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WOMEN WITH DRINKING PROBLEMS

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ABSTRACT

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The research explored the life experiences of women who had histories of drinking problems, to illuminate new understandings about why women may develop alcohol problems, and how they may succeed in achieving sobriety.

Much existing knowledge about women with drinking problems has been based on studies using quantitative research methodology. Frequently such research has used predominantly male or gender-blind samples, which have taken the mandate for defining truths about women with drinking problems, usually assuming that they misuse alcohol for the same reasons as men.

A feminist approach and a qualitative, life history method was used to collect and analyse 13 in-depth, autobiographical accounts. The research participants comprised of a heterogeneous group of self-referred women volunteers, from a non-clinical population, who had personally identified having experienced drinking problems. Each participant's life story was taped over several sessions, and lasted approximately eight hours. Thematic analysis was used across fully transcribed life histories to identify the common themes which had contributed to, or exacerbated, alcohol misuse.

Significant common themes which emerged from the life histories included childhood sexual abuse, other childhood unhappiness, difficult or violent heterosexual relationships or marriage, lesbian sexuality, and depression. These themes revealed significant continuums of individual victimisation and abuse across life course, which were associated with the oppressive social and political gendered contexts of these women's lives. Life stories were also surveyed to identify influences during personal recovery, and two concluding themes were revealed concerning help-seeking behaviours associated with alcohol misuse, and the ways in which recoveries were achieved and sustained. Findings identified inadequate support or understanding about research participants' problem drinking from health care gatekeepers, helping professionals and intimate partners. The notion of individual self-reliance and sustained personal motivation to reach and maintain recovery emerged as pivotal among this group of women who eventually all achieved sobriety without professional help. These findings contrast with much traditional theory which has negatively viewed women's motivation and capacity for recovery from drinking problems. Additionally, the research revealed that participants regularly used alcohol as a strategy for personal survival and control in their lives.

Exploring the previously unheard life stories of women identified that negative life experiences, exacerbated or perpetuated by gender related oppression, are associated with women who may experience alcohol problems. This challenged an essentialist or pathological critique of women with drinking problems, and positioned the gendered nature of the aetiological roots of women's alcohol abuse. The research concluded that traumatic events in personal histories, especially those containing multiple sexual and/or physical abuses, and gender-related oppression, must routinely be considered in the assessment and treatment of heavy alcohol use in women. It was also concluded that a life history research method, informed by feminist epistemology, had much potential for sensitively uncovering new knowledge about alcohol misuse with women who may have experienced traumatic or distressing life events.

Women with Drinking Problems

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Chapter One

Personal Introduction

My decision to study women with drinking problems, and the research perspective and methods I have chosen to use, were influenced by many factors. This decision trail is important to examine, because, as Riessman (1993) suggests, the topics which researchers choose, and the methods we use, are usually intrinsically linked to our own personal biographies. These biographies can help explain, and also underpin, our motivations and commitments towards our research work. Whereas mainstream research usually views a researcher's personal experience as irrelevant, or likely to contaminate the objectivity of a study, the belief that personal experience is a valuable asset and resource, which can be positively utilised throughout the research endeavour, is a major distinguishing feature of feminist research (Black 1989; Reinharz 1992). Within this feminist research tradition, I believe it is important to briefly introduce the personal experiences which may have influenced my approach to my research.

I was born and brought up in the north of England, the second daughter of white, professional, middle class parents. My childhood and adolescence were secure and happy. The beginnings of my commitment to feminism started early. As a young person I recall being confused by the expected gender roles and behaviours which were prescribed for girls and women, and frustrated by the sexual inequalities I identified at the local co-educational grammar school I attended. These views were undoubtedly influenced by my parents' strong support of equality of opportunity for girls and women, but as my sister has not followed my political affiliations, my immediate family influences can only have been partial. My socialisation outside the home, my personality and my personal experiences, have also been significant in shaping my political

and ideological beliefs.

Most critically, perhaps, before embarking on what promised to be successful university studies, aged 18, I suffered a severe mental illness. For over three years I experienced and witnessed social exclusion and control inherent in the mental health system, most clearly pervasive for female patients. I realised that if I was to become well, and remain so, I would need to find explanations about the structural and individual sexism and oppression which frustrate and damage women. Against all clinical predictions, and with the privilege of having supportive parents, I gradually began to establish control of my future. I went to teachers' training college, where I discovered I did not want to be a school teacher, but where I was able to become involved with a feminist group and begin to develop my political views.
I then trained and worked in journalism, and learned much, including having the first-hand experience of working in fiercely male dominated and sexist employment. Acknowledging that working for a national press agency was not meeting all my career aspirations, I decided to train in social work, and also later qualified as a counsellor.

As a social worker, from the mid 1970s, I worked in several parts of the country in generic fieldwork, before specialising in psychiatry and becoming a regional social work addictions specialist in Sussex. In that role I worked primarily with people with drinking problems; with hospitalised people, those attending out-patients clinics and with individuals and their families in the community. I also had some research and training responsibilities as member of a multi-disciplinary regional health authority addictions team. Working within a multi-agency and multi-disciplinary alcohol treatment team, and often being the only woman member, I found my work primarily concerned women with alcohol related problems. I experienced other professionals' attitudes towards women with drinking problems as being generally negative, with typical assumptions being that women were more difficult to treat than their male counterparts, that they lacked motivation to work on their drinking problems, and that they had personalised/pathological difficulties, often vaguely diagnosed as 'neurotic 'or 'personality problems.'

Yet I had found that in professional experience, these women were generally highly motivated

to reduce their alcohol consumption, but regularly complained that the 'experts' who had treated them were not meeting their needs. Common concerns were that women had not felt listened to, understood or valued. They had felt blamed and stigmatised, and had been expected to change their behaviours without recognition of the past or current pressures which may have been exacerbating their alcohol misuse.

As I was not trained or encouraged to carry out woman-centred work with service users, I looked to literature on alcohol problems to find more gender relevant understandings, treatment approaches and methods. However, available literature from the 1970s and mid- 80s revealed that very little work had been carried out on, or for, women. That which was available was often riddled with negative stereotypes and views, or took an androcentric or gender blind perspective, still often prevalent in literature and practice today, which views women's drinking problems from a male standard or ignores the relevance of gender.

I also became critical of what 'research on women' actually meant. I had been professionally involved in a research project with women with drinking problems which had received much publicity, and I note is still regularly cited in current literature. My experience of this research was that as the researchers (experts) we were constantly making judgements about participants (subjects) and entered fieldwork with clearly defined categories to explore which discouraged the emergence of new, unexpected data. In retrospect, I do not feel women participants were truly involved in the research. They were investigated by professionals who had power over them; by supposed experts who did not really try to take the time to find out what these women were actually able to contribute to our sparse knowledge of the subject. There seemed little interest in the aetiology of women's heavy drinking, no wish to link how the experiences in their lives may have affected their current behaviour, subsequently their alcohol abuse was stigmatised, each woman objectified and stereotyped.

In my practice as a social worker, because I had failed to uncover particularly helpful theory, I continued to work on a purely intuitive level with women. Whenever possible I saw them in their home environments rather than clinics, so reducing clinical power and authority, and also de-medicalising their situations. I stopped involving all partners or family in intervention

purely as a matter of course, as this so often reinforced low self image and blame of women, and sometimes introduced collusion between professionals and family, who could almost be seen to conspire against the individual ' for her own good'. My counselling moved to spending much more time allowing women to *tell* their stories, giving my time to *listen* rather than advise. As so many women felt unlistened to, their experiences needed talking out, understanding and validating. Rather than instructing in strict treatment regimes, I encouraged women to work on their own ways of coping, which sometimes involved joining women's support or leisure groups (rather than just Alcoholics Anonymous) assertiveness training or artwork and personal life story writing.

With all my work I tried to concentrate on offering women support which would validate their experiences, reduce self blame and guilt, which I saw was very strong amongst women problem drinkers. I did not really monitor or evaluate my approach, it just felt better to be working with women in these ways. By accident I had begun to work in what could be termed 'women-centred ways', which I believe improved my practice at the time, and positively informed the ways in which I would carry out future research with women with alcohol problems. The life story writing I had encouraged service users to carry out, did prove to be especially therapeutic for women, but I found it less helpful for men with drinking problems, who appeared to respond more positively to task centred work, social skills or behaviourist approaches. This was useful gender-specific knowledge to consider when later assessing possible strategies for research gathering for women.

When I left specialist addiction work in the mid 1980s I felt concerned that research on women still was focussing on clinical populations and investigating pre-defined subject areas. I had worked with hundreds of women with drinking problems, and so frequently their backgrounds weaved a collective picture of oppression and powerlessness. I believed that these issues, so often intrinsically connected to social constructs, needed to be studied to find a clearer understanding of why so many women may misuse alcohol; understandings which would challenge the myth that women and men abuse alcohol for basically the same reasons. My knowledge of women with drinking problems also strongly informed me that, for such research to be effective, a very careful choice of research methodology would be essential, especially in

the collection of data. To encourage previously silenced voices to speak would need commitment, time and trust, and the narrator's belief that her story is important and that it would be listened to and believed. To do otherwise would be likely to cause further abuse in many damaged lives.

From addictions work, I continued to develop my counselling experience, in statutory, self-employed and voluntary work, generally with women who had experienced mental health or drinking problems, or who had suffered abuse or domestic violence. After the birth of my daughter I also worked as a researcher for a regional youth service, investigating counselling and information services for young people, and as a part time psychiatric social worker. While my daughter was young, I also returned to journalism as a freelance writer covering health and welfare issues.

Following a move to Dorset, I have worked at Bournemouth University for the past eleven years, as a lecturer within the department of Health and Community Studies, where I have developed teaching interests in women's health and social care, counselling, mental health, anti-oppressive practice and gender issues, and I now specialise in these areas of teaching and research supervision. I am divorced and currently live in Dorset with my 17-year-old daughter, who attends a local girls' school.

Research Aims

My research will explore the life histories of women who have experienced drinking problems, to illuminate new understandings about why some women may develop alcohol problems, and how they may overcome these.

My research will be addressing some of the major gaps and controversies in current addiction literature, such as: depressive illness, violence towards women, sexual abuse in childhood and lesbians' experiences. My research approach will differ from most that informs current

literature, as it will be based on the uncensored testimonies of women volunteers who have experienced drinking problems themselves. Another very unusual feature of my work is that the self-referred sample has been drawn from a non-clinical population. Crucially, my research, as a feminist endeavour, will explicitly explore what few previous studies have raised – the experiences of women's lives as they remember these, and how these experiences may have affected their drinking behaviours.

The following two chapters will first review and critique significant literature and research concerning women who have experienced drinking problems and then outline my chosen research methodology. The thesis will then develop chapters concerning my themes identified from research data, which will be presented chronologically, from participants' childhoods to the present day. Their shared experiences, enriched by their valued insights and reflexivity will regularly provide grounds to question the validity of the more traditional view of women evident in existing theory on alcohol misuse.

Developed themes will reveal multiple victimisation and abuse across lifespans, associated with the oppressive social and political contexts of these women's lives. Stories describing personal recovery will voice the inadequate help, understanding and support of accessed health care gatekeepers, helping professionals and family members. Ultimately, it was self-reliance and strong personal motivation amongst my research participants which sustained them to achieve control of their alcohol problems. The identification of such important personal resources, such as self-motivation and personal determination, has been absent from much previous work on women with drinking problems.

A different image of women who have alcohol problems will emerge from my research. Traditionally held notions about passivity, weakness, victimhood and lack of control will be challenged by the experiences my research participants vividly recount in their lifestory narratives. Many will speak of how, in the past, they regularly used alcohol to temporarily liberate them from debilitating life-predicaments. They will tell of how they chose to drink alcohol to survive intolerable gender-based oppression in situations where they could find no

alternative means of support. Their choice to use alcohol was often reflected upon by participants as having been a strategy which was necessary for personal survival. Yet invariably, all participants realised that their alcohol consumption was beginning to move beyond their personal control, and each was drinking very heavily. The substance which had brought some liberation from distress and difficulties was now compounding their life-problems and, over time, each chose to stop their alcohol misuse. Their agency, choices and actions will show women of considerable strength, determination and courage. My research will challenge the images of weak, unmotivated, submissive, chaotic 'alcoholic women' given in much literature, for these do not resemble the women who participated in my research.

Chapter Two

Review Of Literature

Introduction

My initial literature review, which informs this chapter, was carried out during the mid to late 1990s. Following this, literature searches were more directly guided by the developing categories and themes emerging from my research, and any additional literature was included in relevant sections in my thesis.

The selected literature review which follows is, therefore, included to set the scene and evaluate some influential literature which was published before my fieldwork began. It contains work about women with drinking problems which may initially appear wider than the thematically driven chapters in my thesis, but, none the less, has had critical influence on the established body of knowledge concerning women and alcohol. I contend that this is important to explore, as it is essential to evaluate how such past work may have influenced the views of professionals within addiction work, the general public, and, most crucially, the self concepts of women themselves who may experience alcohol problems.

There is ongoing debate and contention about the role and place of literature reviews in qualitative research (Charmaz 1995, Holloway and Wheeler 1996). Some writers have strongly advised against any immersion in literature, as this may influence the qualitative researcher's viewpoints, leading to possible preconceived and positivistic assumptions (Glaser 1992). Others suggest an introductory literature search and review in qualitative enquiry can provide important information about prior work in the field of study (Morse

1994).

