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Research paper

Alcohol misuse: contributor to and consequence of violence against women

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ABSTRACT

This paper addresses the possible consequences of histories of violence and abuse on women's subsequent drinking behaviours. Twenty-one autobiographical accounts were collected and analysed, in a qualitative study that applied life history methodology, informed by feminist epistemology. Representative dominant research themes of child sexual abuse, rape and domestic violence emerge, and the effects of continuums of violence on women's alcohol misuse are explored within the oppressive social and political contexts of abused women's lives. Alcohol misuse as an available personal survival or coping strategy for women survivors of gender-based violence is theorised. The chosen research methodology is assessed, and considered to be anti-oppressive and ethically advantageous. Implications for improving health and social care practices with women problem drinkers who may have experienced personal violence are also considered.

Keywords: catharsis, child abuse, domestic violence, ethics, feminist research, life history research, oppression, rape, women's alcohol use

Introduction

To acknowledge links between violence, alcohol misuse (see Box 1) and women is not new. Research studies have consistently indicated that alcohol abuse is often associated with violent crimes against women. Such literature focuses on the role of alcohol misuse by the perpetrators of violence towards women. Physical and sexual abuse in childhood (Rittner, 2002), domestic and interpersonal violence (Willson *et al*, 2000), sexual assault and rape (Abbey *et al*, 2001; Carr and VanDeusen, 2004) have all been constructively linked to excessive alcohol consumption by the male aggressors of such crimes. This paper views the misuse of alcohol through a different lens, to consider how women who have been victims of such violence may then have a substantial risk of subsequently misusing alcohol.

The increase in women's alcohol consumption, and resultant alcohol-related health and social consequences, have been measured with growing concern among researchers and practitioners in health and social care in the UK (Thom, 1997; Scottish Executive Central Research Unit, 2002). Significantly, although average weekly alcohol consumption for both men and women has increased in recent years, the proportional increase among women is now much more substantial (Department of Health, 2004). Women absorb and metabolise alcohol differently from men, and are more vulnerable to a wide range of serious alcohol-related physical and psychological health problems (National Institute on Alcohol Abuse and Alcoholism, 1999; Alcohol Concern, 2001). Women who have alcohol problems face more societal stigma and personal/familial shame than their male drinking counterparts because of social, cultural and political prejudice (Vogeltanz and Wilsnack, 1997). Therefore, the hidden number of women who drink excessively in our communities and workplaces may represent a very significant minority.

Despite awareness of the acceleration of drinking problems among women, the aetiology, presentation and treatment of women's alcohol misuse are frequently misunderstood by health and social care workers, primarily because much existing theory is based on quantitative research studies, using questionnaires

Box 1 Alcohol-related harm: advancing multi-causal definitions

Controversy has always surrounded the definitions 'alcohol problem', 'alcohol misuse', 'alcohol abuse' or 'problem drinking'. In this paper I use these terms to represent current medical guidelines (Cabinet Office, 2004) for the quantity of alcohol consumed (recommended weekly limits of 14 units a week for women) and also with a consideration of the wider effects of alcohol (emotional/psychological, physical, social, familial). Additionally, because 'misuse', 'problem' and 'abuse' can be viewed as potentially judgemental and sometimes unhelpful labels, I sought approval from all respondents in my alcohol research, that they had personally identified that their alcohol use had been problematic and had constituted harmful personal misuse of a psycho-active substance.

and predominantly male or gender-blind samples, which have taken the mandate for defining theory about women's alcohol problems. However, qualitative research methods, because of their capacity to explore and analyse human behaviour, can be invaluable in demystifying problem alcohol use among women, so reflecting a more accurate representation of female alcohol misusers' lives. Yet published qualitative research in addiction studies appears to remain marginalised, with content analysis of leading international addiction journals suggesting that only between 2% and 6% of all published papers contain wholly or partially qualitative methods (Fountain and Griffiths, 1999; Neale *et al*, 2005).

This adherence to positivist methods of research as the primary mode for understanding alcohol misuse has reinforced the perception that women's alcohol problems are similar to those of their male counterparts (Ettorre, 1997) or that disease or individual determinism underlies women's serious alcohol abuse (McDonald, 1994). Treatment systems and beliefs remain embedded within dominant theories that minimise the full meanings of the impact of previous life experiences. This denies the essential centrality of personal life experiences on women's behaviours, and obscures the real potential of supporting women with drinking problems to achieve personal understandings and change in their lives.

