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***“Slowed right down”*: Insights into the use and abuse of alcohol
from research with Aboriginal Australians living with HIV**

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***"Slowed right down": insights into the use and abuse of alcohol from research with
Aboriginal Australians living with HIV***

Keywords: Indigenous, Aboriginal, alcohol, HIV, risk behaviour

Abstract

Objective: To describe the role that alcohol plays in the lives of Aboriginal people living with HIV in Western Australia

Methods: Semi-structured interviews were conducted between February and September 2003 with 20 Aboriginal people who were HIV-positive; almost half the total number of Aboriginal people known to be living with HIV in Western Australia at that time. The main purpose of the study was to document the experiences of Aboriginal people living with HIV and aspects of health service delivery.

Results: Drinking emerged as a major theme in the majority of those interviewed. Alcohol had a major role in disinhibition and risk taking behaviour of both the participants and those they socialised with. It was perceived as a commodity, a way of altering reality, and a pathway through which social connection was maintained and was central to the common narratives of loss, chaos and transformation. Post-diagnosis, alcohol helped with disclosure and temporary blunting of distress as a result of the HIV diagnosis. It also contributed to a lack of capacity to comply with antiretroviral therapy although narratives also included personal growth and restoration of physical health.

Conclusions: Effective strategies to reduce risk of STIs and HIV and prevent other health problems need to address substance abuse issues but this also requires amelioration of the

structural inequalities that make minority groups vulnerable.

Introduction:

The Indigenous people of Australia are Aboriginal and Torres Strait Islanders[¥], and they account for less than 3% of the Australian population. On markers of disadvantage such as income, education, employment and housing conditions, they feature at the lowest point (Department of Indigenous Affairs, 2005). This disadvantage contributes to high rates of environmental and behavioural risk reported by Aboriginal Australians, and to profound health disparities (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2005). Historical factors, including colonisation with its legacy of violence and disempowerment, repressive and exploitative government legislation, poor housing, lack of environmental and social supports and the failure of policy to address these issues contribute to ongoing self-destructive behaviour and disempowerment amongst Aboriginal people (Hunter, 1990).

Like other Australians, many Aboriginal people experience problems related to alcohol consumption. While proportionally there are more non-drinking Aboriginal people, those who consume alcohol do so at levels that are more likely to be hazardous (Chikritzhs et al., 2007; Commonwealth Department of Health and Aged Care, 1996). Harm can result from excessive drinking on a single day or from regular excessive drinking. The health effects include physical harms resulting from risk-taking behaviour and from the effect of alcohol on body organs; mental health problems; and effects on social relationships that impact upon the wider community. In 2004, WA Indigenous alcohol attributable deaths were 10/10,000, more than double the national average (Chikritzhs et al., 2007) and the Aboriginal:non-Aboriginal rate ratio for hospitalisation for all alcohol-caused conditions was 9.3:1 for males and 12.8:1 for females. Other problems include

[¥] There are two Indigenous populations in Australia, Aboriginal people and Torres Strait Islanders. For convenience, and because all our participants were Aboriginal and preferred this term, the term Aboriginal is used throughout this paper in relation to study participants.

alcohol-related violence, over-representation of Aboriginal people in the criminal justice system, and other signs of social breakdown (Makkai, 1997; Mason & Wilson, 1989; Walker, 1997). The Royal Commission into Aboriginal Deaths in Custody which examined 58 Aboriginal deaths in police custody between 1980 and 1988, revealed that two-thirds of those individuals were detained for an offence relating to alcohol and that alcohol was a significant factor in custodial deaths (Smyth, 1989). Alcohol and drug use remains a major factor contributing to the high rates of Aboriginal incarceration.

Anecdotal reports from those who live and work with Aboriginal people link sexual risk behaviour with heavy alcohol consumption. Rates of child sexual abuse and violence are known to be high in Aboriginal communities (Gordon, Hallahan, & Henry, 2002). Epidemiological studies have also shown an association between alcohol abuse and sexually transmitted infections in Aboriginal Australians (G. C. Miller, McDermott, McCulloch, Fairley, & Muller, 2003; P. Miller, Law, Torzillo, & Kaldor, 2001; Panaretto et al., 2006). However, whether alcohol has contributed to HIV infection is more ambiguous, perhaps because information was not collected or is not readily available (Wright, Giele, Dance, & Thompson, 2005).