Before embarking on my research I had experienced several years working in the addictions field, and I was therefore entering the research arena with some prior knowledge of established literature. Rather than disregard this experience or deny its significance, it seemed more useful to use it as a resource to help my evaluation of the literature I found in my searches. In this way, I found my literature review was an additionally important part of my research process. The added insights which my past working experiences brought to my reflective capacities soon highlighted just how much past literature has affected many taken for granted assumptions and negative preconceptions which are often associated with women with drinking problems. Rather than contaminating the results of my research (Glaser 1992), my new wide reading of literature heightened my awareness of the significant gaps in research

An Overview

The field of alcohol misuse has yielded a vast amount of research literature, but it is difficult to find many studies specifically relating to women before the late 1970s (Avon Council on Alcoholism 1982; Breeze 1985; Miles 1991). Reviewers of alcohol literature up to 1978 found only 23 alcohol studies with gender related content, but hundreds of studies conducted on men (Annis and Liban 1980, Celantamo 1980).

Historically, alcoholism had been seen as a male behaviour. Female drinking problems were not regarded as legitimate grounds for professional concern; little was known about women's problem drinking, and those understandings which did exist were invariably based on research on male alcoholics and male rodents (Mello 1980; Chalke 1981; Morgan and Pratt 1982; Smith 1987; McCrady and Raytek 1993).

One American researcher, Edith Lisansky, had already begun to rigourously question the

assumption of whether the psychopathology of alcoholism was the same for both sexes, back in the 1950s (Lisansky 1957). Her pioneering studies challenged standards of male-dominated alcohol research, but further innovative work on alcoholic women was slow to follow (Lindbeck 1972; Schuckit 1972; Beckman 1975). In Britain, the Camberwell Council on Alcoholism (1980) published a report on women and drinking in the United Kingdom, which emphasised that sex differences were qualitatively different with regard to alcohol use, and criticised the serious lack of research information on women in Britain.

By the mid-1980s a steady rise in interest about women and drinking, particularly in the United States, was evolving, and the reasons for this are interesting to explore. It could have been a response to the obvious research gap, highlighted by writers such as Lisansky and Beckman, or it may have been reflective of the growing number of women alcoholics who were becoming more visible in treatment (Gomberg 1981; Baggott 1990). The Women's Movement, and the advent of feminist research, have also been cited as important considerations (Ahlstrom 1983, Thom 1994). Moral condemnation, surrounding the negative stereotype of the woman alcoholic as a bad mother and wife, threatening defined expectations of 'normal' female behaviour, is also likely to have engendered interest - it has been contended that research on women has often only been deemed important when it has reflected the welfare needs of dependants like children, or women with drinking problems changed perspective somewhat, from interest in epidemiology and personality factors, to more biomedical conditions like the Foetal Alcohol Syndrome (March 1985; Glass 1986; Litman 1986; Little and Wendt 1993). This could be seen as reinforcing the contention that interest in women's alcoholism is most ardently stimulated by concern for the well being of others, particularly when this can also legitimize the control of women's drinking consumption.

However, two major works on women and alcohol were published in the 1980s which remain important research texts in the field of women and alcohol misuse. Alcohol and Drug Problems in Women, (1980) edited by Oriana Kalant, of the Addiction Research Foundation in Canada, comprehensively gathered research information and advances in alcohol work, followed in 1984 by arguably the most influential and thorough published work on women and alcohol, edited by alcohol researchers, Sharan Wilsnack and Linda Beckman. Alcohol Problems in Women

(Wilsnack and Beckman 1984) reviewed antecedents, consequences and interventions, and clearly established the need for more women orientated studies, treatment and understandings.

Vannicelli and Nash (1984) had analysed sex bias in literature, concluding that even when gender-related data were studied, it was more sensitively treated when women were the only or first author. They noted that female researchers had sampled nearly three times as many women, in proportion to the overall number of people studied, than had male researchers, and that female writers were also three times more likely to present data examining sex differences. They concluded that traditional insensitive and inadequate handling of research data in alcohol studies constituted a serious sex bias. Other reviewers had also noted a consistent failure to state sex differences (Acker 1982), and the failure of researchers to specify if studies had applied equally to both sexes (Shaw 1982). Unfortunately, over ten years later, Davis and Srinivasan (1994) still echoed very similar criticisms about sex bias remaining a common feature amongst researchers, particularly the use of predominantly male samples and the 'generalising' of findings and results to include women.

Although the potential of examining women's alcohol misuse from women-centred or feminist perspectives has received support , it is acknowledged that there is still a dearth of feminist information on the field (Nichols 1985; Ettorre 1986, 1996; Wincup 2000). My own literature searches confirm this.

The work of researcher Elizabeth Ettorre may be seen as the most significant published feminist contribution to women and substance abuse studies in the United Kingdom. Ettorre, a feminist researcher, has concluded that alcohol research has been a male domain, generated by men, for men, which upholds the traditional patriarchal images of men and women. These images portray men as socially dominant and active in the drinking culture, but women as subordinate and passive. Ettorre (1986; 1996) contends that research has been sex blind (assuming that women's experience of alcohol use is identical to men's) or double blind (ignoring any interplay between sex and gender). Ettorre (1992) is particularly concerned that the existence of sexist ideology defines how women problem drinkers should feel, and also how they should be treated. This ideology conceals the real needs and problems of women, which she states new research must

reveal.

More recent research on women and alcohol continues to be thematically and theoretically fragmented, according to a comprehensive review of literature which proposed that indicators to women's drinking had been distorted by researchers' conception of, and approach to, women's alcohol problems (Schmidt 1990). The study also identified an urgent need to trace the aetiology of women's drinking problems, stating that available studies contained many contradictions and inconsistencies, especially relating to life events and stress related problem drinking.

Other reviewers have additionally stated that much alcohol research gives unclear definitions about research participants, and often labels women 'alcoholic', but does not include women who subjectively feel that they have had alcohol-related problems, whether or not they have acquired a clinically diagnosed alcohol status. Studies of women from minority populations, such as lesbians, and those from different ethnic groups and age ranges, are noted as being particular examples of a serious research gap (Gomberg and Nirenberg 1993, Ettorre 1996) .

Over the last three decades research and literature on women and alcohol has aptly been referred to as a stepchild in the field on research (Lindbeck 1972); a 'non field' (Kalant 1980); a venture into male territory (Ettorre 1992). In response, there have been attempts, particularly by women, to alter misconceptions about female drinkers and to include women within the alcohol field. However, alcohol research and literature has still done little to fill the knowledge gap surrounding the critical social, political and economic factors which affect women who experience drinking problems. Furthermore, and crucially from feminist standpoints, little relevance has been given to the pervasive impact of patriarchy, power and the socialisation and oppression of women in Western society. There remains a need for more work which will highlight the experiences of a grossly under-represented and misunderstood group within alcohol studies, so often judged against the male standard, which still views women as 'the other' (Edwards 1997). An absence in available literature suggests that such new research should include the unbiased hearing and analysis of what women problem drinkers are saying themselves about their experiences. As Ussher (1991) has powerfully argued, each woman is as

real as the pain she may be feeling; we must not deny that, and we must *listen* to women, for they are the best judges of their experiences and their needs.

The following presents a brief overview of some of the key areas which I feel have been influential in constructing much current knowledge and theory about women and alcoholism

Defining Alcoholism

In a field invaded by such diverse perspectives and theories, the quest to define alcoholism has played a major role in research and literature in the field of substance abuse over the past 50 years. Traditionally, alcoholism has been seen as a specific disease (Jellinek 1952,1960; McDonald 1994). It has also been defined as a condition which originates as a symptom of personal circumstances, which, during the course of the drinking career, produces secondary manifestations, and so acquires disease status (Glatt 1970). More recently, alcoholism has been viewed as having no disease basis, but as being a learned behavioural disorder (Heather and Robertson 1989; Alcohol Concern 2001).

Historically, the field of alcohol has been dominated by the medical profession, particularly psychiatrists, whose basis for modern day medical thinking on alcoholism centres on the concept of disease, researched almost exclusively on the male alcoholic, the standard upon which women alcoholics are judged (Ettorre 1997). This preoccupation with disease concepts and alcohol dependence syndromes has primarily resulted from research in clinical settings, where treatment and rehabilitation are prioritised. Social, economic and political issues are not considered within the disease framework. For women in particular, the disease model has ignored fundamental issues such as violence in childhood and the family, domestic stress, sex role conflicts and a whole range of social and cultural issues which interplay between gender and social oppression (Valentich 1982; McConville 1991).

The disease perspective supports the notion that alcoholism is located 'inside' individuals; it is to do with what they are, rather than what they do. An unspecified psychological or physical malfunction drives someone to drink, or drive them out of control if they do drink, and, critical to this understanding, is the concept of powerlessness and lack of restraint. The alcoholic is seen as a diseased person who has no control at all over his or her relationship to alcohol (Rhodes and Johnson 1994; Ettorre 1997). The most influential disease theorist has been E.M. Jellinek. His classic studies of disease theory (Jellinek 1952, 1960) commented on 115 distinct ways in which alcoholism could be described as a disease, and his studies continue to exert a major influence on alcoholism theory (Heather and Robertson 1989; Milam 1992).

According to Jellinek, and other disease theorists such as Glatt (1970), Orford (1985) and Milam (1992), the person with the disease of alcoholism loses control, craves alcohol and exhibits specific behaviours because of compulsion rather than choice . Additionally, the alcoholic is perceived as being intrinsically different from the non-alcoholic. The disease cannot be cured, only arrested, because of biological or psychological abnormalities which would make 'normal' drinking impossible (Collins 1990). Without lifelong abstinence from alcohol, the alcoholic will be plagued by the abuses of increased alcohol consumption.

This disease concept of alcoholism has been challenged as being an inflexible view of the problem, with exhaustive research failing to substantiate either biochemical abnormality or allergy or a specific personality predisposition (Shaw 1982; Heather and Robertson 1989; Ettorre 1997). The pursuit of these theoretical groundings to 'prove' a biological explanation for alcoholism can also be criticised, for taking much research and additional resources into institutional and clinical settings, at the expense of community studies and alternative research strategies (Heather and Robertson 1989; Collins 1990).

Furthermore, research has also shown inconsistencies with predictions from the disease model, notably where loss of control in the presence of alcohol and craving due to withdrawal, are central constructs (Sobell 1981). Other elements which are central to disease theory have additionally been contested. Some studies have shown that not only can normal drinking resume after treatment, but that progressive deterioration is also not evident in research which has

highlighted the significance of positive life events on drinking behaviours (Roizen 1978; Saunders 1984; McCrady and Raytek 1993). My personal clinical experience of working with controlled drinking treatment plans would support these suppositions.

However, the disease approach to alcoholism has been recognised as carrying some positive connotations, notably in engendering a more tolerant attitude from a medical standpoint (Collins 1990) ; a more sympathetic understanding from family, friends and employers (Room 1984) ; as well as from the general public (Crawford and Heather 1987). Alcoholism as a disease may also have added appeal when applied to women, as it continues to emphasize feminine vulnerability and qualities consistent with traditional female functions (Morrisey 1986; Littlewood 1994). Such 'alcoholic' traits in women, deemed to be of biological origin, may also fit well with the traditional medical paradigm of women as naturally defective (Edwards 1997). Supporters of disease theory have claimed that women find it easier to come to terms with their drinking if they see it as a disease; something which is not their fault. Conversely, this could be seen as disempowering, as a disease emphasis may stop women trying to take control of their lives (Wolfson and Murray 1986; Libra 1991).

The significance of disease theory for women who experience alcohol problems is far reaching. *'While the study of addiction is framed by these sorts of 'scientific' questions, 'expert' investigators, such as epidemiologists, are called upon to find the answers, perceived as the 'truth'* (Ettorre, 1992: p3). Such truths, like adherence to the male-researched, disease theory of alcoholism, have been institutionalised and accepted by helping professionals, who have used this framework to understand women with alcohol problems.

Although intensive research has failed to distinguish between a fixed population of alcoholics and non-alcoholics, or a standard concept of alcohol dependence (Caetano 1987), total belief in disease theory continues to prevail, especially within the influential self help group Alcoholics Anonymous (AA) where women now make up at least 34 per cent of the membership (AA Membership Survey 1998) . Significantly, AA is often a problem drinker's only point of supportive contact and information about alcohol misuse.

Problem drinking

Just as the term 'alcoholic' has eluded a specific definition, so the concept of the 'problem drinker' has proved almost equally difficult to categorise, there still being disagreement about what actually constitutes problem drinking (Room 1987; Mendelson 1987; Wells 1992).

What classifies a drinking problem is often bound up with who is making the definition; for what is seen as a problem by one person may be personally or culturally acceptable for another. Gender bias serves only to further cloud the issue. Drunkenness in a woman may be regarded as a serious problem, similar behaviour in a man may be viewed as an acceptable display of healthy masculinity (Hennecke and Fox 1988; Doyal 1995).

A general agreement which has emerged in alcohol literature is that the repeated use of alcohol, which leads to some kind of harm, defines problem drinking (Heather and Robertson 1989). Typically, this harm relates to health, finances, personal relationships and/or legal difficulties. Regular excessive consumption, regular intoxication and alcohol dependence (itself a contentious definition) have also been cited (Thorley 1985: McDonald 1994).

Many studies view the units of alcohol consumed as a true indicator of drinking problems (one unit equals half a pint of beer, or one measure of spirits, or one glass of wine). Reports from the Royal Colleges of Psychiatrists (1986), General Practitioners (1986) and Physicians (1987) and from the Department of Health (1995) have recommended that sensible drinking for women should not exceed 14 units a week. Large quantities drunk over a short period of time may also result in problems, even when the weekly unit consumption is not reached. What actually constitutes a safe level of drinking, however, continues to be debated, with wide personal variations to alcohol tolerance and individual thresholds also needing to be acknowledged

(Makela 1987).

