alcohol use was initiated as a means of psychological disconnection from aversive emotions and situations. Paradoxically however, achieving connectedness with others was also given as a reason for initiation of substance use, in response to emotional isolation and (given women's inability to cope with their emotions and perceived lack of self-worth) in the absence of more adaptive methods of relationship formation. This is also consistent with previous research (Covington, 1998).

Thus, initiation of substance use can be understood as a coping strategy that sought to simultaneously escape from negative emotions and facilitate the formation of relationships. However, this method of coping was ultimately self-defeating. As substance use continued, women found themselves increasingly physically and psychologically dependent. Ironically, increasing dependence was associated with a growing focus on a search for substances at the expense of relationships and, as a result, women spoke of increasing social isolation which seemed to be most prominent in the case of alcohol use. At this point, continuation of substance use was not simply a function of physical addiction; two other factors were important. Firstly, periods of

sobriety led to experiences of extreme emotional distress which were aversive and increased the likelihood of substance use being maintained. Secondly, for many women negative life events occurring after use was initiated, or as a consequence of use, were a further disincentive to desist. These findings are supported by a variety of literature; for example relational theories of women's development (Covington, 1998) where the experience of non-mutual and abusive relationships (typical of those described by women in this study) result in a 'depressive spiral' leading to substance use as a way of coping with intense emotions and the hopelessness arising from these experiences. Similarly, Social Learning Theory, when applied to alcohol abuse, 'posits that problem drinkers exhibit coping deficits and hold positive expectancies or beliefs about effects of alcohol that independently and conjointly promote the generalisation of alcohol consumption as a coping strategy (Britton, 2006. P103). Research, while mixed, has implicated deficits in emotion focused coping as a risk factor for problem drinking (e.g. Windle & Windle, 1996) and a prospective study of heavy drinkers found that progression from heavy drinking to drinking which met the criteria for alcohol abuse was associated with drinking to reduce negative affect (Carpenter & Hassitt, 1998). Drug use has also been linked to deficits in coping and to stress (e.g. El Bassel et al, 1996).

While the above discussion focuses on the relationship between substance use in general and factors associated with initiation and continuation of use, patterns of substance use and choice of substances do not necessarily stay static across the lifespan. Consistent with previous research, the majority of participants in this study had a history of co-morbid alcohol and illicit substance use and used different substances at different points in their lives (see also Gossop, Marsden & Stewart, 2002; Lehman et al, 1990 and Mullen & Hammersley, 2006). Reports of patterns of use revealed that, for about half of these women, alcohol use preceded use of illicit drugs and for the other half the reverse was true. This allowed exploration of women's perceptions of the relative costs and benefits of alcohol and illicit substance use, the factors which underpin initial choice of substance and the considerations which underpin decisions to substitute one substance with another.

In discussing factors underpinning changing patterns of use and substituting one substance for another, it should be noted that, unless otherwise specified, both alcohol and illicit drugs served similar functions i.e. they were used instrumentally to provide distance from aversive emotions and, in the initial stages at least, to facilitate relationships with others. Importantly, when initiating substance use, choice of substance did not appear to be dependent on factors such as the legality or otherwise of the substance, perceived differences in the psychological effects of the drug or considerations of stereotypical risk factors associated with either alcohol or illicit drugs. Instead the choice of first substance appeared to be solely dependent on availability and the perception of its use as normative within the immediate social context⁴. However,

⁴ This said, reasons for the initiation of drug use were different from alcohol use in the respect that drug use was often initiated to achieve connection with a drug-using partner. This connection, however, differed from the more generalised motivations of achieving connectedness in the

factors which drove decisions to change substances, while also predicated on availability, were more complex. As discussed above, substance use in general, while used as a coping strategy, did not address the underlying issues. Thus, switching to another substance was often an attempt to cope more effectively with unresolved emotion or new, aversive life events. Two further points are important here. First, events that women perceived as aversive were not always inherently negative; it was the perception of events as aversive because of a perceived inability to cope that was key. Secondly, switching substances often followed a period of voluntary desistance (often because of the perceived negative effect of the initial substance on women's lives). However, for many participants, sobriety prompted a resurgence of negative emotions that they felt they could not cope with; this prompted recourse to a different substance. Thus, while the perceived negative impact of one drug may prompt motivation to desist, in the absence of adaptive coping strategies, such desistance may itself be a risk factor for initiating further substance use. Evidence suggests that stress is implicated in relapse to substance use (Sinha, 2001). For example stress, when combined with high psychosocial vulnerability, including a relative lack of effective coping skills, can predict relapse (e.g. Brown et al., 1995). In addition, a recent study of female substance abusers who had stopped drinking and/or using substances suggested that inadequate treatment of depressive symptoms was a risk factor for relapse (Ambrogne, 2007). Finally, it should be noted that, whilst substitution of illicit drugs (typically heroin) was seen as a progression in the seriousness of use, substitution with alcohol was crucially not viewed this way. For former drug users, alcohol was perceived as having a number of advantages; in relative terms it was cheap, less stigmatised (because of its legal status), more readily available and perceived to be less dangerous. In a number of cases alcohol and methadone use co-occurred. This would appear to be in line with previous work which had shown a high prevalence of dual use among individuals on methadone programmes (e.g. Statsny & Potter, 2006).