In this paper we explore alcohol use in 20 Aboriginal people who participated in a research project to explore their experiences of living with HIV. Within this context, alcohol emerged strongly both as a dominant factor in the circumstances in which HIV was acquired as well as a prominent consideration in management/treatment of their infection.

Methods:

The project was developed in conjunction with key stakeholders including HIV positive Aboriginal males and females from rural and metropolitan areas and their Aboriginal and non-Aboriginal

health service providers. In addition, an Aboriginal researcher met with a number of rural Aboriginal women attending a Positive Women's Retreat to consult with them regarding the research project prior to commencement. The research was approved by the Western Australian Aboriginal Health Information and Ethics Committee and The Royal Perth Hospital and Fremantle Hospital Ethics Committees.

To be eligible for inclusion, participants had to be Aboriginal, HIV positive and living in Western Australia. Further details about the processes and methods for the study are described elsewhere (Bonar, Greville, & Thompson, 2004). In brief, eligible individuals were approached, generally through their health service provider, and invited to participate. Following consent, participants undertook one (occasionally two) semi-structured interviews generally lasting 40-80 minutes in a setting chosen by the participant. Pseudonyms were used to help ensure confidentiality. Interviews were guided by a series of open-ended questions developed with input from the Steering Committee and Reference Group. Participants were asked about their experiences of initial diagnosis, coping strategies, social support, disclosure, discrimination, HIV and pregnancy, access to health services and the physical, emotional, psychological, social and economic impact of HIV on their life. Interviews were recorded and transcribed (17) or written down verbatim (3); where possible, transcripts were checked with participants. Thematic analysis was undertaken with transcripts reviewed for themes related to alcohol use.

For the current analysis, several limitations related to the context of data collection must be considered. The interviewer was female which may have influenced the participation of some males. In the rural setting where a number of participants were recruited there were disproportionately more women diagnosed with HIV than men. Further, it was difficult to develop a flowing narrative with some participants because of shame and sensitivity about HIV infection.

Some participants had not previously disclosed their status to anyone or participated in research. Therefore, while alcohol emerged as a central theme, the participant/researcher interaction and the purpose of the interview affected in-depth exploration of the narrative associated with alcohol. Finally, differences in recency of diagnosis also influenced the narratives. This paper presents alcohol-related aspects of the participants' narratives, but in drawing out the alcohol themes, segmentation of the narrative potentially dislocates it from the general context which was about health services and living with HIV.

Results:

Twenty Aboriginal participants, four males and sixteen females, were interviewed between February and September 2003. At the time of the study, fourteen participants resided in rural areas and six in the metropolitan area. Participants' ages ranged from 22 to 54 years (females, mean 31.0 years standard deviation (SD) 8.2; males, mean 36.0 years, SD 4.9) with age at HIV diagnosis ranging from 16 to 49 years, with an average of 24.8 years (SD 9.3) for females and 31.0 years (SD 7.8) for males. Most infections were reportedly acquired heterosexually, with two of the four males being homosexual. Eighteen participants received income from a government benefit and one was employed at a Community Development Employment Project.

Although other substance use was mentioned in relation to various scenarios, alcohol emerged as a key factor in the stories of 18 of the 20 participants. As the time since diagnosis varied from a few months to many years, participants were at different stages in the process of coping with HIV.

Many participants reported alcohol use from a relatively young age. Bonnie described clearly her experience of bullying and racism from her school peers in Year 9 (aged 14) that led to her leaving school and starting drinking.

Bonnie: ... Yeah, they been writing about me, calling me this and that, so I had a bit of a fight there in front of the principal. So I told them to stick their school up their arse.

[Laughs] So I left the school and that's it, I didn't go back there any more. Yes that's when I started drinking then.

Anger as a result of racial discrimination has been reported to be predictive of the amount of alcohol young black Americans consumed (Terrell, Miller, Foster, & Watkins, 2006), and there is overwhelming evidence that Aboriginal Australians continue to experience discrimination (Holmes, Stewart, Garrow, Anderson, & Thorpe, 2002; Mellor, 2003; Larson, Gilles, Howard, & Coffin, 2007). Other participants also referred to discrimination, but this theme is not further explored in this paper.

“Good Times”: The Days Before HIV

Many participants recalled the time prior to their diagnosis as a good time, and their stories told of alcohol being intertwined with fun and enjoying the company of friends. For example, Tanya said, “It was good, very good. I’d go see people, all around town.” Asked about what kinds of things she was doing, Tanya replied, “Smoking marijuana all the time....every day.” John reported “I was having a good time partying on”, and Ross similarly talked about a carefree party life “I was in happy days until...[HIV test] Before it I was quite normal – just everyday life. Having a good time with my friends, drinking, going out, having fun. Yes it was good.”