To the observer, seeking to make sense of the labels and categories used and defined within the field of alcohol studies, it may seem that all terminology is subject to the influences of variable research fashion, professional bias and individual preference. To label someone as alcoholic, a problem drinker, a severe problem drinker or an alcohol dependant, has no fixed meaning; perhaps the only definitive answer is that there is no definitive answer. Many people have the cognitive experience of losing control of their drinking, and of their lives, because of alcohol. They do not necessarily fit into a specific category, and responding to them is not necessarily a role for physicians. To impose further divisive and potentially misunderstood labels on them is not necessarily helpful. It may be useful to view problem drinking on a continuum, with non-problem drinking at one end and severe problem drinking at the other.

The nature of alcoholism has been, and perhaps always will be, a matter of vigorous debate. Apart from when clear clinical definitions, relating to identifiable physiological damage, are obvious, I would suggest that problem drinking may be most appropriately defined by the individual herself, who may be best able to recognise when alcohol has become a problem to her. This is the view on which I based my selection of research participants.

As I have discussed, I believe that the definition 'alcoholic' is a contentious one and one which subscribes to the ambiguity surrounding a disease model of problem drinking. Within my thesis I have therefore chosen to use the terminology 'drinking problem' or 'alcohol misuse'. However, when engaging with literature which endorses the terminology 'alcoholic', or when research participants have used this, the term 'alcoholic' will be used to provide authenticity.

Stereotypes and Stigma

Sexual stereotypes which inform people's expectations of acceptable or unacceptable behaviour critically influence how women perceive their use of alcohol and the ways they feel they can

admit to problems they may have with excessive drinking. Overwhelmingly, the stereotypes and myths which concern women drinkers are negative (Wilsnack and Wilsnack 1997; Carter 1997). The ways in which unchallenged stereotypes are likely to have influenced the attitudes of both professionals and the general public about women problem drinkers is fundamental in research such as mine, which seeks to question and, where appropriate, deconstruct negative myths.

Societal double standards between men and women heavy drinkers have been widely documented (Gomberg and Nirenburg 1993; White and Huselid 1997). Male alcoholism is viewed with indifference, or amusement, while drunken behaviour in women remains a social disgrace (Morella 1974; Gomberg 1988; Rhodes and Johnson 1994; Vogeltanz and Wilsnack 1997). Men who drink are often seen as adventurous and manly, getting drunk being often considered to be a male rite of passage which gains approval in Western society (Mulford 1977; Doyal 1995). Male drinking and sexual performance are often linked, but female drinking will be more likely to be associated with promiscuity (Gomberg 1982; McConville 1991). Double standards also condone or support men, viewed as 'providers' who work long and hard for their families, who have earned the right to the sociable and relaxing pleasures of drinking. Of course, women's roles are often more consuming and exacting, yet women are not so easily forgiven the selfishness of time out from domestic responsibilities (Heath 1993).

Societal stigma has been perceived to be the principal factor in the tendency to weave a circle of silence around a women's drinking by her family, which has consistently been shown to be less supportive and more condemning than the male alcoholic's family (Makela and Simpura 1985). Fear of ostracism and negative responses from family and professionals alike has been found to contribute to women's concealment of drinking problems, and to its telescoped development (Stokes 1977; Heath 1993).

Anecdotal clinical reports and adherence to the beliefs of cultural stereotypes have resulted in a lack of empirical data on women and alcohol. Myths and assumptions abound, with notions that women alcoholics are white, middle class housewives; that they hide their drinking from husbands, family and researchers; that most are sexually promiscuous; that they are sicker or more psychologically disturbed than male alcoholics; that they have poorer recovery rates than males, and are harder to treat. Unfortunately, such stereotypes are so strong concerning women

who drink heavily that false assumptions still exist, even when contrary evidence is available (Fillmore 1984; Vannicelli 1984; Edwards 1997).

In women, heavy drinking is frequently viewed as degrading and abnormal; labelled as deviant, shameful, un-feminine, even evil behaviour (Allan and Cooke 1986; Fillmore et al. 1997). Women who defy such social mores challenge both social stereotypes and culturally defined expectations for normal, acceptable women who should uphold moral and social values (Fillmore 1984; Carter 1997). Women are expected to be stabilizing influences, the ones who make the family successful. They are judged unstable and are labelled bad mothers, or irresponsible wives if they threaten family unity; if alcohol releases a woman's frustration or anger she is seen as aggressive or destructive (Ettorre 1992). The notion that women are sexually promiscuous when drinking has further served to exacerbate moral value statements (Sandmair 1980; Rhodes and Johnson 1994).

It has been suggested that in most manifestations of influential popular culture the most misogynistic elements of the female stereotype are exaggerated into the myth of the female alcoholic. In literature, newspapers, television and cinema, men who drink are generally portrayed as amusing, romantic heroes, whereas women who drink are likely to be seen as disgraceful, sluttish or sexless. Popular culture is also likely to explore the woman alcoholic as being a tragic, pathetic creature who deserves pity and disgust, or often as a woman who endangers others (i.e. children and family life) and deserves to blamed for her selfishness. Alcoholic men are generally reflected in much more positive, affectionate ways (Otto 1981; McConville 1991; Carter 1997).

It is not surprising that women drinkers are reported to feel more self hate, guilt and shame than their male counterparts, or that the stigma they feel about their drinking behaviour may drive them to feel they must hide their problem to maintain acceptable social and family appearances (Gomberg 1976; Beckman 1994, Doyal 1995). These societal sanctions which force many to minimize their drinking problems, have been seen as being intrinsic to the continued underestimation of the female problem drinking population (Celentano and McQueen 1984; Kagle 1987).

Professionals involved in the field of alcohol misuse will also be influenced by, and may perpetuate, damaging myths and stereotypes about women alcoholics. Dr. Brian Hore (Independent, 1990) speaking at a meeting of the Royal College of Psychiatrists, stated that the *'classic' female* alcoholic who is *'middle aged, middle class, at home, and keeping her drinking secret from her husband* '. Such comments uphold outdated false stereotypes; Ferrence (1984) found no evidence to substantiate the notion of the middle aged, suburban, secretly drinking alcoholic stereotype. More recent research has also criticized the attitudes and skills gaps of health care professionals towards female alcohol misusers (Owens et al. 2000).

Stigma and discriminating attitudes from alcoholics themselves about women's drinking has also been investigated, and appears to have changed little over time. In many studies, both male and female alcoholics have stated that they feel it is worse for women, rather than men, to be intoxicated (Curlee 1970, Gomberg 1998). This belief is reinforced in non-alcoholic respondent surveys, and has also been found to be the case in non-Western cultures (Gomberg 1998).

Blaming Women

Although focus on women problem drinkers has been under represented in alcohol literature, it is interesting to note that, traditionally, women are often placed within the role of being the prime aetiological agents of men's drinking (Jackson 1962: Ettorre 1997).

In a classic, and most influential, British study on alcoholism, Kessel and Walton (1965) set a standard by not only identifying alcoholics as male, but also as having unduly close, intense or persistent ties with their mothers - the implication being that smothering mothers produced alcoholic sons. Wives of alcoholics were also seen as having pathologically recognised patterns of behaviour, being dominating or insensitive women who married because they wanted to reform their alcoholic husbands, or because they were the daughters of an alcoholic themselves. These

female spouses were portrayed as digressing from traditional gender roles by finding employment outside the house - becoming 'breadwinners'. Their alcoholic husbands were forced to become involved in domestic chores and childminding, whilst their wives remained insensitive to the effect all this was having on them (Kessel and Walton 1965). Presumably the implication here is that independent, achieving women will oppress their husbands and cause or exacerbate alcoholism in men.

Ettorre's view that women are damned and blamed if they drink, and damned and blamed if their husbands' drink (Ettorre 1992), appears to have ample literary support. Other writers have also discussed the expectations that women are expected to be in control not only of their own drinking, but also that of their partners (Wilsnack 1984; Holmila 1997). Even women who are direct victims of their partner's alcohol related violence have been accused of colluding with, and often being subtly responsible for, this male aggression (Ettorre 1992). It appears that women as the underlying cause of male alcoholism, or women as the carers, protectors and supporters of male alcoholics, rather than being potential problem drinkers themselves, is an entrenched and unshifting position.

A sharp illustration of such gender stereotyping came to my notice when I contacted the organisers of a highly publicised international conference on alcoholism, held in Scotland in 1994. I enquired about what content had been included on working with women. After much checking, came the tentative reply: 'It seems we've organised a very good two hour session on working with the partners of alcoholics - so that will be catering for women, won't it' . Not only had the programme apparently failed to include content on women alcoholics, but working with partners of alcoholics had already stereotypically viewed women as carers, helpers and treaters, not as potential problem drinkers with specific needs from their partners.

Literature endorses that although times may have changed, societal attitudes towards women who drink heavily have stayed very much the same. They remain negative, judgmental and stigmatising. For women with drinking problems, the people they know, and the professionals from whom they may seek help, the stereotype of the woman alcoholic is a powerful and dangerous myth. Yet this stereotype is so far removed from most women's reality of their own

behaviour and presentation, that it has been cited as a major reason why many women do not identify themselves as having a drink problem in the first place, and so do not seek help.

Women in patriarchal society already suffer subordinate positions because of their gender, but women who are deemed to drink excessively threaten ideology on multiple levels. They exhibit non-feminine behaviour, and, uninvited, are seen to behave in male ways. Additionally, their drinking is seen to threaten the security of the nuclear family. Children could be placed at risk, families may be embarrassed and marriages threatened. The welfare state may even have to pay for alternative child care or single parent benefits. A woman problem drinker is dangerous and threatening. The stereotype many people have of her and her selfish, unwomanly, indulgent behaviour will serve to heighten stigma to such a degree that women who do digress and begin heavy drinking are likely to feel alone, desperate, confused, ashamed and self-disgusted. The effect of this stigma will cause guilt and unhappiness which will precipitate more drinking, and a collusive silence is drawn around such women's distress.

For women problem drinkers, who are not a homogeneous group, additional stigma can also affect so-called minority status women. Black, disabled, lesbian, older women, and those who are single mothers, are all subjected to oppression because of their differences. For them, the power of such negative imagery and stereotypes, plus the stigma of being a woman with a drinking problem, is likely to have unbearable consequences.

Women's Drinking Patterns

In recent years, evidence has widely suggested that there has been an increase in alcohol consumption among British women, and an increased prevalence of alcohol problems among this group. Over the period 1984-1996, the proportion of women aged 16 and over, who drank above recommended limits of 14 UK units of alcohol each week rose from 9 to 14 per cent; during the same time, men's levels of drinking above recommended limits remained stable at around 27 per cent (Dept. of Health 1999; Plant 1997). Figures concerning alcohol-related harm also indicate increasing and higher risks for women than for men (McCaul and Furst

1994; Ely et al. 1999). An increase in the numbers of women seeking professional help for alcohol related problems has also been viewed as evidence of a rise in the rate of alcoholism among women (Shaw 1980; Fillmore 1984; Miles 1991). If the ever increasing trend in women's drinking levels continue, it has been predicted they will soon be approaching those of men. Such predictions should raise concern, for research evidence has shown distinct gender differences in the consequences of heavy drinking, with women showing greater susceptibility to harmful alcoholic-related conditions (Lieber 1993).

However, it should be noted that all figures compiled about women and alcohol rates are likely to be inaccurate because of personal under reporting about women's drinking (Soutter 1988; Rhodes and Johnson 1994) as well as the reluctance or inability by health professionals to identify alcohol problems among women patients (Owens et al, 2000) and the constant mobility of women in and out of alcoholic drinking sub-culture (Gomberg and Nirenburg 1993). Other factors which influence any estimation of alcoholic rates among women include poly-drug use and differences in collection and presentation of epidemiological data (Cabinet Office 1988). The true picture of how many women have alcohol related problems is therefore likely to remain unknown.

Research in the USA and Britain, has shown changes in the patterns and age distribution of women's drinking (Breeze 1985; Goddard and Ikin 1991; DHSS 1999). Heavy and binge drinking has increased in the 18-35 age group in America, those at highest risk being single, divorced or separated or unemployed. A rise in drinking among younger women in the UK has also been consistently identified (Breeze 1985; Goddard and Ikin 1991; ONS 1998). In 1984 Fillmore demonstrated an increase in women heavy drinkers aged 21-29 who were in work, and speculated that this increase would signal a rise in drinking problems among employed women. However, US survey data, reviewed by Wilsnack and Wilsnack (1993) later contested that women in employment are likely to drink more than those who are unemployed, or who are working at home. In the UK, the proportion of women drinking above recommended levels has increased in social classes I and II, whereas no similar variation by social class was found for men (Dept. of Health 1998).

Gender differences in drinking habits are universally evident, with females more likely to abstain than men, and proportions of males consuming large quantities of alcohol exceeding those of females (Foster, Wilmot and Dobbs 1990; Goddard and Ikin 1991; Dept of Health 1999). Although the precise ratio of women to men alcoholics is not known, estimates vary from 1 : 4 to 1 : 2 (Hennecke and Fox 1988; Corrigan 1987; Carter 1997). According to the Royal College of General Practitioners, alcohol misuse among women is now established as a chronic problem in its own right, yet women's drinking continues to be viewed in comparison to mens' (Young 1992) with the R.C.G.P's also cautioning that women's drinking patterns must not be exaggerated or distorted, as they still consume less alcohol than men (Plant 1992). This view has been challenged by other writers who feel the nature of women's health risks and oppression concerning alcohol, is hiding a large, unsupported group, which requires both increased research focus and intensive health education (Wilsnack et al. 1984; Plant 1997).