Methodology: researching lives

Research approach

Drawing on my knowledge and practice from previous work within the addictions field, and my concerns about the lack of authentic women's voices within longitudinal alcohol research, I carried out in-depth qualitative research, from a feminist theoretical standpoint, to explore the life experiences of women who had histories of drinking problems. To realise the full potential of qualitative research, methodological rigour is essential through all stages of the research process, from preparation and design, to field work, final analysis and theoretical deduction.

Research participants

The appropriateness of the qualitative sample will often determine the final quality of the findings (Boyatzis, 1998). I did not want to target a specific subgroup of women within those with drinking problems, as my research aimed to gain as wide an overview as possible. The only selection criteria I imposed were that volunteer participants should have personally experienced drinking problems during their lives, that they had the motivation to engage in life history giving, and that they were able to make the necessary time commitment to complete this with me. My final research sample comprised a heterogeneous group ($n = 21$) of self-referred women volunteers, collected from non-clinical, community populations. Research participants were gathered by five methods: advertising and news stories in regional newspapers, informal recruitment through postcards and small posters in neighbourhood shops and post offices, chain/referral/snowballing, contacting suitable agencies for collaboration/introductions, researcher's personal contacts/professional network. Short newspaper pieces about my research, with a contact address, proved the most fruitful method of recruitment ($n = 13$). Following personal meetings to establish rapport and trust, each participant chose to tell me her autobiography in her own home setting. Because of the positive rapport I had built up with my participants, I needed to offer only minimal prompts during life story giving, so reducing the risk of researcher distortion or bias, and also avoiding the fracturing of stories within context. Each life history was taped over several sessions, and lasted approximately 10 hours in total.

All the women who joined my research had a clear history of alcohol misuse within clinical, recommended units criteria (see Box 1), often to a very dangerous

physical level. Most participants were totally abstinent at the time of fieldwork and many had been so for several years; only three in the sample chose to still occasionally drink socially, but none to excess. All participants wanted to give their narratives accurately, and took this commitment seriously. Pseudonyms have been used in this paper to protect identities.

Data collection

I chose life history data collection primarily due to my previous positive professional experience of the method during in-depth life history therapeutic work with women problem drinkers, and because I recognised this method would have considerable potential for offering rich, reflexive data within the qualitative research context. Additionally I believed it would present the least exploitative method for obtaining information from women who may feel stigmatised, ashamed or distressed.

The advantages of using the life history method for health or social care research have been noted, yet there remains a scarcity of longitudinal, life course analysis in alcohol research (Hagemaster, 1992; Martin, 1995; Andersen, 2004). Survivors of violence, abuse and oppression, who are often silenced because their accounts are both hard to tell and difficult to listen to, are known to be able to make more sense of their experiences, however painful, by translating them into narrative form (Riessman, 1993; Finch, 2004). Thus life history work can offer sound ethical advantages, as well as being more likely to reduce distortion. The process of life history research, also known as life story research (Riessman, 1993; Plummer, 2001), documents and analyses autobiographical accounts of individual lives, and attempts to gain understandings of that person's life, which has been told in their own words, in their own way. As a selected method of data collection, life histories can be written in biographical or diary form by participants, or, more typically, recorded on tape by the researcher as the participant narrates their life story. My research was informed by feminist epistemology, which is also congruent for researchers who strive to work anti-oppressively with the subjective experiences of disempowered individuals from invisible, marginalised groups (Jansen and Davis, 1998; Smith and Watson, 1998).

Data analysis

Thematic analysis, sometimes referred to as thematic content analysis (Burnard, 1991), was used to develop, and then reduce, a considerable amount of raw material into manageable sizes. Within life history research tradition, I chose to first analyse each life history individually (Atkinson, 1998). Each was first revisited by listening to each taped full autobiography twice. This very concentrated listening helped me to bridge the time span between interviews and analysis, to recall each autobiography in detail, and to regain the important essence and value of each participant's life. I made relevant informal notes and also referred back to any relevant field notes I had made during fieldwork. This process, although time-intensive, was crucial; it ensured that each participant's voice was equally privileged within the initial stages of my analysis, and also offered a more rigorous approach to thematic induction. When maximum insight had been gained from re-listening to a tape, spoken words were then carefully transcribed verbatim, with the inclusion of relevant non-verbal content, such as pauses, significant silences, emotional responses and distress. Codes, categories and concepts were generated for every transcript. Thematic coherence, as important and repeated chunks of text about particular themes, was established (Reissman, 1993) before comparisons and common themes were generated from across the whole research group. These were generated at both a manifest level, where they were directly observable in data, and also at a latent, analytical level, where they were underlying, or only partially implied, to identify common themes that had contributed to, or exacerbated, alcohol misuse in the lives of the women in my sample.