Although alcohol was an integral part of this fun, the good times reflection was juxtaposed with stories of harm associated with alcohol consumption emerging during their conversations.

“Too Drunk and Stupid”: Alcohol as a Risk for Acquiring HIV

Many reported heavy alcohol use in describing how they came to acquire HIV, not just as an incidental matter, but implying that their loss of control was central to their exposure. For example, Carmen attributed alcohol an important role in allowing herself to be infected. "Um, well I went with one bloke, he didn't tell me about himself. At the time I was a little bit drunk." Similarly, Carole was also not clear about who had infected her. She knew it was probably through sex, but she wasn't sure exactly who. "Don't know. Don't know who would have done it, I was too drunk. Too drunk and stupid." In these examples, the women describe their vulnerability as a result of alcohol and express an underlying belief that the men they had sex with were withholding important information or taking advantage of them. Even though Carole is self-deprecating in saying she was stupid as a consequence of intoxication, her language "who would have done it" suggests she saw the person who infected her as having an active, perhaps malevolent role; something inflicted upon her.

John also described being infected through (heterosexual) sex, and was also not sure who had infected him. "Don't know which one though. Had that many when I was boozed, drunk....Don't remember anything." Frances on the other hand knew exactly who had given her HIV, and described trading sex for alcohol: "Yeah I know. That white bloke. He give it to me. He give me drink for that, you know?" As these quotes and the ones below illustrate, alcohol impaired the judgment they might otherwise have exercised and was sometimes a commodity traded for sex.

Participants who were aware of HIV ignored warnings that they might be at risk. This is well illustrated by Ross, a self-described alcoholic who was living on the streets at the time he was infected. Any thoughts he had around his risk for HIV were suppressed as he really didn't want to know about it. He talked about ignoring hints about HIV from girls that he'd been with, thinking "Oh why shouldn't I?"

Ross: But the other girl I had, she mentioned something about HIV on one of the days I was with her but I didn't take much notice of that. I think she was referring to people in Perth. "Oh bugger Perth, they've all got HIV down there in the parks and that." That was where she was hanging out. I didn't worry about looking for a blood test or anything then, I didn't want to know if I did have it or not. I just thought I'd rather not know...

Ross's preference for not knowing and denial of risk means that he can continue to keep living as he is, and is preferable for him than having to deal with a diagnosed infection.

Jayne had been sexually abused by her stepfather and two uncles from an early age, and was diagnosed as HIV positive when only 16 years. She also was not sure how exactly how she became infected. Although she has not disclosed to them, she expresses concern about the role that alcohol plays in her brothers' and sister's sexual activity and that they might put themselves at risk of HIV after drinking heavily.

But you know when they get drunk and they say they are going out looking for boyfriends and girlfriends, I said, "Well here take some of these with you." And I chuck a big handful of condoms at them....And I say to them, I said, "Don't make that mistake."

Jayne frames alcohol use as the basis for risk, even though alcohol was not explicitly mentioned in her story about acquiring HIV. Further weight is given to this later in her interview when she responds to a question about interventions for reducing HIV risk in the community with "burn the liquor store to the ground".

"The Biggest Shock of my Life": Diagnosis During Treatment for Alcohol Abuse

Two participants found out about their HIV positive status when their alcohol use had led to the point of starting rehabilitation and counseling, just as they were beginning to regain control of their life.

John: *Oh well I was disappointed because I was just starting a relationship. Just starting, down in Perth. I had been on the streets for about six to four months. Yes I got off the alcohol. 'Cause I had been drinking, binge drinking. I know all the mob on the streets. Got out of that, off the streets and then started working on it, alcohol counselling. Then that... It ruined my relationship. Finished with me when she found out. It would never work out. I lost it really. Yeah when I found out. Well I went for a test and that and then I had it. That's when I got the most biggest shock in my life. Very distressing and all.*

Given John's distress at his diagnosis and that the relationship which was the catalyst for him curbing his drinking no longer exists, he continues to use alcohol to numb reality and help forget about his diagnosis. He has insight into the use of alcohol as a means of distraction and recognises the self-pity and sadness that goes with drinking heavily.

John: *I'll have a beer and that, or wine. Get drunk, like I usually do.*

Interviewer: Do you feel getting drunk – does that help you cope?