As discussed above, many of the findings regarding factors underpinning initiation and continuation of substance use have been found elsewhere in relation to this and other populations. The strength of this research is that it situates understandings of physical and sexual health and risk to health within the trajectory of substance use. As such, the issue of health is not divorced from the larger context of women's lives, allowing detailed examination of the role of health in decisions to initiate, continue and desist from drinking and drug use. Unsurprisingly, the health risks associated with alcohol and other substance use were not a deterrent to initiation of substance use. This was largely due to feelings of personal invulnerability to health problems associated with use. This is

sense that, for non-drug using women living with a drug using partner, initiation of drug use was seen as a route to engaging with a partner who was disengaged because of that use. Wincup (2000) reports similar reasons for the onset of illicit drug use among women involved in the criminal justice system.

consistent with both general socio-cognitive research which suggests that individuals are generally unrealistically optimistic about their vulnerability to health risks (e.g. Klein & Weinstein, 1997) and specific research which suggests, for example, that heavy drinkers are likely to deny the potential harm to health associated with alcohol use (Hansen et al, 1991) and that raising awareness of the risks of drinking is most difficult among heavy drinkers (NHS Health Scotland, 2002). In addition, the functional nature of use meant that the immediate benefits (to relieve emotional distress) outweighed any possible long term negative physical effects.

Considerations of risk to health did not prove to be a disincentive to initiating substance use; however as women continued drinking or using drugs, obvious signs of physical ill health emerged in most cases. This did not appear to prompt desistance, or indeed motivate health care seeking. Instead, the severity of such symptoms was usually minimised and health problems that did not cause immediate difficulties, or were perceived to be treatable or curable, were easily ignored. Whilst some women attributed continued use of substances (in the face of sometimes very serious health threats) to lack of control over their use, others clearly felt that the costs of coping with the extreme emotional consequences of sobriety was a powerful disincentive to desisting. In addition, substances, at this point, served a dual role; relieving both psychological pain and serving as an analgesic for the physical pain associated with deteriorating health. Indeed, medical help only tended to be sought as a last resort or where health conditions were seen as impeding the ability to procure substances (given the ready availability of alcohol, this latter issue was more salient for drug users). This is consistent with previous research concerning the chaotic and sporadic use of health services by drug users (e.g. French et al. 2000). For alcohol users a significant barrier to help-seeking was their self-imposed isolation. Such isolation was associated with feelings of security and comfort whilst contact with others was seen as threatening (in some cases threat was associated with fear of being humiliated and stigmatised because of their drunkenness in a public setting).

It was clear therefore that, despite general reports of failing health and indeed a number of life threatening illness and near-death experiences, these were insufficient to motivate desistance. Indeed, worsening physical health was only cited as a contributory factor to desistance when women became aware that they had reached a crisis point where desistance was their only option. For some women, this was clearly linked to extreme physical deterioration and the acknowledgement that continued substance use may be fatal. For other women it was simply the fact that physical deterioration left no avenues for substance use i.e. veins had collapsed making intravenous drug use impossible. Similarly, other types of extreme situations had not promoted desistance in the past e.g. incarceration. Instead, what appeared to be the crucial trigger in motivating wishes to desist was an awareness among women of 'hitting bottom' (this is consistent with other research examining desistance from heroin use among adult men; Mullen & Hammersley, 2006).

In the current study, 'hitting bottom' represented the lowest point in the cycle of addiction in terms of social, physical and psychological welfare. The primary motivation for desistance at this point did not appear to be related to health; crucial in the recognition that behavioural change was a necessity was the issue of relationships. At this point, women described a growing awareness of the damage done to relationships because of substance use and a wish to repair or renew some of those relationships. However, such awareness was not arbitrary. Instead, it appeared to be prompted by a perceived shift in their understanding of a valued relationship. Thus, the possibility of gaining, or indeed losing a relationship they now came to realise as valuable appeared to be the key factor in decisions to desist. The importance of positive changes in interactions with significant others for desistance has been noted in other work (Klingemann, 1991).