Validity and objectivity or plausibility with coherency?

Verification or validity are quality standards necessary in all research (Cresswell, 1997). Notions about objectivity and validity, however, can be viewed as androcentric or biased when pictures of reality in research have often represented neither truth nor reality for women. The strength of life histories, within this context, lies in the personal, subjective contextualisation of women's lives, which offers the formation and evaluation of theories directly relating to women's experiences and oppressions. Hartsock (1997) contends that a feminist standpoint is based on the foundational issue that truth is always mediated by an individual's understanding of reality. Any research endeavour will have a degree of bias and subjectivity, not only from the research respondents but, just as critically, from within the researcher's understandings and perceptions, at every stage of the research process. Uncritical concepts of reliability cannot be applied to life history study (Atkinson, 1998), but Riessman (1993) suggests that plausibility, whether the story is both convincing and reasonable, and coherency, that is themes re-occurring across the sample, can offer validation of

reliability. My participants were consistently plausible, and also personally reflective of the responsibility they felt in being part of a research study on women and alcohol. Coherence was shown individually, and commonly, as the large amount of data gave much opportunity to find very consistent common themes across the 21 life histories. Both plausibility and coherency were repeatedly evidenced in my collected life stories.

In the final analysis, I agree with Riessman (1993) and Plummer (2001), who stress that our research work is ours, and we have to take ultimate responsibility for its truths; but we also should accept that no research, from any methodological or political perspective, can be a complete and ultimate truth. Perhaps the key issue may concern the importance of the researcher being reflexive throughout the research, to be able to identify her/his own bias and judge how this could affect the study, both positively and negatively (Holland and Ramazanoglu, 1994). By being more prepared to face the challenge of having to defend objectivity, a more rigorous method and self-critique may be facilitated.

Uncovering new truths

By collecting the unique and uninterrupted voices of women who had lived with personal drinking problems, new theoretical perspectives about the aetiological roots of women's alcohol abuse were identified. Many important emergent themes from my research were revealed in the final analysis, yet it was the repetition of stories of abuse and violence throughout lives which most resonated. Violence and abuse rarely appeared singly. Autobiographies detailed how those who had experienced sexual abuse in childhood frequently then become victims of sustained physical and sexual violence in adolescence and adulthood, which previous research has failed to adequately develop.

Although some research has doubted predictive links (Fleming *et al*, 1998; Spataro *et al*, 2004), connections have been found between alcohol misuse and previous abuse in childhood (Schuck and Wisdom, 2001) or alcohol misuse following rape or domestic violence (Kilpatrick *et al*, 1997). My research does not contradict such findings, but rather seeks to provide a wider frame of reference, by which experiences of personal violence in histories need to also be examined as part of multiple contexts. Previous work on women alcohol misusers has frequently presented isolated and fragmented aetiological experiences, by selecting samples solely from clinical populations and treatment settings (Wincup, 2000) or using records such as court documentation or basic questionnaires for data. Thus, a significant population of women, who may not even present directly to recognised health and social care agencies with their alcohol problems, have largely been excluded from study, and their truths have remained unheard.

Contexts and continuums of violence

The major themes emerging from the analysis are discussed below and linked to the subsequent development of alcohol problems. All quotations used to illustrate the discussion have been directly transcribed from research participants, whose anonymity has been protected by pseudonyms.

Childhood abuse

Alcohol misuse in women who have been sexually abused as children is not consistently prominent in the aetiology of addiction. As I worked with research informants, they spoke repeatedly of their experiences of sexual abuse in childhood. The types of childhood sexual abuse experienced often involved severe physical violence, many having been penetrated orally, anally and/or vaginally. An additional, and disturbing, factor was that so many had experienced numerous abuse experiences, from different male adult perpetrators, at varying stages in their childhoods. For instance, one participant spoke of very early years of bizarre, sadistic victimisation by multiple male perpetrators in a paedophile group, and then of later rapes by her father. Another was regularly abused by three older brothers, and later by a youth club worker. Some women recalled sexual abuse by male family members, as well as by respected family acquaintances such as priests and teachers and, less often, by strangers.