John: *Oh no, just a kind of escape I suppose.*

Interviewer: You escape?

John: *Yes you know. Get the blues, you know?*

“Escape but it still knocks at your door”: Coping with Diagnosis

Alcohol provided a solace, of sorts, for many participants during their initial reaction and adjustment to their diagnosis. As Pauline said “I felt very uncomfortable when I was told...got the shock of my

life. That's when I started drinking a lot." John reported a similar reaction "Yes, it shocked me, yes. I got drunk just thinking about it. Drink the shadows away, yeah".

Most participants recognised that alcohol provided only temporary relief and didn't solve their problems. As Kimberley stated, "alcohol is like an escape in not dealing with it." This reaction, trying to avoid confronting their diagnosis and its implications by heavy drinking was common.

Jay: I was depressed then like...I'd see like going through a bottle. You know try to drink alcohol to solve my problem and then it puts more headache on me because you think, oh they're out to get you, you know. Like there's the squad [police] coming out, you know So you escape to be like into the drug scene, drink, whatever to try to escape but it still knocks on your door when you wake up the next morning.

"I sort of slowed down a bit": Managing the transition

After a while, participants generally realised that drinking didn't solve their problems but made things worse. With this realisation, other strategies were initiated in an attempt to exert some control over the situation. This included seeking support, keeping busy, finding meaning in life. The support they received from other people was helpful in reducing their drinking and in coping with their diagnosis.

Carmen: Well at first I thought that drinking would help me, but it wouldn't. I had one of my relatives, she was very close to me, and she caught on [about the HIV] and she tried to help me, like talk to me and said "Oh, you are not the only one" and all this and that. But I did drink a bit too much but then as she kept on talking to me I sort of slowed down a bit.

Another strategy commonly adopted was keeping their mind off their HIV infection by being busy and trying not to think about it.

Bonnie: Oh just getting on with my life without thinkin' about it because the more you think about it, the more it make you mad. Make you want to go off. Getting fidgety, don't want to sit still, then you want to go and get drunk and do silly things to yourself and that's the wrong thing you know?

Many people drank, but through it all realised that they didn't want to die, a real risk if they did not change their behaviour. For those with responsibility for children, this often provided the focus that gave them the will to keep going and to make each day count so they could be around to help their children grow up. As Bonnie said "I worry about my kids most of the time. I didn't want to lose my life so early."

"...Only after I got Drunk": Helping with Disclosure

Most participants disclosed only to close friends and family members. Telling others was difficult, and a number of participants used alcohol to make the disclosure easier.

Nick: Told my brothers about six months after and that was by phone and that was only after I got drunk. Yes thought I'd have a few drinks and drink a bottle first. Told them over the phone. Told them not to tell mum or anybody else which put them in a really bad position because they're all very close...

Nick regretted the circumstances and telling his brothers over the phone, recognising that "It [alcohol] made me emotional and made them very emotional as well, hearing it on the other end of

the phone.” But disclosure was a major challenge, and at the time he felt the disinhibition induced by alcohol was needed.

Similarly, Carmen initiated her disclosure after consuming alcohol and thereafter developed a greater level of comfort with the people she had taken into her confidence.

Carmen: *Yeah and even though it had to take drink, a little bit of drink just to make her and me talk about it, we sort of talked about it when we had no drink and that is what helped me too.*

Interviewer: Was it hard telling people that you are positive?

Carmen: *Yeah at first it was, but like I said before it had to take me a little bit of you know, a little bit of drink to tell mum and them and my kids and then, like when I woke up the next day they got up, they were sitting there waiting for me. At first mum pushed my oldest daughter on to me and said “Go and ask mum if it is true”. I sat down and I said “Yeah”, and brung it out in the open. Now that they know about me, like they know where they stand for me, yeah.*

Bonnie had only disclosed to her sisters, but at the time that was right for her she had difficulty achieving a private moment with her sister. She made her disclosure while angry, with her brother-in-law present against her wishes. The effects of alcohol then provided a useful reason for her disclosure not to be taken seriously. She recognised that she was more likely to give away her own HIV positive status when she was drunk.

Bonnie: *... And I told her straight out in front of her husband. No one said anything and everything went quiet. Well it got me pissed off, that’s the reason why I said that in front of everybody. But they must have thought I was joking but I wasn’t. So every time I’m drunk I*

say I've got this and that you know. Everybody in the community they all say the same thing about themselves too you know. They swear, abusive language and all that, you know? But me, I keep it to myself. But when I get drunk I go off too sometimes (laughs).