Why Women Are Drinking More

Increases in per capita consumption in a social group have invariably been related to increased availability of alcohol to that group because of wider distribution outlets and reduction in the real price of alcohol. Shaw (1980) suggested that as women's disposable income increased, they would drink more, especially employed women who would have greater buying potential and more personal pressures than men because of their multiple roles of breadwinner and housewife/mother. Multiple role pressures have also been cited as explanations for increased alcoholism among employed women who are married, compared to single employed women or housewives (Soutter 1988; Parker and Harford 1992; Burman and Allen-Meares 1994). Other research has cast clear doubts about whether role increase is hazardous for women's drinking patterns (Wilsnack and Wilsnack 1993).

Drinking habits have long been noted to vary among different occupational groups and high risk occupations for alcohol misuse, such as pub and club work, often undertaken by women, thus increasing vulnerability. Mortality tables for the UK have also shown high rates of alcohol

related deaths among women in artistic and literary occupations and women in male-dominated occupations such as banking, insurance and executive positions (Hammer and Vaglum 1989). Interpretations of these findings have included work colleagues influence on women, imitation of high status male drinking models by women and specific stress of working in male-dominated environments (Wilsnack and Wilsnack 1993).

The effect of advertising promotion is also noted to have been influential on women's drinking patterns (Kent 1990; Ettorre 1997, Alcohol Concern 2001). In Britain the advertising industry is now spending huge amounts targeted specifically at women, not just to create brand switching, but to persuade women to drink more. Advertisers use different ways of portraying male and female drinking. Advertising promoting alcohol for men often enhances the stereotype of male strength and supremacy and men are viewed in adventurous, exciting pursuits. Women are more often portrayed in terms of sexual attractiveness and sophistication , or as needing to be more attractive, alluring and interesting, and so be more able 'to get a man'. Many alcohol advertisements also identify the drinking of alcohol with the consumption of women's bodies (Heather and Robertson 1989; McConville 1991), a theme common in pornography. Consequently it may follow that many heterosexual women will respond to alcohol advertisements in an attempt to feel more desirable and attractive to men. Advertisers of alcohol are undoubtedly aware that many women's low self image, and the pressure of social and cultural expectations, will make them respond to the promise of improved approval by others, particularly men. Through the endorsement of sex role images and stereotypes which are often negative and subordinate, advertising is falsely offering alcohol as a possible means for women to achieve fulfilment.

Physical & Psychological Consequences Of Alcohol Misuse

Alcohol is unique among psycho-active substances in having the capacity to cause widespread tissue damage. Research has consistently found that women are more vulnerable than men to the harmful physiological and psychological consequences of heavy drinking (Lieber 1993; Ely

et al. 1999). Gender differences are therefore crucial when reviewing the potential physical and psychological results of alcohol abuse.

For women who severely misuse alcohol, life expectancy is markedly curtailed (Smith and Cloninger 1981; Smith 1983; Andreasson and Brandt 1997). The rate of alcohol-related deaths for women is not only 50 to 100 per cent higher than for alcoholic men (Morgan 1992; Gomberg and Nirenberg 1993) but is also estimated at being up to nine times that of non-alcoholic women (Cyr and Moulton 1990). The overall death rate for women dying from alcohol-related damage in the U.K. has been calculated as 2 per 100,000 , and increasing (National Association of Health Authorities 1989; O.P.C.S. 1990). However, these figures do not take into account other indirect consequences such as accidents, suicide and circulatory disorders (Oppenheimer 1991).

The reasons why women are more physiologically compromised by alcohol than men are complex. These include gender differences in weight, tissue saturation, stomach enzymes and the proportion of fat to water in the body. The most significant difference is that women experience an alcohol tissue concentration one third higher than men of similar weight and alcohol dose. This affects not only increased blood alcohol levels, but also the time taken for the blood alcohol level to return to zero (Niaura 1987; Morgan 1992). Alcohol consumption is also known to disturb hormone secretion and breakdown, which extensively affects body tissue and a variety of diseases likely to make women more vulnerable to alcohol-related harm (Galambos 1972). There is also substantial evidence that women experience alcohol related problems earlier in their drinking careers, and as a result of less consumption than men. This phenomenon, termed the 'telescoping of problems', places women at accelerated and much greater risk of alcohol related damage (Piazza 1989).

Research suggests that the potential for physical harm for women problem drinkers concentrate on several key areas:

Liver damage is the most common long term effect of heavy drinking, and women develop significantly higher liver pathology after a shorter duration of heavy drinking and at lower

levels of drinking than men (Gavaler and Arria 1995), with most liver disease reported in women under 45 years (Alcohol Concern 2001). It has been suggested that pre-menopausal women are more vulnerable to the hepatoxic effects of alcohol because of differences in gendered drinking patterns, the adverse effect of estrogen on liver function and differences in autoimmune responses (Hill 1984). Death from alcoholic cirrhosis among women in Britain increased by 40 per cent between 1979 to 1989, compared with a 6 per cent increase in men (Baker 1992). By 1997, increased alcohol liver disease accounted for the deaths of women at a ratio of 2:3 men (Institute of Alcohol Studies 1999). There is also evidence that liver damage may continue, even after a woman becomes abstinent, whilst this damage in men is usually halted by stopping drinking (Kent 1990).

The **central nervous system** will be affected by alcohol misuse. Contrary to popular belief, alcohol acts not as a stimulant, but as a depressant of natural inhibitory mechanisms, leading ultimately to stupor or coma (Camberwell Council on Alcoholism, 1980). Alcohol can cause brain damage and impairs sensory, perceptual, mental and motor functions. Concentration, memory, judgement and insight can be reduced, and general mental deterioration occurs (Beatty et al. 2000). The nervous system is additionally sensitive to abrupt abstention from alcohol, and withdrawal symptoms, including tremor and shaking, can occur. In one survey it was reported that 19% of heavy drinkers admitted to alcohol treatment units suffer chronic organic brain syndromes, and that women are three times more likely to suffer such syndromes than men (Royal College of General Practitioners 1986). Women alcoholics are also likely to develop patterns of brain abnormalities and damage, after markedly shorter and lighter drinking histories than men (Mann et al. 1992).

Heavy alcohol consumption is associated with **cancers** in women, especially of the mouth, oesophagus and digestive tracts (Royal College of Physicians 1987; Grombaek and Becker 1998). Over the past 25 years research has also shown an increasing association between breast cancer and alcohol misuse (Plant 1997), with some studies indicting an increased risk of breast cancer of up to 40 per cent (Royal College of General Practitioners 1986; Thun 1997). Other studies have suggested more conservative risk (Willett et al. 1987; Van den Brandt 1995), or only very marginal statistical evidence of a link (Rohan et al. 2000). In women, misuse of

alcohol has also been associated with greater risk of cancer of the lip and tongue, pharynx and esophagus, stomach and lung (Hill 1984; Doll et al. 1993; Harnack et al. 1997; Rachtan and Sokolowski 1997). Nutritional deficiencies connected with alcoholism and the dangers of direct exposure to alcohol have been cited as promoting cancers among problem drinkers, however, such explanations do not account for gender differences in the incidence of certain cancers.

Mortality rates from **cardiovascular and circulatory disorders** indicate that alcohol misuse presents at least the same risks for women and men (Hill 1984), however increased vulnerability of damage to the heart muscles for problem drinking women has been noted (Urbano-Marquez et al 1995).

Menstrual, gynaecological and obstetrical disorders are considered to be frequent among women problem drinkers. Dysmenorrhoea, heavy menstrual flow, premenstrual discomfort and sexual dysfunction are cited (Wilsnack et al, 1984), as are infertility, miscarriages and hysterectomies (Morgan and Pratt 1982; Blume 1992). Clinical observations have indicated that alcoholic women often relate increases in drinking, and problems during the premenstrual period (days 21 - 28) and susceptibility to high peak blood alcohol levels have been found in women during premenstrual and ovulation times (Mello 1980; Allen 1996). However, findings from research have been conflicting, some studies indicating there is no simple correlation between alcohol consumption and premenstrual difficulties (Belfer and Shader 1976, Plant 1992). Indeed, research and data concerning menstrual cycle related changes and alcohol consumption and effect, although viewed as important information in the field of female problem drinking, has also been criticised as portraying women as helpless victims of their hormones, so as supporting a male supremacy position (Tiger 1970).

The **menopause** has been identified as another high risk period for physical complications for problem drinkers, with hormonal changes, compounded by negative cultural attitudes towards women and aging, said to affect vulnerability (Della Torra 1992).

Drinking and pregnancy

Alcohol intake during pregnancy has engendered more research interest than any other aspect of problem drinking for women. Throughout history the suspicion that alcohol consumed by the mother may be harmful to her foetus has been reported, but it was not until the nineteenth century that scientific research was carried out to assess the effects of alcohol on pregnancy (Plant 1987). In 1968, studies on the backgrounds of babies who failed to thrive recognised certain abnormalities of babies associated with maternal heavy drinking; this effect was termed the Foetal Alcohol Syndrome (Jones 1973). Clinical characteristics of affected babies could include: low birth weight; slow 'catch up' rate; abnormalities of the head and face; organ and brain damage; retarded IQ scores; hyperactivity; and alcohol withdrawal symptoms (Streissguth 1980; Day et al, 1990; Streissguth et al. 1994). Since then, numerous animal and human studies have assessed drinking during pregnancy (Rosett 1983; Plant 1987), yet finding safe drinking levels in pregnancy has eluded researchers, although many now recommend that women who are pregnant, or hoping to become pregnant, should avoid alcohol altogether (Heather and Robertson 1989; McConville 1991), or drink only one or two units a week (Alcohol Concern 2001).

Much controversy surrounds Foetal Alcohol Syndrome, particularly the difficulties in recognising it, and the evidence that many other factors can similarly affect the foetus. A Scottish study which monitored over 1,000 pregnant women indicated that foetal harm could be related to a wide constellation of variables in women who drank, e.g. previous maternal obstetric history, socio-economic status, tobacco smoking, height, diet, use of prescribed or illicit drugs and age (Plant 1987). Although maternal alcohol consumption was associated with abnormalities, it was judged as being of only minor consequence in the outcome of pregnancy. Double standards between male and female sexuality have also been highlighted concerning parental drinking with evidence of testicle shrinkage in men who drink heavily rarely being mentioned in literature (Morgan and Pratt 1982; Soyka and Joffe 1980). Almost forty years

ago, researcher Dul'nev (1965) confirmed that children conceived during active paternal alcoholism showed intellectual reduction. However, despite some promising preliminary research, very little scientific interest has surrounded paternal alcohol abuse compared with inordinate interest in maternal drinking patterns. Women who are pregnant and have drinking problems have been seen as presenting a special risk to society, and have been considered to be the most stigmatised of all female alcohol users. The implications of Foetal Alcohol Syndrome as a political, as well as medical syndrome are implicit (Jessup and Green 1987; Ettorre 1992).

The Foetal Alcohol Syndrome message could be viewed as another bias aimed at controlling women's bodies and behaviours, but not men's. Women drinkers may be seen as less responsible than men, and as needing to be monitored and controlled. A woman who drinks, and so who may harm her foetus, is viewed as negligent within the Foetal Alcohol Syndrome debate, where the baby has already taken priority over the woman. Moral condemnation of potential mothers who drink invades a pregnant women's right to take responsibility for her own body and drinking practices (Ettorre 1992), whilst men's possible influence in foetal harm has significantly evaded interest.

Personality

Researchers have consistently tried to identify an underlying psychopathology or personality type among women alcoholics (Beckman 1975; Mello 1980; Bergman et al. 1998), and it has been suggested that the same double standards which apply to acceptable drinking behaviour between the sexes are likely to have influenced the view that women alcoholics have more psychopathological difficulties than male alcohol misusers (Boothroyd 1980).
Early studies of alcoholic women claimed they showed inadequate personalities and lacked preparation for adult roles, and often had an over-identification with one or both parents (Kinsey 1968). Rathod and Thomson (1971) further suggested that women alcoholics showed more maladjusted personalities than men because of their higher rate of mental illness, suicide attempts, and because they chose alcoholic partners more than their male counterparts. These variables can be challenged by findings from other research, such as those which show that pre-alcoholic psychological damage is difficult to separate from alcohol-induced factors, that

intolerable pressures are placed on many women to drink by their alcoholic husbands (Haavio-Mannila 1991), and that sex bias in diagnosis of mental illness is likely to cause misdiagnosis (McCrady and Raytek 1993).

A close link between unsatisfied dependency needs of alcoholic women and drinking to develop feelings of personal power has also been demonstrated (McClelland 1972). These findings conflict with Wilsnack's (1973) studies which showed no gratification of dependency needs nor increased power among women who drank, but did show that women were more likely to misuse alcohol because of feelings of unwomanliness, further reinforced by societal disapproval of women drinkers as unfeminine.

Distorted self-concepts and low self esteem among women drinkers have been identified in many studies (Berg 1971; Vanderpool 1969; Klee et al. 1991; Turner 1992; Ambrogne 1999). However, low self esteem is invariably associated with a variety of psychiatric disorders in women; furthermore, low self esteem has been noted as being part of a condition for many women, heavy drinkers or not (Williams 1987; Kagle 1987; Russell 1995).