Every experience of sexual abuse in childhood will inevitably have its consequences, and my research findings found that these should not be simply inferred because of a particular form the abuse may take. Sexual abuse often occurred before the age of 12 years for victim-survivors, but the age of onset of the abuse, or whether perpetrators were inside or outside the family unit, appeared to be relatively insignificant in predicting the severity of later alcohol problems, which disputes many previous studies (Jarvis *et al*, 2000). Similarly, accounts of voyeurism, extreme innuendo and other sexually threatening behaviours, although constituting 'non-contact' childhood sexual abuse, were strongly associated by some participants with their later alcohol problems. Feminist analysis argues that creating a hierarchy of abuse denies the

importance of the clear power relationship between perpetrator and victim (Kelly, 1988). In my study, it appeared that the distress caused by a threatening non-contact act did not usually minimise the powerlessness of the girl's situation, or her fear of what she dreaded may happen next. The threat of knowing, the humiliation of enduring, the waiting for the physical contact which may never occur, was an ordeal which could cause significant psychological consequences. This opposes theories which maintain that it is the more 'serious' types of child sexual abuse, involving penetration and physical trauma, which will inevitably result in more severe psychological repercussions or drinking problems in adulthood (Beitchman *et al*, 1992; Moncrieff and Farmer, 1998).

Among my research participants, many child abuse victims blamed themselves for somehow being responsible for their abuse, perhaps offering an illusory sense of personal control in terrifying and powerless situations. Although persuaded by an adult into regularly having sex, some found it hard to label the experience as child sexual abuse, rationalising it as being a pay-off for receiving rewards, privileges or acts of friendship. The persuasive power of perpetrator suggestion additionally intensified self-blame and guilt. Abusers convinced victims that the abuse was their fault, that they enjoyed what was happening, or that they deserved it because they were naughty girls. Even when, as adult women telling their stories, some objectively stated they had no way of preventing the abuse, they still often felt personal blame for the childhood events:

> 'I sometimes think of what happened, and that I should have stopped it ... but they were so strong, you see? I was such a little girl, not knowing what or why it was happening ... what more could I have done?' (Jean, regularly sexually abused by three elder brothers, from age 6 years)

In all the narratives involving child sexual abuse, active resistance to the abuse at the time did not prevent it from happening again; indeed to some extent the women who felt they had resisted most believed their situations became even more powerless and hopeless. Distressing repercussions to resistance during childhood had considerable influence on subsequent adult beliefs and behaviours.

Pressures placed on victim-survivors to maintain secrecy about their abuse included those that are consistent with literature on the topic (Bifulco and Moran, 1998). Finding someone trustworthy to confide in during the time of the abuse was central, with some disappointing reflections on health and social care professional practice:

> 'There was no one to tell, so it wasn't an option. I knew that if I told the social worker she'd have immediately told my parents – she told them everything, even after she'd told me our talks would be confidential.' (Jill, sexually abused by a family friend, aged 13 years)

> 'I did try to tell the school nurse once, but she didn't want to know. I was on my own.' (Moira, sexually abused by her form teacher, aged 10 years)

Such statements represented several strong testimonies from participants that, when they had tried to tell someone about the abuse, they were neither believed nor supported, and that their desperate hopelessness was more intensified than before, when they had remained silent.

Just as children may receive disbelieving or insulting responses if they try to tell of their abuse, adult survivors also experience the frustration of disbelief and ridicule (Bass and Davis, 1988). One participant had finally summoned up the courage to talk of her abuse to a trusted community psychiatric nurse. His response only served to reinforce her shame, as he told her to 'forget about the past and get on with living'. Another informant was humiliated to be told by her psychiatrist that 'dwelling on negatives from the past would make her more depressed'. Seeking understanding but finding the opposite response concurs with other research which has found deeply resistant and defensive responses to reported child abuse by medical professionals (Russell, 1995). The perceived rejection by a helping professional clearly could have far-reaching effects:

> 'He [GP] just didn't want to know about the abuse. I went home feeling totally worthless and insulted ... and downed half a bottle of gin ...' (Maggie, paternal sexual abuse, aged 12–17 years)

Many spoke of the futility of living a life which they believed had been destroyed in childhood by abuse. Others remembered feeling death would have been a welcomed release during or after the abuse, and several went on to attempt suicide in later life, an expression of the distress prevalent among women who have alcohol problems (Russell, 1995). However, without the knowledge that these women had been abused in childhood, a secret most would not have easily shared, their self-harming behaviour is likely to be associated with their excessive drinking, rather than being identified as a possible symptom of child sexual abuse, where the incidence of suicidal behaviour is also very high among adult survivors (Motz, 2001).