Bonnie's story illustrates another issue that some participants talked of, that of "loose tongues" through inappropriate disclosure or name calling by people in their family or community when they are intoxicated. Participants recognised that people who drank heavily and became talkative and indiscreet were not to be trusted with secrets such as HIV status. While she could talk to her sisters, Bonnie felt unable to tell her mother.

Bonnie: *...And my mother... I don't tell her nothing because she don't even know yet what I've got. She don't know so I don't really want to tell her because she's a sick woman herself, plus if she get drunk she will bring everything up.*

Underlying concerns related to disclosure which featured in many participants' narratives were the shame and stigma of HIV and discrimination.

"I Slowed Right Down": Changing Lifestyle

Most participants had been heavy users of alcohol and often other drugs prior to their HIV diagnosis. Their stories always told of shock, dismay and often anger at their diagnosis. A number had short-term increases in their alcohol intake, but many then reduced substance use and improved their nutrition in an effort to keep healthy. For some participants, the reduction in alcohol and other drug use was easy, whereas for others it signaled a much more profound life change. Nick gave up smoking and drinking because he got really tired and was unable to keep up with friends, but was really missing the drinking, smoking and partying.

Underpinning many of the stories was a tale of transformation after coming to terms with HIV. Participants commented that cutting down alcohol, slowing down, was part of looking after themselves and reducing the impact of HIV. As Karina describes, following her diagnosis “The biggest change is that I stopped drinking for a while. I slowed right down...’cause I’m looking after myself now.” Tanya similarly had reduced her alcohol intake to protect her health.

Tanya: I've slowed down. Stopped doing things. I just look after my health...can't even get drunk these days.

Interviewer: Why is that?

Tanya: It affects the virus...too much alcohol gets into the bloodlines. The virus will be rising, so I don't drink no more to protect my health.

These narratives are consistent with those described by others after a diagnosis of HIV in terms of individuals re-framing their life and revealing hope for a longer life (Ezzy, 1998). At least five participants described themselves as alcoholics prior to diagnosis, and all were aware of the toll drinking took on their health and their poor nutrition while abusing alcohol. John described his skin as “just hanging” and Ross could barely eat: “When I was drinking, my stomach must have been the size of a 20 cent piece.” After diagnosis, many spoke of reducing alcohol intake, starting to eat more and being more conscious of nutrition.

Ross: Oh. Well only in the last week to tell you the truth, only in the last week since I've been home, I've been moving along. Haven't had a drink since last Wednesday so, yeah. If I can give that up, the alcohol, and start getting some more better food into me, yeah.

Interestingly, some participants equated stopping drinking with staying healthy.

Interviewer: What do you do to stay healthy?

Denise: *Nothing...well, I just stopped drinking.*

Interviewer: Yes.

Denise: *Yes. I just eat and drink tea and cold water.*

Bonnie had reduced her drinking, motivated by knowledge that it was harmful to her health and wanting to be around for her children.

Bonnie: *But the thing when I started getting it, the first time I found out, well it's over 10 years now and I'm still alive, you know, just coping. Fighting off with the drink and that. Try to step down on it. I used to be an alcoholic before I knew - I found out I had HIV. I was an alcoholic then. But after that, when I found out I slowed down on it.*

Interviewer: And what made you slow down then?

Bonnie: *I worry about my kids most of the time. I didn't want to lose my life so early.*

These stories illustrate a common theme reiterated among the stories of the participants, of a vision for life that now goes beyond today, with concern both for their physical health and emotional wellbeing. These are similar to the narratives described by Mosack and colleagues (2005) around restoration of health and personal growth.

"...Just for a couple of days": Interfering /Coping with Medication

Many of the participants were not on anti-retroviral treatment, some because of side effects, and others who had been too erratic with taking medications. Many had worked on reducing their alcohol intake and improving compliance. As Darren admitted, "well at first when I started I was drinking and all that, so you know it wasn't, yeah I missed a lot of the dosages, but after that I tried to improve a bit better."