It appeared, therefore, that the primary factor in recovery was to attain mental wellbeing and to reconnect with the self and others. Relationships were key in initiation of desistance, and also in the process of recovery, where positive and loving attachments supported desistance by giving a sense of being valued by others. Participants were clear that achieving mental well being was the main goal of recovery (this involved achieving a sense of self worth and identity, an important part of which was learning to cope with their emotional and psychological issues without the use of substances; see also Mullen & Hammersley, 2006). Indeed, other work has shown that abstinence is underpinned by better mental health (Mertens et al, 2003; Weisner et al, 2003) and less avoidant coping (Chung et al, 2001; Moggi et al, 1999; Moos and Moos 2005) whilst severity of mental health problems are predictive of relapse (Scott et al, 2005). Improvement in physical health was felt to follow an improvement in psychological wellbeing as the increasing importance of valuing the self was extrapolated to valuing the body. The primacy of relationship concerns over health concerns per se is further illustrated by the finding that women wished to recover physical health primarily to support efforts to maintain valued relationships. However, while research has highlighted the relationship between risk of substance misuse and a variety of mental health issues, such as depression (Ambrogne, 2007), childhood sexual abuse, (Schuck & Spatz-Widom, 2001) and later sexual victimisation (Walters & Simoni, 1999), treatment of substance abuse tends to be carried out without sufficient reference to mental health concerns as part of that treatment (HEBS, 2000); thus, there is a need for an integrated treatment model (Ambrogne, 2007)

It has been noted that alcohol and other drugs largely served similar functions for participants in relation to coping with aversive emotions and life events. In the context of sexual health, however, participants clearly perceived alcohol use to be a much more salient factor in relation to sexual decision making and sexual risk behaviour than were other substances (i.e. illicit drugs). The lack of perceived impact of illicit drug use on sexual risk behaviour was a function of a complete lack of interest in sex associated with such use. While, for some women, involvement with alcohol abuse also meant that all interest in sexual activity ceased, for many participants, the role of alcohol in sexual risk behaviour was more complex.

Some participants did attribute a causal role to alcohol in relation to sexual behaviour, in the sense that being drunk meant that they were more likely to engage in sex. Others, however, reflected on the instrumental nature of alcohol use in relation to sexual behaviour. Some participants, for example, acknowledged the role of alcohol in facilitating sexual activity and this was associated with a perception of increased confidence as a result of alcohol use which facilitated enjoyment of sex. For some, enjoyment meant the ability to experiment, however for others, who lacked sexual confidence and who gained little enjoyment from sex generally, alcohol provided a means to overcome these difficulties. In the context of sexual risk behaviour, alcohol was perceived as both causal (in the sense that use was an impediment to sexual decision making, both in terms of partner choice and condom use) and instrumental, with alcohol used to facilitate risky behaviour by some participants where that risk simultaneously fulfilled another need e.g. obtaining love and acceptance or facilitating sexual behaviour outwith an established relationship. The instrumental use of alcohol in relation to sex have has been found in other populations (e.g. Cooper, 2002). Indeed, in a study of women attending a Genitourinary Medicine clinic, no evidence could be found a causal role of alcohol or drugs in sexual behaviour; rather substances were used instrumentally in order to be able to engage in sexual behaviour (Taylor et al., 1999). It should be noted that the instrumental use of alcohol may be especially salient in women who have aversive reactions to sex because of earlier sexual victimization. This suggestion is tentative, because of the nature of the data. However, there is a relationship between childhood sexual abuse and elevated sexual risk behaviour later in life (Maillings et al., 2003). In addition, a study by Walters & Simoni, (1999) found that a history of sexual assault by a non partner was associated with both substance use and elevated sexual risk. The authors speculated that substance use may mediate the relationship between sexual trauma and elevated sexual risk (Walters & Simoni, 1999).

In relation to perceptions of risk, women typically understood unprotected penetrative sex with multiple partners (i.e. 'sleeping around' or being 'promiscuous') or sex with an individual whose sexual history was unknown as high risk, whilst unprotected sex with a long term or known partner was viewed as low risk (and therefore as not requiring safe sexual practices such as condom use). While alcohol use was cited as a contributory factor in condom non-use, it was clear that it was women's own perceptions of risk that primarily drove decisions about the 'safety' or otherwise of sexual partners. Issues such as knowing and trusting one's partner were important factors in calculations of risk, as was wanting to be close to that partner. This is consistent with previous research in other populations (e.g. Kershaw et al, 2003; Misovich et al., 1997; Duncan et al, 2008). Given the association between lack of interest in sex and illicit drug use, the association with risky sexual practices and such use was only salient in relation to commercial sex. While women involved in prostitution clearly stated that condoms were used consistently in this context, reports of drug use while selling sex means that this assertion must be treated with caution. Experiences of prostitution also impacted on perceptions of risk,

with women who had been involved in selling sex positioning themselves as high risk in relation to their personal sexual partners.