Patterns of low self-esteem, self-denigration, guilt, secrecy, self-destructiveness, emotional isolation and depression have been included in the range of personality and behavioural characteristics associated with women who misuse alcohol (Briere and Runtz, 1986; King *et al*, 2003). It may be significant that these traits are also thought to be prevalent among those with a history of child sexual abuse and adult violence (Wilsnack and Wilsnack, 1997). Studies of women

who misuse alcohol often suggest that a primary site for depression lies with the alcohol itself, which is a depressant. Based on descriptions from my research participants, depression regularly preceded their alcohol misuse, and may more logically have been the result of negative life events, such as child sexual abuse, which affected the coping strategies of the adult victim-survivor:

> 'I just didn't have another way to fight it ... I grew up feeling worthless and depressed. Alcohol really helped at first ... I called it the perfect anaesthetic.'
>
> (Wendy, paternal sexual abuse, aged 5–10 years)

Linking childhood abuse with subsequent alcohol problems

Most participants expressed the view that alcohol had initially provided important and easily available 'self-medication' against the distress of the invasive memories of childhood abuse; that alcohol had been used as a strong short-term coping mechanism. Many considered that their times of alcohol misuse correlated directly to when their memories of their childhoods were most invasive – times when they found it most difficult to cope with their depression, flashbacks, insomnia and nightmares. During these life periods, alcohol was an accessible and reliable means to find temporary release and moderate their physical and mental distress. Coping strategies are different for each individual. Psychological coping methods that are used, consciously or not, during the abuse and after can be developed and refined, to provide complex defensive strategies. Within this theoretical framework, alcohol can be seen as being part of the wider context of dependence on coping strategies, which may initially help numb the memories and pain of childhood sexual abuse. However, for all the victim-survivors in my research, alcohol misuse in later life resulted in new and additional difficulties because alcohol misuse, just like their child sexual abuse, soon became another guilty secret to endure. With growing feelings of powerlessness, each participant realised that alcohol had not permanently erased the trauma of her childhood abuse; it had not been a solution to the problem at all, in fact it had invariably made matters worse.

Domestic violence

Much research carried out on alcohol misuse within heterosexual relationships has examined male, rather than female, drinking behaviours; most specifically, heavy drinking by violent men (Gomberg, 1998; Ptacek, 1998; Schumacher *et al*, 2003). Far fewer studies have linked women's problem drinking within dysfunctional marital relationships, nor have these studies reached a consensus about whether women experience marital conflict because of their drinking, or whether they turn to alcohol as a result of their marital problems (Jacob and Seilhamer, 1991; Fagan *et al*, 1998). In my research, marital problems, particularly involving violence, overwhelmingly preceded alcohol misuse for women.

Violence in heterosexual relationships was a powerful mechanism of control and fear that had been experienced by most respondents, including those who had later identified as lesbian. This violence encompassed physical or sexual assault, but also included emotional and psychological intimidation, designed to oppress, humiliate and terrify. High levels of emotional or psychological violence from male partners may be a possible predictor for problem drinking among some women (Kantor, 1993), although it has been noted that alcohol treatment initiatives insufficiently screen women for such abuse (Miller, 1998).

Unsuccessful intimate relationships left several participants in my research feeling deeply ashamed because they felt they had failed, and shame is an intensely disempowering emotion for women who are socialised to place so much self-worth and positive female identity on the success of their relationships with men (Richardson, 1993). When these relationships had started, most participants had hoped for the companionship and intimacy which many had lacked in childhood; the realisation that this would not happen caused profound disappointment, and possibly a reliving of the loss and grief experienced in childhood. Although most had tried repeatedly to make their relationships work, to change and be changed, they felt their attempts had been futile, and that unsatisfactory relationships left them feeling totally alone and without control in their lives.