A number of participants had stopped or markedly reduced their alcohol intake so that they could manage the medication. For example, Charlie said: "I decided to just stop [drinking] and take the medications. Stayed off it for six years". This decision was made so she could look after her health, although she now drinks "a couple of cans" occasionally. The issue of how to deal with missed doses had obviously been discussed with those who were on medication, but they did not have a consistent understanding of the best way of dealing with missed doses. Krysta described drinking as the only thing that would stop her taking her tablets, just for "a couple of days" when she was drinking, Jay tried to catch up missed doses "... if you've had a hard night out it stops you. But you know you make it up until... you don't double your dose but you take your one dose again, you don't double it, until you start catching up" and Frances reported she would only drink beer, nothing stronger "Only after I take my medication, I have a drink....but I don't drink until I take that last one, then I have a drink."

"I would enjoy life": Drinking as a Social Activity

Drinking alcohol with friends was a social activity for many of the participants, something they missed if they had stopped and something many continued with a different social group and at different levels. Tanya spoke about not drinking or smoking marijuana anymore, but wistfully "I would enjoy life more....." as though she would like to return to the days when she did those things.

Many participants talked about enjoying drinking with friends and family, although for many their social circle had obviously decreased. For example, Pauline said, "I have a few drinks with friends or families. Girls that I like to sit with. I like to mix with the same people."

A few participants insisted that their HIV infection made no difference to them, and that life had continued unchanged.

Carole: Yes I drink and I smoke, cigarettes and dope...Nothing's changed.

Carole had only been recently diagnosed, and it is possible that she will follow the pattern of many others and after drinking heavily immediately after diagnosis she will later moderate her alcohol intake.

Others obviously missed the social contact of drinking. Asked about how she enjoys herself, and about the impact of HIV on her socialising Carmen responded, "Well HIV did change me. I still have my drink but not as heavy as I used to." Despite drinking at a reduced level, drinking continues to form a major part of her social activities with a smaller social circle.

Interviewer: Do you drink until you are full drunk? [colloquial term to describe intoxication to the point of loss of consciousness, inebriation]

Carmen: Oh, not any more, I just drink, I just get drunk and that's it.

This is a major change, as before she was diagnosed...

Carmen: Yeah, I used to socialise, I would go out a lot, not with a lot of boys but I still mixed in with a lot of boys and girls, go drinking, go disco, go pub and things.

Interviewer: So you don't do that now?

Carmen: No I just like to sit around with my friends and drink, like my families especially, like the very closest friends that is part of my family, because they grew up with my families.

Ross avoids going out with the friends he previously socialised with, as he knows it will inevitably lead to drinking. He is pleased with himself for learning not to put himself in such situations.

Ross: Oh just got to look after yourself on an everyday basis I suppose. Yes people influence you to do things too. If you say, "No," you walk away feeling good. You know, you walk away, "Oh, bugger them. I've got enough to do on my own."

Ross's description is consistent with the conceptualisation of personal autonomy that Brady referred to in relation to Aboriginal people stopping drinking, and the belief that individuals need to look after themselves and not interfere or worry about the drinking of others (Brady, 1993).

Brady also talks about the Aboriginal drinkers' preoccupation with alcohol. Alcohol use was embedded so strongly in many daily activities that when Carmen was asked about what she did these days she responded, "Well, when I am not drinking I like to rake the yard and clean up, and like when I get my money I just go down the shop and buy fruit and things."

There were two women whose conversations about HIV did not include alcohol. One was deeply religious and living in Perth, and the other infected as a teenager living in a remote community and had not disclosed to any family or friends. Both led very quiet lives and were not interested in relationships with men. For three others, while not an overriding feature in their life, alcohol was still strongly embedded in their story about HIV. Thus, Nick had been doing hotel work up until he found he was infected, talked about missing the smoking and drinking he had given up, and used alcohol to assist with disclosure. The two other women had both been infected as teenagers and sexually abused as children, Shona by a stepfather "where I took on sniffing glue and you know, wipe that thing out" and Jayme, abused by a stepfather and two uncles. Shona's narrative included her partner's "ex" abusing her when she was drunk, and using drinking as an excuse for feeding her infants with the "titty bottle" [bottle feeding]. In the latter case, alcohol served a utilitarian function to help disguise avoidance of breast feeding because of her HIV.