Women who misuse alcohol have much in common with women who do not. Because of the heterogeneity of women with alcohol problems, and the methodological difficulties surrounding whether personality characteristics are precursors or consequences of problem drinking, or both, identifying basic personality traits has often served to reinforce negative stereotypes (Kagle 1987). As Stephenson (1980) has stated, alcoholic women, as members of an oppressed social group, should be seen as mirroring the problems experienced by many women. By stigmatising alcoholic women's difficulties, it is easy to see them as having abnormal personalities, and pathologically disordered behaviours.

Depression

The coexistence of alcohol misuse and depression in women has typically been the subject of much disagreement in research and literature on alcoholism. Such controversy has been exacerbated in many studies by findings of very wide variables of estimated rates of

depression among women with drinking problems. These range from between 3% to 98%, and like so much research on women problem drinkers, have generally focussed on clinical populations (Schuckit 1986; Glass 1991; Turnbull and Gomberg 1988; Haver 1997; Weaver et.al., 2000). However, there is agreement from research that women with drinking problems do suffer from depression more than their male counterparts (Gomberg and Lisansky 1984; Jensen 1993; Hesselbrock and Hesselbrock 1997), although the reasons for this are complex and inconclusive, making the topic of particular interest for feminist study.

Additionally of importance, in addressing this research deficit, is the need to assess the impact of depression on alcoholic women's lives, most specifically whether depression occurs before or after alcohol misuse. The prevalence of pre-alcoholic (primary) depression, as well as alcohol-affected (secondary) depression among clinical populations have both been noted, but the case of depression as a secondary condition among alcoholic women has gained widest acceptance (McMohan and Davidson 1986; Turner 1992; Dixit and Crum 2000).

Exploring the significance of, and initial development of, depression for women with alcohol difficulties offers particular potential in my research, which, uncommonly, focuses on life events both before, during and after alcohol misuse.

Suicide and Self Harm

Completed suicide rates among alcoholics are reported to be between six to twenty times the rate of the general population and it has also been estimated that around 30 per cent of the general population who attempt suicide have alcohol problems (Goodwin 1973; Glass 1991). Studies which have considered gender differences show higher rates of suicides and attempted suicides among women alcoholics, compared with alcoholic men or non-alcoholic women (Hill 1984; Gomberg 1989; Merrill et al. 1992).

The higher rates of suicide and self harming behaviours among women with drinking problems has attracted various explanations, particularly with regard to alcoholic women's feelings of desperation, worthlessness and hopelessness which is compounded by societal stigma about women alcoholics (Camberwell Council on Alcoholism 1980; Boothroyd 1980). Women who misuse alcohol additionally frequently report symptoms of desperate depression and extreme social, emotional and personal difficulties (Long and Mullen 1994). These overwhelming personal and social pressures may precipitate suicide attempts, often carried out whilst under the influence of alcohol, which may act as a behavioural disinhibitor.

Other Psychiatric Disorders

Debate surrounding the intricate interplay of societal norms, labeling and self perception, has questioned whether drinking promotes more psychiatric disorders in women, whether mental illness is purely the result of severe social sanctions against women alcoholics, or whether, in fact, women need to be maladjusted or sick to overcome intense stigma and demonstrate alcoholism in the first place. Jacobson (1987) has suggested that women's alcoholism is more reactive or secondary than men's, secondary alcoholism being that which follows a psychiatric disorder. Other research has indicated that increased prevalence of general psychiatric disorders among women alcoholics both antecede and develop secondary to alcohol abuse (Haver 1997). Davidson and Ritson (1993) believed that women alcoholics, more than male alcoholics, suffered from additional psychopathology, with up to two-thirds of clinical samples having a lifetime diagnosis of another psychiatric disorder. Indeed, psychiatric disturbances has been described by some as underlying all cases of alcoholism (Glass 1991).

Studies have also indicated a higher rate of histories suggesting psychiatrically ill near relatives, among female alcoholics, compared to male alcoholics, especially in the area of affective disorders (Dahlgreen 1978). However, psychotic disorders have not been found to be of significance among alcoholics, nor among the relatives of patients (Bernadt and Murray 1986).

Eating Disorders

The term eating disorders refers to the conditions bulimia, anorexia nervosa and compulsive eating, disorders characterised by the excessive ingesting or expelling of food. The ratio of women to men who suffer from eating disorders is thought to be in the region of about 20 to 1 (Duker and Slade 1988; Malson 1998). Eating disorders are very much women's disorders.

Women with eating disorders, like those with alcohol problems, are often hard to survey effectively because of self denial and finding reliable criteria to select individuals, but some studies on eating disordered women have revealed co-existing alcohol disorders, with up to one third of eating disordered women also reporting a history of alcohol problems (Mitchell 1985; Goldbloom 1993; Taylor et al. 1993). Prevalence rates for eating disorders among alcoholic women have also been found to be high, compared to non-alcoholic women (Peveler and Fairburn 1990).

It has been considered that the high rates of alcohol misuse associated with eating disorder may be because of the similarities in the clinical features, aetiology and response to treatment, for various forms of so-called addictive behaviour, including alcohol misuse and eating disorders (Miller 1980; Orford 1985). Anorexia nervosa and bulimia have been compared to alcoholism in their shared inabilities to be defined neither as a physical illness, a mental illness, nor resulting from personal deliberate action. Bulimic binge eating has also been directly compared to bouts of binge drinking (Duker and Slade 1991), with states of 'altered consciousness' associated with starvation phases being similar to sensations when intoxicated. So, starvation (eating disorders) and intoxication (drinking disorders) may both have a potent ability to alter thought and perception. Additionally, restricted food intake will enhance the effects of alcohol. Recent findings have suggested that the links between eating disorders and alcoholism in women are indirect, and mediated only by a history of major depressive disorder or post traumatic stress disorder (Dansky and Brewerton 2000).

The search to medicalise problem drinking with eating disorders does little to explain why eating disorders and problem drinking are often co-existing conditions; however, feminist analyses may suggest the connections between the two conditions are not surprising. In their search for control and power in personally or structurally oppressive worlds, many women may be doubly harming themselves through combined misuse of food control and alcohol, both of which may induce temporary relief from distress because of similar, powerful perceptual and mind-altering states. Misusing alcohol and food, and being seen as being out of control, threatening, difficult to treat or unfeminine, may be an unlikely, but ultimate personally controlled response. Women addicted to food or alcohol could be viewed as defying their unacceptable roles and challenging what is stereotypically perceived as being a woman's traditional and natural relationship to food and alcohol.

Multiple Drugs Use and Alcohol

In Britain, as in other developed countries, admissions to psychiatric hospitals, community mental health care, and the prescribing of psychotropic drugs, are consistently higher for women (Cafferata and Kasper 1983; Johnson and Buszewicz 1996; Payne 1998). This is thought to explain why high alcohol consumption in women, but not men, is frequently combined with higher uses of other drugs (Kaplan 1980).

One of the major differences between male and female alcoholics is their use of medications, with women using tranquillizers and sedatives at twice the rate of males, and women problem drinkers often showing significant problems with other drugs, usually prescribed ones (Curlee 1970; Mulford 1977: Robbins 1989; Davison and Marshall 1996). Illicit drugs use, such as marijuana, cocaine and heroin is also thought to be more common among female than male alcoholics (Gomberg 1989; Chan 1991; Lex 1991).

Drinking, Sexual Behaviours and Sexuality

The belief that alcohol is an aphrodisiac has been present throughout recorded history, and drinking and sexual activity have long been assumed to be associated. But the relationship between sex and alcohol consumption is complex.

Data collected from both alcoholics and non-alcoholics support a widely held belief that alcohol enhances sexual activity and enjoyment in women because of its ability to disinhibit (Beckman 1979; Critchlo 1990; Wilsnack and Wilsnack 1995). However, some studies have disputed this widely held stereotype that alcoholic women tend to be more sexually active, or that they are more likely to engage in unsafe or undesired sexual behaviour after drinking (Taylor and Fulop 1999). There is also evidence that rates of sexual inhibition, low sexual interest and other sexual problems have been high among alcoholic women, with some findings suggesting that women may use alcohol to 'treat' their sexual problems, and that sexual difficulties may well precede or contribute to the development of a drinking problem (Wilsnack 1984). Impaired sexual functioning can also result from the direct toxic effects of alcohol on hormonal and central nervous system levels (Green and Hollander 1980). Sexual dysfunction could, therefore, be seen as either the cause or consequence of heavy drinking.

Although historically ignored in research studies, the question of the role of sexual partners in alcoholic women's sexual dissatisfaction should be noted . Alcoholic women are more likely to have partners who are alcoholic men (McCaul and Furst 1994), and men with drinking problems have an increased risk of sexual dysfunction from decreased sexual interest to impotence (Van Thiel and Lester 1979; Wilsnack 1984). Men have also been noted to encourage problem-drinking female partners to use alcohol so they can take advantage of them sexually, or to deliberately sabotage alcohol treatment efforts, fearing that less alcohol will mean less sex (Berenson 1976; Klee et al. 1991).

Some literature suggests that it is the psychological, rather than any physiological effect of alcohol, which leads women to believe that drinking will improve sexual pleasure (Kline 1990). This belief may heighten sexual expectancy and induce relaxation, so giving some women the permission to behave in ways they may find difficult when sober because of possible moral condemnation (Klassen and Wilsnack 1986; Leigh 1990).

Research has indicated that males believe that drinking alcohol makes females more sexually available (World Health Organisation 1994). Consistent with this stereotype, if women are seen drinking, this may be a cue for some men to pursue them. In turn, such women may feel more attractive and ultimately more sexually liberated. It could be suggested, therefore, that if sexual activity is enhanced by alcohol, it is the behaviours surrounding drinking, rather than the effects of alcohol itself, which are likely to promote this.

Lesbians / Bisexual Women

Early literature revealed very little information of lesbian or bisexual experiences amongst women drinkers, but this is more likely to have reflected repressive moral attitudes of the time, rather than critical research findings. A paucity of research in Britain has been published on lesbians and alcohol use, but available studies do generally indicate a much higher risk of drinking problems among lesbians, compared to heterosexual women (Swallow 1983; McKirnan and Peterson 1989; Abbott 1998). However, such findings have been contested by questionnaire data research by Bloomfield (1993), who reported that, contrary to previous research, no statistically significant differences in alcohol consumption could be found between heterosexual or lesbian or bisexual women.

Subgroup differences between lesbians and bisexual women have been established (Wilsnack 1984), and Covington's (1982) study of women alcoholics found bisexual activity was more likely during periods of drinking, whereas lesbian preference increased during sobriety. Bisexual women may have a less identified subculture and it has been suggested that they can feel alienation from both heterosexual and lesbian women (Schaefer and Evans 1980). Some

bisexual women have also been identified as having a primary lesbian identity which they try to sublimate through drinking and through bisexual or heterosexual activity (Covington 1982).

Undoubtedly, work on lesbians who drink heavily remains a major research gap in alcohol literature (Wilsnack and Wilsnack 1995); until more studies focus on this area, lesbian women will remain a largely invisible, but perhaps substantial, sub-group.

Incest and Sexual Abuse

Sexual abuse was considered too sensitive a topic to include in early studies about women and drinking, but more recent literature has shown a marked correlation between incest, sexual abuse and rape and alcoholic women. Elevated rates of incest and other forms of childhood sexual abuse for alcoholic women range from around 12 per cent to 53 per cent, and up to 74 per cent for all sexual abuse combined (Murphy 1980; Covington 1982; Mc Cauley et al1997; Spak et al. 1998; Moncrieff and Farmer 1998). However, one recent study has suggested that child sexual abuse is not by itself a significant predictor of alcoholism in women (Fleming et al. 1998).

There are also thought to be strong links between alcohol misuse and the behaviour of perpetrators of sexual abuse, with rates of alcoholism among incestuous fathers ranging from 20 per cent to 70 per cent (Forrest 1983). Other sexual and physical violence towards women, when alcohol has been consumed by the attacker, has been widely acknowledged (Freize and Schafer 1984; Willson et al. 2000).

Sexual Behaviour, HIV/AIDS And Alcohol

Concern about the spread of AIDS/HIV has focussed some research interest in possible increased risk of HIV infection among women who drink heavily (Robertson and Plant 1988; Plant 1990b; Murgraff et al. 1999). Studies have shown that women are less likely to use

condoms whilst under the influence of alcohol. Young people appear to be at greatest risk, with results suggesting that males and females who regularly combine alcohol with sexual activity are seven times less likely than non-drinkers to use condoms (Bagnall 1991). The findings of such studies raise concerns about alcohol use and safe sex and suggest that women who combine alcohol with sexual activity are at risk of greater exposure to AIDS/HIV than non-drinking women.

The Aetiology of Alcohol Misuse

There is agreement among researchers that women's drinking is more stigmatised than men's drinking and that attitudes strongly oppose intoxication and alcoholism among women. There is also evidence that women's drinking is clinically different from men's and that alcohol consumption is different between male and female alcoholics. Physiological consequences for women drinkers are greater, and women appear to experience more personal and family disruption (Schmidt 1990). The consequences of women's drinking has therefore repeatedly shown that women's drinking may be more personally damaging than men's, but researchers who have examined the reasons for women's alcohol problems, and the factors which may predispose alcohol misuse, have often issued conflicting findings.