The levels of violence within intimate heterosexual relationships endured by my research participants are known to cause poor self-esteem, internalised anger and high levels of clinical depression among women (Orava *et al*, 1996; Miller, 1998), conditions which are also linked to women who exhibit drinking problems (Walitzer and Sher, 1997). Within many life histories, sexual relationships with husbands and partners were also often described as problematic and violent. Many women had been socialised to believe that there were no choices about sex for a married woman, that the sexual rights and needs of husbands or partners were unquestionable, confirming the assertion that male sexuality traditionally serves as the only model for all human sexuality, so marginalising the needs and rights of women (Smith, 1996):

> 'I really did believe I had to put up with it ... that as a wife I had no option. You were brought up to think that a man

needed to have his sexual needs met, and as a wife, that was what you had to put up with.' (Liz, 10 years of domestic violence)

All of the sexual violence described by participants preceded their drinking misuse. Yet in alcohol literature, because of expressed lack of sexual satisfaction or low interest in heterosexual sex, the stereotype of the woman alcoholic as sexually dysfunctional endures. This sexual dysfunction has been identified as both contributing to, and preceding, problem drinking (Wilsnack, 1984), but there has been a failure to recognise that women's sexual partners may contribute considerably to their sexual problems, as was indicated in my study. Problem drinking women are known to commonly have heavy-drinking male sexual partners, who experience more sexual problems, and engage in more sexually and physically abusive behaviours than other men (Cornel *et al*, 1995). Of additional interest, in view of previous literature predicting the contrary, no participant complained of impaired sexual functioning during periods of her alcohol misuse, as long as she felt she had personal choice in her sexual situations. Feeling in control, and having power within sexual behaviour and decisions, was pivotal.

Many women had asked explicitly for help from a wide variety of health and social care professionals, but this was rarely given. Such testimonies challenge the myth that abused women will suffer in silence, are weak and passive, or do not want to try to find outside assistance (Davison, 1997). The helplessness of their situations was intensified by frustration, powerlessness and humiliation:

'People might say I had a choice – but I had no choice. I asked for help so often. Police, marriage guidance, his PO, the doctor and district nurse – you name it. But they didn't really believe how bad it all was ... and afterwards I always got a worse beating. Despair and hopelessness all over again ... experience soon taught me there'd be no help.' (Jane, 18 years of domestic violence)

The majority of experiences with welfare and health services reflected the consensus that practitioners may still view working with adult victims of domestic violence as peripheral to their statutory work duties, and that they endorse unenlightened woman-blaming attitudes (Mullender, 1996). Such attitudes compounded isolation and secrecy. In desperation, some had tried desperate measures to escape from relentless physical, sexual and psychological violence:

'I begged to get into psychiatric hospital, anything to get some peace from him – that was another mistake. Now he had another taunt, another excuse. Whenever I called the police now, he'd tell them I'd been in a mental home, I was mad. They'd be all sorry for him and leave, telling me to quieten down.' (Carol, 15 years of domestic violence)

Linking domestic violence with later alcohol misuse

The narratives in my study reflected that women's lived experiences of problem drinking during or after domestic violence are very varied. However, it was clearly corroborated in all their stories, that they believed the reasons for their excessive drinking were specifically linked to their experiences of domestic violence. Alcohol was sometimes used in a preventative sense, to ease the pain of anticipated beatings, or as a means of trying to relieve desperate feelings of depression, loneliness and abandonment. These women had not been silent victims, functioning within a self-perpetuating context of learned helplessness (Coid *et al*, 2001). They had all tried many ways to leave unhappy relationships, and used alcohol as a substance of self-medication to try and cope with the unmanageable. Most women were only able to stop alcohol misuse when they had left unhappy relationships, often then choosing to live alone. Acknowledgement and support concerning the oppressive relationships in which some felt trapped, and early recognition of the reasons behind their drinking, may have reflected a very different outcome on the development of their subsequent drinking misuse.

Rape

Although sexual abuse and physical abuse were coterminous for many, some research participants specifically described rape from partners who appeared to exhibit little or no other physically abusive behaviour. Marital rape is thought to be the most common form of sexual abuse of women, with rape occurring in at least 10% of all marriages (Anderson, 1997). However, because of the expected intimacy, duty and sexual access within the marital relationship, many wives/partners are said to be less able to name this forced sex as rape (Kelly and Radford, 1996), thus sublimating the humiliation and degradation of such attacks by their partners, despite the very real and serious nature of the crime, and the inevitable personal impact of this. Some participants mentioned marital sexual violence almost as an aside, as if non-consenting sex within marriage was not unusual, certainly not something to draw attention to. Yet rapes by husbands and partners are believed to be as traumatic as those inflicted by strangers (Mullender, 1996):

'I didn't see it as rape, not at the time ... but looking back, I can see it was as vicious and frightening as any rape would be ... even worse, in some ways, because he felt he had the right to do it when ever he wanted, and I couldn't escape.' (Audrey, regularly raped by her husband)

In addition to rape from partners or boyfriends, some women in my research had experienced rape by acquaintances and/or strangers during their adulthood. Very few had reported the crime, and only one case had eventually reached prosecution, where the perpetrator was not found guilty.