Given that perceptions of risk seemed to be an important factor in women's decisions about sexual risk taking, these decisions were often made in the absence of accurate knowledge about sexual risk, sexual health and sexual ill health. This lack of knowledge was a function of a number of factors, including a lack of opportunity to learn about sex and sexual health early in life (due to lack of engagement with the issue by caregivers) and chaotic lifestyles which precluded the opportunity to gain information from other sources (e.g. school). In common with other populations, the stigmatised nature of STIs and the non-normative nature of communicating about personal sexual concerns, exacerbated this situation and also made assessment of health status difficult (due to lack of accurate knowledge about STIs) (Duncan et al, 2008). Women also reported problems communicating with sexual partners, which mitigated against negotiation of safe sexual practices. While difficulties in such communication are not confined to this specific population (e.g. Amaro et al., 1995) such difficulties may be exacerbated among these women, both because of the prevalence of sexual victimization in this group and also because normal anxieties about appropriate behaviour within a sexual encounter may be magnified by the experience of prostitution. The difficulties in maintaining an intimate relationship while selling sex is associated with elevated sexual risk (e.g. Warr & Pyett, 1999). Finally, it was notable that, among women with a history of drug use, one health risk did appear to have some salience i.e. Hepatitis C. Compared with HIV, the higher prevalence of Hepatitis C among IV drug users in Scotland (HPS, 2008) and more numerous routes of transmission meant that Hepatitis C was a greater objective threat to drug using participants than HIV. However, lack of accurate knowledge about calculating risk, and the use of alcohol and/ or drugs in the context of sexual behaviour, suggests that behaviour was unlikely to be modified significantly in sexual encounters in response to this threat. Further, the data also suggests the salience of Hepatitis C may serve to further minimise consideration of the risk of STIs in general.

The increased vulnerability to sexual risk and sexual ill health among this population increases the importance of being able to seek prompt and appropriate health care in this context. Substance use was associated with delay in help seeking and participants were rarely proactive in help seeking. The sexual health care that participants had experienced was largely opportunistic i.e. delivered in prison, while pregnant or, more rarely, delivered via a specialised drop-in centre for women involved in prostitution. Even when women were aware that sexual and reproductive health care was available in the community, engaging them appeared to require proactive efforts from health care professionals. Finally, regardless of route of transmission, a consistent finding worth noting here is that testing for HIV or Hepatitis C was associated with a number of barriers. Most importantly perhaps, for women who did consider testing, the perceived *process* of testing (involving discussion of risk behaviours) was often seen as aversive. For women whose lives were chaotic due to substance abuse, the time and effort involved in engaging with the testing process was seen as unrealistic. For women who

were already suffering feelings of guilt about their past risk behaviour, the expectation about being expected to discuss past behaviour was threatening.

Issues of reflexivity must be considered in the presentation and interpretation of qualitative data. The aim of IPA research is to understand the topic of interest from the participants' perspectives. This type of in-depth research requires that participants' have the ability to reflect on their experiences and communicate these experiences to the researcher. Participants in this study were able to reflect on their experiences of substance use, and consider possible causes for such use. They also spoke frankly about issues associated with health and sexual health. As such, the authors believe that the data is representative of the women's understandings of the issues under discussion. That said, consideration should also be given to factors which may have impacted on data collection. It should be noted that women who participated in the study were, at the time of interview, taking part in ongoing intervention and treatment programmes at the rehabilitation centre. Thus, their narratives could have been influenced by previous discussion of similar issues within a therapeutic context. In addition, women may have been motivated to discuss their experiences in such a way as to present themselves in the most positive manner possible, especially since the interviewer was a professional woman from a different background to themselves. However, while these influences cannot be discounted, the complexity and depth of women's accounts would suggest that they were giving frank and open reports of their experiences. That said, it should be noted that the situated nature of our findings mean that they cannot be generalised to the wider population of female offenders or problematic substance users. However, this data provides valuable information on which to base future research. In addition, given the fact that very few research studies of this kind have been carried out in this area, this data is itself a valuable addition to knowledge.