A general aetiological theory about the causes of drinking problems with women was conceptualised by Shaw (1980) who stated that female drinking problems are multifactorial, including economic, social, psychological and physiological variables. The heterogenity of women with drinking problems was outlined by Davison and Marshall (1996), who suggested that transition points in life, such as pregnancy, marital break up, bereavement or physical illness may make women more vulnerable to alcohol misuse. Olenik and Chalmers (1991) included family of origin drinking history, heavy drinking among spouses, stress, anxiety and depression as causal agents. A model proposed by Hill (1981) merged both biological and psychosocial approaches and viewed alcoholism in women as a joint expression of vulnerability, coupled with the occurrence of important life events or personal stressors.

Sandmaier (1980) suggested a more radical theory; that in general terms women drink because of dependence on men. This dependence relates to psychological and physical ill health caused by specific life crises such as divorce, conflicts around traditional gender roles, lack of occupational skills, economic dependency, child rearing responsibilities, and the marketing of alcohol which presents images of heterosexual attractiveness and freedom for women.

Stress And Life Events

A complex and controversial area in tracing aetiology lies in relation to stress factors in drinking among women. Some researchers believe that women's drinking could be associated with life situations concerning their stressful family caring roles or loss of role when children leave home, the 'empty nest syndrome' (Curlee 1969; Thom 1997). Such women have been described as 'reactive alcoholics' (Gomberg 1984). In a study by Thom (1986), 92 per cent of women felt daily stress or events made them drink excessively, compared to 40 per cent of men. Thom concluded that whilst men found alcohol consumption caused them problems, women still believed it was problems which actually caused them to drink. Additional literature supports the view that women use alcohol to relieve stress and the discomfort of everyday life (Snell et al. 1987; Reed 1987), but other researchers have argued that the association of stressful life events to drinking is unlikely (Morrisey and Schuckit 1978; Allan and Cooke 1986).

As there are few comparative studies, and little is understood about 'normal' life flow events for women; without these norms it can be contested that cause-and- effects of stress and life events are difficult to quantify. Furthermore, in studies which have raised the importance of stressful life events for women with drinking problems, very little analysis has reviewed the interconnections of women's subordinate roles in society, or the significance of them being members of an oppressed social group whose problems will tend to reflect the inequalities experienced by many women. How and why women may misuse alcohol because of life events remains an under researched area (Kent 1990).

Marriage

Women with alcohol problems report more marital and familial disruption than men (Perodeau 1984; McCaul and Furst 1994; Coker et al. 2000), but it is unclear whether women experience marital conflict because of their drinking, or whether they turn to alcohol as a result of their marriage problems.

However, many more alcoholic women than alcoholic men are said to have spouses with drinking problems (Wilsnack 1984; McCaul and Furst 1994; Thom 1997) and men are more likely to leave an alcoholic spouse than vice versa (Plant 1997). Problem drinking has been proposed to be highest among divorced and separated women (Gomberg and Lisansk 1984; Wilsnack 1994), with difficulties associated with lone childcare, poverty, loneliness and stigma for women alone likely to be important factors, although generally data does not clarify whether in fact the problem drinking began during marriage. Alcohol problems are also commonplace among women who are cohabiting (Wilsnack and Wilsnack 1995), however, older women who are married have higher rates of drinking problems than those who are divorced, separated or widowed (Johnson 1982). As married women have a higher incidence of mental illness than single women, but as single men experience more mental health problems than married men, it could be deduced that the structure of traditional family life and its possible oppressive effect on women should be questioned (Stoppard 2000).

Genetic Factors

A frequently occurring theme in alcohol literature is the belief that female alcoholics often come from families where a parent or a sibling is also alcoholic (Hill et al. 1991; Pickens et al. 1991; Hesselbrock and Hesselbrock 1997; Heath et al. 1997). However, although most research supports the notion that some family transmission occurs, the most contentious

question, of whether family transmission is because of social and environmental, or biological genetic factors, has yet to be satisfactorily proven.

When a child grows up there are usually role models who will affect her or his view of alcohol consumption. Alcohol may be absent or unimportant, or may stay a very significant role in the family life. Parental drinking practices, as a possible cause for transmission of alcoholism has, perhaps not surprisingly, shown connections between parent alcohol abuse and children's later drinking patterns.

The belief in the genetic transmission of alcoholism has been used by some theorists to validate disease concept theory in alcoholic women, although it can be argued that there is insufficient evidence to uphold this (Clifford et al. 1984). Many larger studies focussing on genetic work, using adopted and twin sibling samples, have been carried out on males, and until more research targets women with drinking problems it will be difficult to determine the validity of the popular belief that of genetically mediated alcoholism in women (Gomberg and Lisansky 1984; Hill 1984, 1993; Whitfield and Martin 1994)

Emancipation

Financial, economic and social emancipation have been suggested as indicators in the increase amongst women with drinking problems (Shaw 1980). In fact one early study predicted that alcoholism was the ransom many women would pay for their emancipation (Massor et al. 1956). The Royal College of Psychiatrists echoed this view, when stating that increased alcoholism in women is 'one of the prices to be paid for a more equal place for women in society'. (Royal College of Psychiatrists, 1979:4.) Beckman (1978) agreed that the Women's Movement may be associated with female alcoholism, but discounted a specific causal link. Sandmair (1980:242) suggests: 'if female drinking problems are increasing, it is most likely not because women's liberation has arrived, but because it has not .' The arguments which have implicated emancipation as a cause of drinking problems in women has devalued alcohol as a feminist issue, with the image of liberated, drinking women purely reflecting the status quo or

a male view of the world (Ettorre 1992).

Alcohol: A Feminist Issue?

Some researchers have discussed the potential of feminist standpoints for offering greater understandings of why some women may misuse alcohol (McConville 1991; Ettorre 1992, 1997; Doyal 1995). Feminist perspectives are seen as offering new frameworks for examining women's experiences and behaviour, while recognising the gender roles and sexism which will invade areas of women problem drinkers' lives, before, during and after their problems with alcohol.

The majority of women in Western society are still locked into traditional definitions. Patriarchy still conditions many girls into women who lack confidence and self respect. Women continue to be encouraged to be more nurturant and passive than men, and are still socialised into believing marriage and children will provide unlimited gratification, but, in reality, often discover a tedious routine of daily activity, and isolation from adult company. Women who have families and also work outside the home may fight to accomplish two jobs. It is not difficult to speculate why attempting to live out traditional gender roles in modern day society may prove very difficult for many women; feelings of frustration, failure, guilt and depression manifest in many conditions, especially mental illness and substance misuse (Valentich 1982 ; Stoppard 2000).

Despite the optimistic claims of some post-feminists, most women, worldwide, have yet to experience equality with men (Bell and Klein 1996). Many women suffer the tyranny of controlling and sexist psychiatric services (Chester 1972; Allen 1986; Russell 1995) and health care (Webb 1986; Roberts 1992). They often suffer unequal treatment in our criminal justice system (Smart 1989; Worrall 1990). They are overwhelmingly more likely to be sexually abused in childhood, raped in adulthood or suffer repeated domestic violence (Dobash and

Dobash 1992; Mullender 1996). They can be victims of femicide (Radford and Russell 1992) and regularly find themselves financially subordinate to men (Payne 1991). At every life stage, in almost all situations, women may be disadvantaged compared to men.

McConville (1991) noted that, during her interviews with female problem drinkers, she constantly met women who felt guilt, shameful, anxious, inadequate, bored and frustrated with their lives and their relationships. McConville believes that problem drinkers must be encouraged to challenge the stereotypical image of womanhood, rather than question their personal feelings of failure and worthlessness.

Similarly, Swallow (1983), a lesbian researcher, had contended that substance abuse is part of patriarchal oppression. By using alcohol to try and manage the oppressions of sexism, racism and lesbophobia, women are inadvertently reinforcing patriarchal weapons of low self esteem, anger, depression, hopelessness and loss of purpose.

Ettorre (1992) states that feminist ideas within addiction studies have been viewed as unconventional, and resisted, and that feminist critiques of substance misuse do not exist because so few feminist scholars have focussed on women and addictions. If gender is recognised as a key concept in alcohol this may cause intense discomfort, but there is a need to move beyond traditional beliefs within alcohol abuse, and challenge patriarchal notions (Ettorre 1989). Ettorre reinforces that researchers need to look beyond purely clinical populations. They need to challenge the stigma and disgrace which is linked to women's drinking, and to examine women's experiences in terms of traditional gender roles and relationships: *'Finally, women alcoholics of whatever age, sexual orientation, social class and race need to reclaim their lost power; to name their experiences from an awareness of what it means to be a woman in a society that brands them as outcasts'* (Ettorre 1992: 50).

The consequences of a woman's perceived deviance from patriarchal norms and expectations by stepping out of gender role, acting or behaving in a 'deviant' manner (by choice or consequence) will invariably be negative. Both societal and self sanctions are great. The continuum of consequences from traditional role digression for women may exist in varying degrees - from

those who choose some kind of self liberation in the form of acquired attitudes and behaviours such as political ideology or sexuality, to those who may manifest extreme unhappiness, in symptomology labelled psychiatric disorder or problem drinking.
Feminists' views of problematic behaviour for women are constructed from a political context. Whilst girls and women, institutionally and individually, are experiencing oppression in our society, it seems inevitable that many will continue to seek accessible means of escape; for some, alcohol could provide such temporary freedom. Within the field of alcohol studies the centrality of men's experiences has been dominant. The needs and experiences of women urgently need to be heard. Alcohol is very much a feminist issue.

Conclusions

The literature searched has shown that women's experiences surrounding the misuse of alcohol are complex, yet have often been presented in simplistic, androcentric or biased ways. Additionally, much literature poses as many questions as it answers.

There is entrenched controversy around definitions of 'alcoholic' or 'problem drinker', which serves to confuse professionals and problem drinkers alike. Boundaries are further clouded by many conflicting theories concerning whether alcoholism should be considered a lifelong disease, or a learned, changeable behaviour. The impact of such disease theory and pathological emphasis for women continues to be significant.

Several studies have focussed on stereotypes and myths, which are invariably negative and degrading, perpetuated not only by popular beliefs and culture, but sometimes from the literature itself. The stigma surrounding women problem drinkers appears relentless, as is the tendency to blame women, not only for their own misuse of alcohol, but also that of their male partners or children.

Women's drinking patterns appear to be changing, and we are drinking more. Yet there is little evidence that primary and secondary treatment sources are offering the support to meet the

needs of such an uncatered for group. There is also very strong evidence that lesbians are particularly at risk, as are those who have suffered abuse, although in-depth qualitative studies which examine these sub-groups are very uncommon.

In almost all aspects of physical and psychological illness and damage linked to heavy drinking, women are more vulnerable than men, and these consequences should warrant particular concern. Similarly, multiple drugs use, of both prescribed and illicit substances, is a particular problem for many women who drink heavily.

Works studying the aetiology of women's alcohol misuse points to several possible antecedents. Stress and life events, family and marital disruption, changing roles and sex role conflicts, financial and social problems, mental illness, alcoholic personalities and genetic vulnerability have all been cited. Many of these topics will be further developed during exploration of the life histories in my sample. Some of my findings will concur with, or extend previous analyses, some will differ, or openly challenge them.

Chapter Three

Selection And Use Of Research Methodology

Foreword

It should be noted that my literature searches, which informed my initial sections in this chapter on methodology, were located within the framework of available literature at the time (mid to late 1990s).

Feminist research

'If we continue to speak this sameness, if we speak to each other as men have spoken for centuries, as they have taught us to speak, we will fail each other. Again words will pass through our bodies, above our heads, disappear, make us disappear.'

(Irigaray, 1980: 69.)

Feminist theories, philosophies and practices have had a considerable influence on my life. I believe that feminism has the power to change and improve lives, and make sense of the political, cultural and intellectual worlds we inhabit. Whilst celebrating the important advances in the women's movement over the past three decades, I still believe that the challenge to broaden feminist knowledge by research is as important as it has ever been. My beliefs and philosophy, the way I live my life and work, are underpinned by my political

convictions. When undertaking a research study it has been a natural consequence for me to carry this out from a feminist standpoint. Within the context of this study, the methods I have used, and the principles I have followed, also define it as feminist research.

In my research I wanted to address imbalances which I felt had been consistent in malestream research - often based on all-male samples - which has taken the mandate for defining truths about alcoholism and the lives of women who have drinking problems. An obvious gap remained. Where were the voices of women in the debate; where were the accounts of their experiences? Focussing on these gaps, within a feminist framework, suggested listening to the uncensored voices of women, and trying to understand these women's lives in their own terms (Stanley and Wise 1983b, 1993; Brown and Gilligan 1992).

I believe that feminist approaches within research have the most significant potential of any research process for investigating women with drinking problems - a topic which has significantly lacked previous in-depth women-centred work (Babcock and Connor 1981; Ettorre, 1986, 1992). For, although it is true to say that some research has included women, this has often followed a gender-blind approach, has simply compared women drinkers with standards from male counterparts, or has completely ignored the impact of gender oppression and the potential for integrating feminist theories within the theoretical framework.

Significantly, previous research on women with drinking problems has also often used data collection methods which have not encouraged the exchange of women's personal experiences from their own frame of reference; by this I refer to methods such as structured interviews, questionnaires, and the collection of information directly from professionals. When using methods which encourage prescribed categories for the research, which do not allow for the establishing of rapport, empathy and trust and the subsequent sharing of unexpected information, I suspect that the accuracy of the research will be impaired.