Alcohol misuse is cited as a major contributing factor in males who are sexually abusive (Carr and VanDeusen, 2004), and alcohol use by rapists was mentioned by several in my research:

> 'Mostly when he raped me he'd been boozing, so that was most nights, looking back. After a few years I thought ''what the hell, I'll drink too and maybe I can get some peace from what is happening to me'', so I did ... and because I'd never really drunk before, I felt so knocked out I could escape into my head when he started.' (Jean, raped/multiple abuse from husband and regularly sexually abused by three elder brothers from age 6 years)

Within life histories that contained experiences of sexual violence while the perpetrator was drunk, there was sometimes a tendency to blame excessive alcohol consumption for the release of sexually aggressive behaviours (Abbey *et al*, 2001). However, there is little evidence to support the belief that alcohol can be excused as being a primary cause of male violence towards women (Scully, 1990; Leonard, 2002). It may be more accurate to conclude that alcohol only acts as a function of expectancy; in other words, that aggressive personalities will act into expected behaviours connected with alcohol, and that alcohol should not be seen as a drug which releases new violent inhibitions (Gelles, 1993; Abbey *et al*, 2004; Bushman 1997). Challenging the power of alcohol as a disinhibitor has far-reaching implications for cases of rape and domestic violence, and society's attitudes towards the abuser/rapist who drinks, then seeks, and often receives, vindication because of this.

Linking rape with subsequent alcohol misuse

Rape was a life event that was mentioned less frequently than domestic or child abuse, but within the developmental context of life histories it was evident that rape had preceded or certainly exacerbated any alcohol misuse by my participants. For social and healthcare practitioners, linking rape with a subsequent drinking problem is problematic, as at least one-half of all women who have had experiences that would meet the definition of rape, do not label themselves as rape victims (Kahn *et al*, 2003; McMullin and White, 2006). Excessive drinking is a significant behavioural predictor for the rapist, yet the trauma of the attack may have far more significant repercussions concerning potential future alcohol abuse for the victim, and this needs to be considered during all post-rape interventions (Acierno *et al*, 2003) as well as in work with women who may have drinking problems.

Conclusions

The cathartic potential of life history work

Life history and feminist research methodology encouraged a sound anti-oppressive and ethically sensitive framework. The contexts and self-understanding gained through life history narration were said by many participants to have offered them the opportunity to at last be heard, be believed and be validated. In turn, this process facilitated increased self-knowledge, a stronger self-image and relief in the sharing or releasing of traumatic, violent memories. Although a demanding experience, participants found that the insights they discovered in their memories affirmed, clarified and validated their dilemmas and experiences in relation to their lives, in a new and welcomed way. The cathartic and therapeutic value of life history giving was often profound:

> 'After talking about the childhood stuff, it began to make sense. I've always thought what a wicked, terrible person I'd become ... now I can see I was a victim as well. I've just now allowed myself to break down and sob for that poor little child who I was – how could I have blamed her so much?' (Alice, 48 year old, with over 20 years of drinking problems. Paternal sexual abuse in childhood, acquaintance rape in early teenage, domestic violence in adulthood)

Continuums of violence and women's problem drinking

The influence of personal violence across the life span has largely been overlooked as potentially being a primary factor in the development of drinking problems among women. Alcoholism, seen as an addiction from a biological base, has not been viewed as a very possible or logical response to the suppression of identity, self-concept and freedom, which oppression and violence towards women represents. Yet analysis of the constraints of gender-based violence in my research has provided important connections and insights into the ways in which the personal identities, experiences and actions of my research participants have been influenced; how the gendered nature of the everyday lives of these women, with structures and relationships of power and control, has provided both the possible reasons for their pathways into individual

experiences of drinking problems, and the processes to perpetuate them.