Conclusion

This research has provided a contextualised view of understandings of health outcomes among women who use substances problematically and are involved in the criminal justice system. While a number of the findings of the current study support previous work, very little of this research has been based in UK or Scottish settings or with this specific population. Even fewer studies examine mental, physical, sexual health in the context of substance use trajectories among women or, indeed, groups of women who represent a particularly high risk of negative health outcomes (such as the current sample). Data from this study suggests that this population faces a multiplicity of challenges (e.g.. substance use, high risk health and sexual health behaviours and mental health issues) and that these issues cannot be understood in isolation; rather, results suggest that each of these factors interact to increase vulnerability in every area of women's lives. This research has demonstrated the value of situated studies in providing new insights into the complexities associated with understanding health beliefs and health behaviours in a population with multiple disadvantages and risk factors. Given the dearth of literature

investigating physical, sexual and mental health among heavy drinkers in the UK, and the evident vulnerability of this particular high risk group, further research is needed.

Recommendations

- Findings indicate that the main factor motivating choice of first drug used (either alcohol or illicit drugs) is the relative availability of these substances in the immediate social environment. In addition, there is also a tendency among users of illicit drugs to view alcohol as a safer, cheaper, more socially acceptable alternative to such drugs. The ready availability of low cost alcohol, and the culturally acceptable nature of alcohol consumption appear to be associated with initiation of alcohol use in this vulnerable group. Given these findings, the Scottish Government's (Scottish Government, 2008) emphasis on addressing low cost and high availability of alcohol as a route to societal change with regards alcohol misuse would appear to be well founded.
- According to the findings, continued heavy drinking appears to lead to increasing self-isolation; as such, points of contact with health services are few. Especially in the case of problem drinkers, voluntary contact usually occurs (e.g. with general practitioners) when health is failing. Otherwise, the key events which bring women into contact with the healthcare system are life events such as pregnancy or imprisonment, or being on a methadone programme. Thus, healthcare professionals need to be proactive in offering healthcare opportunistically to these women. In addition, when women do attend healthcare settings every effort should be made to identify them as problem drinkers and to involve Community Health and Care Partnerships in an effort to meet their multiple needs.
- Findings suggest that women perceived their ability to care for their physical health as compromised by poor mental health. Therefore, efforts to promote physical health are unlikely to be successful in the absence of support for mental health needs. Equally, prolonged abstinence without adequate social support appeared to be unrealistic for this population, especially when women felt unable to cope with problems in living. It is also likely that this support will need to be long-standing, as positive effects are unlikely to be seen in the short-term.
- Given the interrelated nature of factors underpinning health and substance use risks in this population, no one factor (e.g. physical health, sexual health, mental health) should be addressed in isolation; a holistic approach is required. Overall,

findings are consistent with policies to increase the integration of all services. Efforts to divert women from the criminal justice system to substance abuse treatment in community settings where such a holistic approach is possible (within a safe and non-threatening environment) should be increased.

- Results suggest that risk factors for this population, in the context of sexual health, do not differ dramatically from other populations in terms of factors that increase risk (such as risk perceptions and lack of accurate knowledge and the instrumental use of alcohol to facilitate sex). However, the degree to which alcohol is used instrumentally in this population may be higher than in other populations. While this point is certainly speculative, the data does illustrate that there was an association between high levels of sexual victimisation among participants and difficulties with, and aversion to, sexual intercourse. Discouraging alcohol use in the context of sexual behaviour in this population may require addressing, in the first instance, the sexual difficulties associated with earlier sexual victimisation. Interventions are needed to promote risk reduction practices such as condom negotiation skills. Interventions are also required to improve self-efficacy and promote skills which would allow women to feel secure in both refusing unwanted sexual encounters and communicating their sexual needs to non-commercial partners without the use of alcohol. Finally, given the high level of sexual difficulties reported by participants, there may be a need for psychosexual therapeutic intervention with this population.
- A significant barrier to seeking testing for HIV and Hepatitis C was the perception that testing was a process involving a number of steps, most notably disclosure of past behaviour to a health professional. This was perceived as both unrealistic and threatening in the context of these women's lives. Significant outreach work may be necessary in order to reduce the perceived aversiveness of this process and increase uptake of testing. Training women in this population (who are in recovery and who have undergone testing) as peer educators may be especially useful in allaying fears.
- In the process of initiating, continuing and desisting use, physical health is not prioritised among this population. Therefore, health promotion efforts focussing on the negative health effects of alcohol and other substances may not be the best strategy to aid desistence. Given the focus and primary importance of establishing and maintaining relationships as a reason for initiating drug use, and re-establishing relationships as a reason for desistence, health promotion efforts may be more usefully targeted at the social and relational consequences of alcohol and other substance use.

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