Discussion

This analysis provides an insight into the many ways that alcohol influences HIV infection in Aboriginal Australians. Comparing the narrative provided by the participants and the primary themes reveals similarities and differences between the HIV/illness narrative theory and descriptions by Frank (1998) and Mosack et al (2005). Alcohol had a major role in disinhibition and the risk-taking behaviour that led to participants' HIV infection. Alcohol enabled escape from the reality of everyday living and coping. Contrasting with Frank's Chaos narrative, the participants observed that their life changed little as a result of their HIV diagnosis, reflecting the turmoil in their lives before diagnosis. The lack of vision many participants had for their own future, in addition to the stress within their lives, their experience of trauma and repeated pain and grief within their family and community mediated the impact of the HIV diagnosis. The reasons underlying alcohol abuse undoubtedly varied, but included participants' experiences of racism and discrimination that limited their life opportunities. While alcohol abuse among Aboriginal Australians is recognised as an effect of land dispossession, socio-economic inequity, and loss of cultural links, to the extent that our participants interrogated their drinking behaviour, they located alcohol abuse much more in the here and now, without a broader context of "blame".

A constellation of mental health and/or substance abuse issues and sexual risk can identify adolescents at risk of HIV (Houck et al., 2006). Six of the women were aged 17 years or less at diagnosis of HIV, and two mentioned child sexual abuse in their interviews. Interpersonal violence is known to be associated with poorer mental health and HIV-risk sexual behaviours (Evans-Campbell, Lindhorst, Huang, & Walters, 2006) and child sexual abuse to increase the risk for HIV infection (Myers et al., 2006) and alcohol and drug misuse (Boden, Fergusson, & Horwood, 2006). Alcohol had a major role in disinhibition and the risk-taking that led to participants' HIV infection.

Unsafe sex in adolescents, as shown by lack of condom use and more sexual partners, increases substantially with the use of alcohol and other drugs (Tapert, Aarons, Sedlar, & Brown, 2001). This study further supports the need for underlying issues of sexual abuse and alcohol to be addressed in programs that seek to prevent sexual risk behaviours and which treat HIV-positive individuals.

Overwhelmingly the participants were reliant upon government welfare support. The link between an individual's social and economic status and health is well documented (Marmot & Wilkinson, 1999), and community stress associated with poverty is closely linked to health risks and poor health outcomes, and specifically related to HIV transmission risk behaviours (Stewart, Cianfrini, & Walker, 2005). Poverty and community stress have been linked to alcohol and drug use and to HIV risk (Kalichman, Simbayi, Jooste, Cherry, & Cain, 2005).

Many participants described drinking as being associated with good times, being carefree and having fun, but recognised it made them careless about their personal health, sexual relationships and heeding advice from others. Alcohol was interwoven into many aspects of their life, before and after diagnosis – helping them with disclosure, temporarily limiting the pain they felt as a result of diagnosis, and being important in maintaining their social connectedness within family, friends and communities, where alcohol is a key component of social life. Brady has previously described this connection between Aboriginal drinking, community structures, kinship and social obligations (Brady 1993). While the participants observed that their life had changed little as a consequence of HIV, there was a narrative of loss common to many stories. The loss related to the wistful memories associated with alcohol fuelled good times, the loss of innocence, and changed relationships.

It has been argued that drinking is a major way in which some Aboriginal people construct their social relationships with each other, and that it may serve to allow for feelings of empowerment

(Shore & Spicer, 2004). The concept of alcohol allowing “time out”, as a facilitator, disinhibitor of emotional expression, and creator of loss of behavioural control was evident in many of the stories told by participants. Intoxication increases sexual risk taking and a number of participants spoke of using alcohol as “liquid courage” to help with disclosure to family and others (Stoner, George, Peters, & Norris, 2007). Drinking prior to disclosure provides an opportunity when sober to deny HIV infection and alcohol intoxication enables community gossip to be discounted. In this way alcohol was common to the transformational stories told by many of the participants as it allowed them to progress disclosure by claiming a loss of inhibition, allowing them to move to a more empowered state. However, moderation of alcohol consumption was common to the more successful transformational stories. Part of this was the individual recognising that alcohol had a negative role in their life, but advice from doctors and health staff in supporting the reduction in alcohol consumption was also very important.

That alcohol abuse significantly impacts on an individual's ability to comply with antiretroviral therapy (ART) was borne out in the narratives of participants, many of whom were unable to manage treatment within the context of their lives, even those for whom alcohol was not a current issue (Newman, Bonar, Greville et al, 2007). Most clearly understood the negative consequences of continuing to drink heavily and that alcohol interacted with antiretroviral medications. How those prescribed HIV therapy should deal with medications while drinking alcohol was unclear, with participants describing different approaches. A range of beliefs about how ART should be adjusted in response to alcohol use has been previously described for black Americans (Sankar, Wunderlich, Neufeld, & Luborsky, 2007), and closer examination of those authors' key messages to ensure consistent advice are pertinent for Australia.