Heavy drinking served to briefly mediate the dilemmas of oppressive female experience by blunting conflicts between dependence and interdependence, personal power and powerlessness. Most women spoke of using alcohol as a way of trying to cope with their psychological and physical pain. They described how they often drank to subdue or contain their distress, hopelessness and depression, so that they could manage to continue with their lives. Many, such as the child abuse and rape victims, also drank to forget. Some drank to try and cope with the concurrent trauma and physical pain of experiences like domestic violence. Others drank to self-medicate, to try and relieve their depression, which was in turn often misunderstood by sexist theory and practice in mental health services. And the more they drank, the greater the shame they felt, for they were breaking a gender taboo of universal proportions – that women should not drink excessively. The treatments or supports that they accessed usually failed to acknowledge either the primary reasons for their drinking, or the additional shame and hopelessness which their alcohol misuse produced. Several stories recounted feelings of utter rejection and re-traumatisation by the professionals they had tried to confide in, and the hopelessness they felt when professional arrogance refused to value their experiences and self-knowledge. Their buried distress was temporarily medicated by alcohol, which had become their major coping mechanism. In lives where there was little else to rely on, their dependence on alcohol intensified.

My research has shown that debates about women and alcohol misuse must be linked to wider social and political dimensions. Many participants had used alcohol to help manage intolerable experiences, unsurprising personal responses to the suppression of identities and self-concepts. Their individual progress towards sobriety was invariably precipitated by their realisation that alcohol was adding to their oppressions. It is paradoxical that their life stories have so frequently shown that it was through the process of having, and recovering from, their drinking problems, that they have been able to confront their oppressive pasts and presents, and move on to more liberated and self-determined lives.

Clearly, to propose that all women who develop drinking problems have been uniformly abused or oppressed would be incorrect. Alongside patriarchal structures and ideologies are other important social divisions which will have influenced women's lives, power and control. However, striking commonalities and consistencies in histories emerged from rigorous data analysis, to verify that continuums of personal violence significantly affected subsequent drinking problems among my participants. Personal agency for oppressed women requires an ability to know not only the scope, but also the limits of individual responsibility. Recognising the constraints and complexities to which one has been subjected is a vital step towards acknowledging one's own moral agency under oppression. Within this context, many were able to conceptualise that their heavy drinking should be viewed as an expression of their oppression, their adoption of a coping mechanism which had arisen from, and reflected, the distributions of violence and powerlessness throughout their lives.

Issues for practice

The ways in which women experience drinking problems, and their individual needs for treatment and support, are heterogeneous. It is not possible either to prescribe standardised or simple solutions for such individual and complex problems, or to advocate one ideal treatment response. Certainly, outdated concepts in addiction theory, such as biological determinism, do need to be challenged, for to believe that women who drink heavily are sick, diseased or inherently different from other women centralises negativity and powerlessness. Hopefully, as the associations between continuums of violence across the life span and the possible development of female alcohol misuse are better appreciated by health and social care workers, that knowledge can be used both within preventative interventions with victims of violence and in encouraging more anti-oppressive, diverse work. Efforts could helpfully be focused on abused and victimised younger women to try to reduce their future risks of alcohol misuse. Sensitive support and education, in groups or individually, which address the risks of using alcohol as a mechanism for survival, may prove an essential mediator against the development of subsequent alcohol problems for those who have been victims of violence.

A decisive affirmation from my research participants was that women who drink are the experts about their own situations. With support they are able to make valuable judgements about their past and present needs, and all treatment approaches would do well to accept and value this available resource. Women's strengths and potential for working in partnership with professionals must be validated; those women asking for support from 'experts' should be encouraged to be actively involved in the creation of their own treatment or care plans. My work has revealed that the use of a non-judgemental, respectful method of collecting information, such as life story work, could offer much for professionals who work with women problem drinkers. Not only can such assessment approaches facilitate a detailed overview of each woman's life, but they can also encourage her to

draw confidence from being more in control of her own recovery process.

Alcohol treatment services need to target resources towards the investigation of, and subsequent support of, women whose behaviour may indicate a history, disclosed or not, of previous or ongoing abuses. A routine part of clinical and social assessment for women problem drinkers should be an exploration of the possibility of abuse, and recognition of the probability of previous differential or confused diagnoses which has been based on categorising presenting symptoms. Knowing some of the consequences of abuse will not necessarily work directly in the essential arena of prevention, but it will at least afford recognition to the many victims who would like to make their journey towards becoming survivors without the continued misuse of alcohol.

Ultimately, I have learned from women who have experienced drinking problems that their personal capacity to recover, from what must have seemed like insurmountable difficulties, has been remarkable. However, if they had received understanding, compassion, respect and belief from others, their struggles towards sobriety could have been achieved more safely, from outside the destructive vacuum of rejection, which has left indelible damage on their lives. If we begin to listen with more integrity and care to the voices of women with drinking problems, they can help guide us towards both the individual and collective solutions that are so badly needed.

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CONFLICTS OF INTEREST

None.

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