From the 1960s, feminists have questioned the representations and theories developed about women. They have challenged patriarchal adherence to singular or universal concepts of truth and the methods used to verify this. Commitments to objectivity, observer neutrality and

unquestioned theoretical values have also been opposed and replaced by more representative knowledge which comes from the position of the oppressed and a wish to understand that oppression (Crowley and Himmelweit 1992; Davison 2000). This has required a rethinking of 'knowledge' and the ways in which this is produced and validated.

For over three decades feminists and anti-feminists have been debating, writing and rewriting what makes research feminist. The politics of feminisms is not a unified intellectual movement; feminist research continues to evolve and develop, and still imposes real challenges for researchers who seek to follow academically respected methods within a morally and politically acceptable philosophy (Reinharz 1992; Stanley and Wise 1993).

Feminist approaches to epistemology, the study of how knowledge is constructed, challenge modernist thought which has constituted women as inferior. Feminist research is openly carried out to enlighten and empower women and to transform the patriarchal structures and social relations which perpetuate the oppression of women. Acknowledging the lived experiences of women , never denying or denigrating the personal, is an inherent part of any feminist study. Ethical considerations, which avoid the exploitation of women as objects of research, or simple providers of research data, are paramount (Eichler 1988; Neil and Watts, 1991).

Research carried out by feminists does not adhere to a specific methodology, although quantitative methods have sometimes been criticised for being too 'masculinist', emphasising the detachment of the researcher, and the collection and measuring of objective, value-free data. In fact, most methods endorsed by feminists were not created by feminism. Methodologies including the use of in depth and unstructured interviews, ethnography, grounded theory, all have non-feminist origins. Even reflexivity, reflecting on the process of doing research and locating oneself within both question and topic, although relatively unusual elsewhere, is not unique to feminists (Kelly 1994).

Undoubtedly, what makes research *feminist* is not the methods used, but the *framework* and *perspectives* within which these methods are located - it is the intent and means by which the research project is carried out which determines its appropriateness as feminist research

(Abbott and Wallace 1990). Indeed, contrary to research theory which may claim the importance of strict adhesion to one specific methodological approach, the value of feminist research lies precisely in the way it is prepared to jump the traditional and to set new boundaries, bridging artificial gaps between theory and method and policy and practice (Sutherland 1986; Stanley and Wise 1993). In this way feminist research is different from previous research on women, even if that research has been undertaken by women. Barbara du Bois (Bowles and Duelli Klein 1983) claimed that the traditional, androcentric research perspective , accepted as the natural order, has rendered women not only unknown, but virtually unknowable. The overt ideological goal of feminist research must therefore be to correct both the invisibility and distortion of female experience, to challenge women's unequal social position, and to construct new knowledge (Maynard 1994).

Although there is no uniform conclusion about a definitive way to carry out feminist research, it is possible to collect a dominant conception of methods or perspectives amongst feminist scholars. In reviewing these principles - beyond the obvious and specific contribution of knowledge to the individual research topic - I have found commonalities within eight major components :-

- Feminist research methods are used by researchers who identify themselves as feminist (Reinharz 1992).

- Feminist research must be for women, and with them, rather than just on them, to help improve the quality of lives; and should be strengthened by the application of relevant feminist theory (Stanley and Wise 1983b; Bowles and Duelli Klein 1983; Kelly, Burton and Regan 1995).

- Research should incorporate a clearly defined, non exploitative relationship between researcher and researched, based on openness, co-operation, respect and empathy. A genuine rather than instrumental rapport between parties is essential (Oakley 1981; McRobbie 1982; Graham 1984a; Finch 1984; Harding 1987; Skeggs 1994).

- Theory, used and generated, as well as having a feminist ideological base, should, where possible, also be grounded and validated by participants (McRobbie 1982; Cummerton 1986; Lather 1991).

- Feminist research will emphasise and value the importance of the researcher within the process, so ensuring that the research is a consciousness-raising experience for the researcher herself, as well as the researched, and the research findings audience (Mies 1983; Stanley and Wise 1993; Alldred 1997).

- Non-exclusive, accessible and non-sexist language, as well as theory, should be used and presented (Eichler 1988; Parr 1998).

- The research will recognise gaps in our knowledge created by researchers who have ignored women's true concerns, or who have viewed them as invalid. Thus a critical framework will be created within which the production of new feminist knowledge will become a real possibility (Shapiro 1981; Cook and Fonow 1990; Ettorre 1997).

- All literature reviewed should be critically assessed for potential sexist elements, to carefully avoid re-making the same mistakes (Eichler 1988).

Definitions of what makes research feminist, of what constitutes distinct methodology or methods, will continue to be vigorously debated (Webb 1993; Stanley and Wise 1993; Griffin 1995; Holloway and Wheeler 1996). Kelly (1988) suggests that it is the questions which feminists ask, grounded in their political beliefs, which make them different researchers. It is these aspects of connecting ideology which will bring commonalities of approach, but not necessarily methodological agreement.

The life history method

I chose to use life histories for data collection after the careful reflection of many relevant

issues. A major consideration was that my literature search did not reveal an in-depth life history approach being used in previously published research on women with drinking problems. This suggests that the methodology should provide new, innovative perspectives on the topic.

Taking account of my knowledge and experiences of past work in the addictions field, I felt that life history work would offer the least exploitative method for obtaining information from women who may sometimes feel ashamed or guilty about their behaviours. Question and answer techniques, however expertly undertaken, could raise new distress and possible misinterpretation for participants who have often been upset in the past by interactions where they felt misunderstood or interrogated, or had learned to give the replies which they felt the questioner might be looking for. Thus life histories are probably more ethically sound, as well as being more likely to reduce distortion.

I also judged that my experiences as a counsellor, a journalist, and someone with a depth of knowledge about the research topic, should allow me to facilitate the life history approach in a skilled way. As this was likely to be a method which I felt comfortable using, I would be able to carry out the research in a confident manner, releasing me from conflicting ethical reservations which would undoubtedly impair my capacity to support women in clear, open and honest way.

A life history is an account of an individual's life, given by the person living it; an attempt to gain an understanding of the person's life told in their own words, in their own way. When used in research studies, as the 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 her or his story. There is debate concerning the precise definition of life history research, but Riessman (1993) states that sequence is necessary, that as a story it should have a beginning, a middle and an end.

The life history method has been identified as being a valuable way of identifying and documenting health patterns amongst individuals and groups, and of understanding the ways in

which attitudes and behaviours are influenced by past events (Hagemaster 1992). Life history research has also been selected as being the most appropriate method when working with disempowered, silenced service users in professions such as social work (Martin 1995) and as the most productive method of collecting untapped sources to develop new theory (Showalter 1985). Another important reason for choosing life history methodology is that people who have experienced severe difficulties may naturally find it hard to speak of them within a structured, more confrontational question and answer situations. Survivors of violence, abuse and oppression are silenced because such accounts are both hard to tell and difficult to listen to. Research has shown that individuals can make more sense of their experiences, however painful, by translating them into narrative form (Riessman 1993). However, despite such qualities, life history research methodology still remains at the margins of mainstream academic research (Plummer 2001).

Research on sensitive topics which seeks to understand the subjective experiences of devalued individuals from invisible, marginalised groups are also ideal studies for feminist interpretative inquiry (Jansen and Davis 1998; Smith and Watson 1998) I am confident, therefore, that my linking of feminist standpoint with life history methodology will have the potential to capture and document the individual meanings and experiences of participants, whilst also observing the important feminist contexts of social and personal power relationships.

However, the limitations, as well as the advantages, of using life histories in research have also been documented. The method is slow and painstaking, requiring that researchers must have the skills to build up rapport, communicate and understand others well, and be able to reach substantive theoretical points through careful comparisons of small samples (Riessman 1993; Plummer 2001). It is clearly not suitable for all studies, nor for all researchers, and like all methodological approaches, life history work offers only partial truths, but when matched with the right research topic, life history work can provide a unique method for the systematic study of personal meaning and experience.

Traditional models of alcoholism advance deterministic views of the aetiology of disease and illness. This medical perspective has been criticised because of its impact on the lives of

women who are stereotyped and pathologised, where there has been little place for the listening of the views, the words and the voices of women. Ussher makes the point powerfully: *'Labelling us mad silences our voices'* (1991:7). However, if women's stories are taken seriously in the research process, their participation and power becomes clearer. Rather than passive subjects, they can become active agents. Through their stories we can hear not only women's oppressions, but also their strategies for resistance. This analysis can highlight endless variety and important similarity - the commonality and diversity among women.

Ethical considerations

The potential damage of research which serves the researcher's purposes rather than also tries to address the needs and aspirations of the researched has been articulated by feminists (Davison 1998). This controversial, 'research as rape' model is explained by Shulamit Reinharz:

' conducted on a rape model, the researchers' take, hit and run. They intrude into their subjects' privacy, disrupt their perceptions, utilise false pretences, manipulate the relationship, and give little or nothing in return.'
(Reinharz, 1983: 80).

Dilemmas about the ethics of research have continued to challenge the many feminists who view anti-oppressive practices as the foundation of all their research work. Stanley and Wise (1983b) describe the standards and procedures which contribute good ethical practice in feminist research. These include the recognition of the reflexivity of the researcher in the research, the acceptance that the researcher is not an intellectually superior being who can construct absolute truths and reality, that research participants should not be purely seen as objects within the research process, and that the quality of the research relationship and mutual trust must be maintained.

Several other feminist scholars have been rigorous in debating and defining how traditional

research methods could be seen as being ethically questionable, by dehumanising individuals by treating them as objects, viewing their experiences merely as research fodder (Filstead 1979; Oakley 1981; Heron 1981; Pease 1990; Mason 1997). Indeed, Daphne Patai (1991) argues persuasively that any wholly ethical social research is not possible, as research is conducted among individuals less powerful than the researcher herself. The dilemma for feminist researchers, Patai feels, is that it is impossible to write about the oppressed without becoming one of the oppressors; that the objectification, the using of others for one's own purposes, is always exploitative. This could be compounded, using Patai's rationale, by researchers who use life history methodology, who reject narrow definitions and engage in collecting lengthy personal narratives which encourage intimacy and incite subjects to speak of things which they would usually only talk of in private, within safe, intimate relationships. Participants who receive undivided attention from another may feel eager to talk, but no research interview can represent a fair exchange. The intimate sharing is very much one way, and the researcher inevitably retreats to her own separate life.

Whether the contribution of research to feminist knowledge can justify using another person for one's own purposes may be arguable. Does feminist research give a voice to those who would otherwise remain silent, or is this supposed empowerment just a means of appropriation? Anne Opie (1992) gives a more encouraging perspective when she highlights some ethically positive dimensions of feminist research, which include the potential for the personal empowerment of research participants. She explains how the socially marginalised may feel that they can at least contribute to the analysis of a social issue; in simple terms, that their opinion is of consequence. Certainly within my research experience, most volunteers said one of their main reasons for taking part was to try and offer some help for other women with drinking problems , through making their own experiences known in the research. Opie (1992) also identifies a built-in therapeutic dimension of research, when participants are able to reflect and re-evaluate their experiences because of the research process. This potential of gaining greater self-awareness and a more positive self image through the process of life history narration has been outlined by others (Riessman 1993: Atkinson 1998).

The potential therapeutic or cathartic experience of life story narration proved to be a

positive aspect of my research. Most volunteers suggested they found the recounting of their life stories had given personal insights and offered them a unique opportunity to see how their life histories may have influenced their behaviours which they had previously viewed as self-inflicted or pathological.

An illustration of this came from one volunteer, Jean, who sent me a letter after she had disclosed sexual abuse in childhood during our life history taping sessions. She had previously tried to talk with family members and professionals, but felt silenced by their disinterest, disbelief or discomfort. She had resolved never to talk of the abuse again, to protect herself from the humiliation of further rejection. This was a common experience:

> *Dear Judy,*
> *It's late and I'm tired out, you said I would probably feel a bit drained and you were right. I wanted to write a small letter to thank you for being with me this morning and being able to listen to it all. It was such a relief to talk at last. I want you to know that. The fear is still here, after all these years, of having told, of betrayal. It's still so painful, will it ever go away. But you have to tell someone before you can stop all the lies and stop blaming ME! Coming to terms with self is very difficult, accepting things I can't change takes courage and I still don't like myself enough to find much strength. But maybe I've made a start now. I have a lot of thinking to do. God bless you and thank you for listening and believing everything I tell you. I can't tell you what that means to me. See you next week.*
> *Jean*

Personal accounts which contain harrowing personal details, do, I believe, need to be acknowledged as being potentially distressing for the researcher – this will also be discussed in the Final Conclusions chapter. Listening to personal accounts, such as Jean's, of serious abuse and violence, both during research interviews and later at tape analyses, required the repeating hearing and relistening of experiences which frequently had a profound effect on me.

Women sometimes telling of their abuse for the first time, often graphically reliving their

physical as well as psychological pain, sometimes regressing into the psyches of vulnerable little girls again, made it very hard for me not to try to ' make them feel better'. I was left with their haunting words and images; how it is to have experienced and somehow survived sexual abuse, and the enormous personal cost that inevitably takes. It was impossible to remain detached from these stories; they filled me with a range of emotions, from anger to acute distress.

Perhaps, because of my previous professional counselling role with victims of child sexual abuse, I had expected to be less affected, less emotionally exhausted. But my current role, as researcher, was very different. As a researcher I explicitly had no counselling role. To listen to stories such as these, without an active part in the guiding of the healing process, was far less comfortable than interactive, supporting counselling . This was hard to come to terms with. Although I always offered details of local incest and domestic violence helplines, for those who wished to access further support surrounding issues which may have been raised during their life history narrations, this often felt to me as offering token gestures of support.