Individuals with higher levels of stress and unstable housing are less likely to be adherent to anti-retroviral treatment than clients with lower levels of perceived stress (French et al., 2005). Given the need for high compliance with antiretroviral therapy to avoid development of viral resistance, there are important practical implications of heavy alcohol use for those treated for HIV.

Participants understood the negative consequences of continuing to drink heavily and that alcohol interacted with antiretroviral medications; many told of impressive reductions in their alcohol intake after coming to terms with their diagnosis. HIV appeared to serve as a reminder that their time on earth was limited and that they had people and things in their life that they valued and wanted to be around for. "Slowing down" was a term used by many individuals to describe looking after themselves, and it was associated with marked reductions in alcohol intake and better nutrition.

Brady has referred to medical conditions and/or a doctor's warning as being major catalysts for Aboriginal drinkers giving up alcohol, and that the social context of high alcohol use hinders efforts to stop (Brady, 1993). Many participants had access to compassionate health care providers who provided holistic health care including welfare services that supported participants in the broad context of their lives (Bonar, Greville, & Thompson, 2004). This suggests that when there is a strong personal rationale for reducing heavy alcohol consumption and broad social and health support to do so, Aboriginal people can markedly reduce alcohol use, even when the social context of their community life includes high alcohol consumption.

The narrative of self-deprecation ('too drunk, too stupid') was evident in many stories, especially in those that also had a narrative of transformation. The transformation consisted of changes in lifestyle (slowing down, improved food and reduced alcohol consumption), the reaffirmation of the importance of aspects of their lives (such as children and family) and altered relationships to gain power and control over their situation. The transformation described seemed to lack the spiritual

changes described by Mosack et al (2005), and nor was there great evidence of negotiated involvement with their treatment. However, engagement with health services was part of their desire to be around for the things they valued. Frank's (1988) quest narrative identifies the emergence of an optimal state as opposed to a return to one's previous state. Some of the participants in this study described progress to a perceived optimal state, yet it was within a context of low expectations. Contrasting with Frank's chaos narrative, the participants in this study did not describe a life descending into chaos as a consequence of contracting HIV, but their observation that their life had changed little as a result of their HIV diagnosis reflected the chaos already in their life before the diagnosis, and often in a setting of ongoing turmoil and stress.

Prevention efforts must necessarily include a focus on improving the everyday reality of Aboriginal peoples' lives. Lives in disarray, which change little or improve as a result of contracting of HIV are an indictment of the society in which they occur. Measures to reduce sexual abuse and violence are important, and undoubtedly linked to both empowerment and reduction in excessive alcohol consumption. Restrictions on access to and abuse of alcohol are an important component (Loxley et al., 2004), although the ready availability of alcohol in Australia will be difficult to change. The interrelationship of empowerment, alcohol reduction and reduction of sexual violence highlights the need for multi-faceted cross-sector interventions that address the whole range of social, physical and mental health problems for Aboriginal people. Although Aboriginal people with alcohol problems report more family conflict (Kelly & Kowalyszyn, 2003), family support emerged in this study as an important positive influence on stabilising participants' lives.

Interventions in Aboriginal Australian communities have had limited success in reducing substance use. This has been manifest in the revolving door of incarceration, unsurprising given the substantial social inequalities that Aboriginal Australians continue to face. The recent "emergency

intervention" in the Northern Territory was initiated under the pretext of preventing child abuse and has a strong focus on alcohol restrictions, but there are grave concerns about whether the process used can create sustainable, safe and nurturing communities, and tackle upstream contributors to psychological, physical and sexual abuse (Brown & Brown, 2007). Effective strategies to prevent health problems require focusing not only upon individuals but on ameliorating the structural factors that render people vulnerable, or amplifying those that render them resistant (Loxley et al., 2004). In addition to focusing on interventions necessary to address substance misuse, it is essential that strategies are identified that address the underlying social determinants of health and that this includes an appropriate focus on empowering approaches for healing, mental health and support for those who have experienced profound inter-generational disadvantage, marginalisation, trauma, grief and loss (Gray, Saggars, Atkinson, & Strempe, 2004; Brown, & Brown, 2007). Commitment to improving Aboriginal health requires not just commitment of resources but acknowledgement of the past, respect for Aboriginal autonomy, and cooperative approaches across many levels of government. The transformation in the lives of our few participants suggests the possibility for it to be replicated more broadly if we achieve an appropriate environment of care and support for Aboriginal people.

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