On a personal level, while listening to tapes, transcribing and analysing, memories of my own emerged, experiences in my own life which echoed similar reactions and emotions. These have also been hard to live with and resolve. My fear of the seemingly epidemic proportions of child sexual abuse led me to be more fearful for my young daughter, and indeed all girls and young women. Was there really no safety from the evasiveness of sexual exploitation?

Yet, by hearing and accepting my changing responses to each life history, rather than objectively rejecting my feelings and the place of these in the overall research process, I was able to understand, more critically, the importance of abuse in women's lives. My observations, interpretations and critical analysis have been enriched. In sum, my conscious use of reflexivity has immeasurably enhanced the research process and potential.

Reflexivity in research, incisively explored by feminist writers such as Liz Kelly (1988), Sandra Harding (1991) and Liz Stanley and Sue Wise (1993), is considered to be a core, essential quality within any feminist research. It has also been documented as being an

essential requirement of life history research (Plummer 2001). Reflexivity is a reflective process which ultimately demands feeling, and an ability to gain an understanding of that feeling; a conscious filtering process that separates the subjective from the objective, and enriches the analysis and rigour which is essential for all research to reach its goal. Plummer (2001) believes it requires a greater social and personal self-awareness by the researcher, and a raised consciousness of the whole intellectual and research process. Within the research domain of women's experiences of abuse, the impact and potential of reflexivity entered my lived experience as a researcher, a feminist and a mother. I can now acknowledge reflexivity as the crucial process which has guided me to amplify and celebrate the voices and courage of women who misuse alcohol.

Reflexivity requires mutual, high quality rapport with the research participant, but this is not achieved without certain ethical dangers. A foundress of feminist research methodology, Ann Oakley (1981), was in agreement with many feminist academics who have strongly promoted the principle that feminist researchers must reject the concept of the objective, controlling interviewer, and work towards engaging sympathetically with every research participant. In contrast, Judith Stacey (1988) has usefully highlighted the dangers of feminist researchers unconsciously raising expectations and inducing dependency of our research participants, who often come to value their personal relationships with researchers. This possibility will probably have occurred to most researchers, when we build up relationships with participants who seem lonely and isolated, who suggest that they value and enjoy our visits . Perhaps there can be no easy solutions to the dangers of our research producing false relationships - I use the word false, as I know that had I not been carrying out research, I would not have been calling in at the homes of the women in my research group. But I feel that the alternative strategy, to remain distant and aloof, would have been more exploitative and power-taking. If feminist research is to emphasise a collaborative, respectful and warm relationship between participants and researchers (and I firmly believe it should) then the boundaries of the research relationship need to be openly discussed and clarified at the start of each research encounter, to make clear the expectations, and hopefully make the process of research more ethical and equal.

I consider that a crucial factor here is that, as feminist researchers, we must not delude

ourselves that because our research is feminist that in some miraculous way it will not contain unethical practices. Ethical dilemmas are latent in all research. As researchers we have more privilege than our participants, for we are considered able to study them - the hierarchy of power is cast. Ultimately we must decide whether the research we have chosen is worth doing , that the justification for the work has included a recognition and examination of relevant ethical considerations, and that we are committed to do the research with thoughtfulness and sensitivity towards all those involved . Individual research efforts can then be used to enrich feminist theories, and, in turn, that knowledge may hopefully have the potential to positively affect the lives of those whom we study.

During my research I was reflective of my 'outsider status', that in many ways I was very different from my volunteers. Many of these were from working class roots, some had minimal formal education. I have not experienced drinking problems, and from my middle class, relatively well educated and privileged position, their expectations and assumptions would often be very different from mine. To show respect and honesty to the participants, I felt I should be as open as possible about my own life, especially in explaining my motivations for wanting to research women with drinking problems, and my position of not having had drinking problems personally, but having worked for many years in the addictions field. As I would have expected, all women were concerned to 'place' me in relation to alcohol problems, and there were no negative statements regarding my ability to work with them, even though I had not personally had drinking problems. I admitted that I could not be placed alongside them, but I hoped to be seen by them as someone who was genuinely interested in their experiences and crucially, as someone who was 'on their side'. I tried to establish relationships with them in which they felt they had some power, they had knowledge I needed which they could chose to share with me; this acknowledgement about their superior insider knowledge enhanced rapport, and the confidence of participants.

Practical, yet crucial ethical issues such as confidentiality were raised explicitly at the initial meeting with each participant. Volunteers were told that all identities were protected, both on my records and on the cassette tapes , and that the indexing method and coding would only be

known by me. It was fully explained how I would be extracting certain sections or statements from volunteers tapes and transcribing them verbatim in my thesis, but that pseudonyms would be used for all identification purposes. I also agreed that no one else would have access to the tapes or life stories, but that if, for research purposes, anyone else did request access, that full permission would be sought from the volunteer. I stated that on completion of the research, all tapes would be destroyed, unless I decided to use them in further work, in which case new agreements would be negotiated. The confidentiality and safety of the tapes was of specific importance to many volunteers, which is most understandable, in view of the intimate and explicit details given in the life stories. It was important to reassure that tapes would only be listened to by me, and I did in fact reinforce this issue on subsequent meetings, and I believe any initial fears were allayed.

The Research Group

Geographical limitations

I gathered my research participants from within my immediate locality of Dorset, Somerset, Hampshire and Avon . This imposed restrictions, especially regarding diversity of race/ethnic background within the group, as my location is mainly rural, with a predominantly white population. However, targeting areas for participants which would have involved a lot of travelling would have been very difficult, especially in view of my part time commitment with the research.

Sample gathering

Research volunteers were contacted by five methods:

- Promoting the research in local publications/newspapers
- Contacting suitable agencies for collaboration.

- Informal advertising through postcards in newsagents shops etc.
- Chain referral / snowballing
- Researcher's personal contacts.

1. **Press.** Local papers were targeted and sent a short 'press release' about my research, which requested volunteer participants . I was able to exert some influence in this, as I had already established contacts in most local papers during my previous work as a freelance journalist. Several newspapers - paid for and free - published short pieces (see Appendix 2). Using local press coverage was a successful method of contacting suitable participants as six women who responded agreed to become involved in the research . From this press coverage I also received one reply from a man, who severely criticised my woman centred perspective and asked to meet me. In view of his potentially threatening approach, I declined his invitation, but in a written reply I explained the reasons for the research perspective. The management of hostile enquiries when undertaking feminist research has been discussed by Stanley and Wise (1983a).

2 . **Collaborating agencies.** Contacting local agencies who had contacts with women with alcohol problems proved to be the least fruitful method of reaching volunteers and also the most time consuming for me to organise. My links with relevant agencies were already established because of my social work lecturing work. I knew the 'gatekeepers'- the managers – of local statutory and voluntary agencies who agreed to collaborate with my research by giving permission for fieldworkers to pass a personal letter from me to suitable service users. Following the managers' approval , I felt it would be advisable to talk to as many fieldworkers as possible about my research, to answer questions and generally illicit their support. I attended several team meetings and group events and was able to highlight important themes such as confidentiality, ethics and exploitation. Organising and attending these meetings proved to be time consuming and the resulting number of referral was disappointing. In total only two referrals were made, one of whom decided to withdraw after further discussion with me·

In view of the pressures currently affecting front line workers in welfare agencies, it is understandable that so few referrals were made for my research. On reflection, however, if I had followed up the agency contacts I had made at regular intervals, this may have reminded

workers about the research, but this would have necessitated more organising and time. As I was receiving sufficient volunteers from other methods of contact, this seemed unnecessary. I had additionally been rather concerned that one woman who had been referred by a collaborating agency may have felt under some pressure to see me by the community worker involved. This was quickly resolved in that particular case, but did raise some doubts in my mind about the advisability of involving others to target possible volunteers, subsequently making me less eager to pursue agency collaboration for referrals.

3. **Informal advertising** was carried out by randomly targeting some shops and post offices which offered notice board card display for advertisers. There was no specific rationale for this, other than my wish to extend sample gathering from as wide a potential audience as possible. This method of promoting my research attracted two enquiries from women who joined the sample.

4. **Chain referral** or **snowballing** (Biernacki and Waldorf 1981) was an unplanned method of reaching volunteers, when women who were involved in the research, or who had approached me for more information, spoke to acquaintances whom they felt might be suitable volunteers, and advised them to contact me. Two women joined the sample from this referral method.

5. **Personal contacts** I had with people who knew of my research resulted in several enquiries, and two volunteers joined the sample.

Group composition

The appropriateness of the sample is crucial in qualitative research, for this will 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 the purpose of the research was to gain as wide an overview as possible. The only selection criteria I imposed were that participants should have personally experienced drinking problems during their lives, and that they should have the motivation to engage in life history giving, and be able to make the necessary time commitment to complete this with me.

All research volunteers who participated in the study had self-identified problems with alcohol. Judgement about their research suitability, based on their alcohol consumption, that is the severity of their problem, was not viewed necessary. I have recognised through professional experience that very wide variants exist in the effect the amount of alcohol consumed has on an individual's life. Definitions of whether someone has a drinking problem, based on standards established in physiological research, which judges units of alcohol consumed in terms of physical harm and functioning, may, I believe, deny the social, psychological and political dimensions of when an individual woman feels alcohol is a problem to her. In fact all the women who referred themselves as believing they had drinking problems had a clear history of alcohol misuse within clinical definitions, usually of an extreme and dangerous level.

Within the sample, participants either had a prior history of alcohol problems but were now abstinent, or were still using alcohol under control, in moderation, although the latter group was in the minority. Theories of alcohol dependency which I favour, challenge disease led notions of recovery and cure anyway, and to ascertain that all participants were in total control of their drinking behaviour would have been theoretically debatable, in addition to being ethically questionable. Within the sample most had not drunk to excess, or had been completely abstinent for many years. If I had been aware that any volunteer had recently consumed alcohol, I planned I would continue with the taping on that occasion, to avoid embarrassment, then afterwards disregard that particular taped session, as her story content may have been impaired, and I would have discussed this fully with her. In practice this did not occur. I found all participants were committed to giving their narratives accurately, and they took this commitment seriously. Endorsement of this was evidenced by no meetings being cancelled or non-attended, and by the action of one woman who telephoned me to postpone her planned session as she had unexpectedly drunk alcohol the day before - in response to a sudden personal loss - and wanted to wait until ' her head was clear again'.

The methods used to identify potential research volunteers gathered a varied sample of thirteen women whose ages ranged from 23 to 64 at the time of their first interview. This self-

referred, non-selective method of sampling recruited an enthusiastic and articulate group of volunteers. The group was not homogeneous. Women from different backgrounds and social classes, ages, occupations, sexuality and drinking habits are represented in the sample. Also those who were living alone or with partners/family, those who were single or divorced and those with or without children.

As previously mentioned, no black or ethnic minority women participated. Also none with disabilities were in the sample, although several women did have long term physical ill health or mental health problems. Although permanent residents of south west England at the time of the fieldwork, six were originally from the Midlands and North of England, one was from southern Ireland and one from Northern Ireland. Over half the sample had not received formal treatment or clinical diagnosis relating to their drinking, which offered a valuable and unusual source of data, with information from both the women who had been diagnosed as alcoholics, and those who self identified their problem . This sample mix is in contrast to most previous research which has concentrated on clinical populations. Investigating this 'view from below' (Mies 1983), the group which had been untreated by professionals working in the field of alcohol, raised important areas of focus, such as appropriateness of treatment, labelling, self-labelling and family interaction, which will be discussed later.

All who volunteered were accepted into my sample, consequently the possibility of researcher bias in selecting research candidates was eliminated.

Brief profiles of research participants

All participants are white, British women, currently living in the South West of England'

All names used are pseudonyms.

ALEX, aged 32 , grew up in London, with one older brother, in a middle class family. She was educated locally, then sent to a boarding school. She left school at 17, and, at the time, broke all ties with her family and travelled independently overseas for several years, where she developed drinking problems which continued for 8 years. She returned to further education in the UK in her late 20's and graduated with a BA in Social Studies. She now

lives with her partner in their owned house in a large town in Somerset, and works as a senior manager with a national voluntary agency in social care. She has been abstinent for eight years.

ANNE, 53, was born into a materially privileged family in the Home Counties, where her mother was a titled heiress. She had two younger brothers and was initially educated at home by a governess, before attending boarding school, and then a Finishing School in Europe. In her early 20's she attended art college, and continues to work as a self employed designer and dress maker. She has been married, and divorced, twice, and has three adult children. She is now single and lives alone in a small cottage in a Dorset village. Her drinking problems lasted for around 15 years. She has been abstinent for one year.

CLAIRE, 45, grew up in the Midlands, the only child of working class parents. From school she attended university, graduating with a first in English Literature. Shortly after, she married and had 2 daughters, and worked as a secondary school teacher. While her children were still young she divorced her husband, and moved to live in an 'alternative lifestyle' group in the South East, where her drinking problems, which were to last for 15 years, deteriorated. In her late 30's she moved to a city in the South West to study MA in Sociology. She now works as a part time lecturer and writer, and lives alone in her city flat, nearby her long term partner. She has been abstinent for ten years.

FRANCES, 64, is a retired doctor, now living alone in her comfortable country cottage. She was born in the South East, into a medical family, and has two elder brothers. She attended school and university locally, and then worked in a series of hospitals throughout the UK, where she reached the grade of Junior Registrar. When in her late 30's she married briefly, then divorced, and has since remained single. Her drinking problems lasted for about 20 years, during which times she worked in mainly temporary, hospital based junior posts. She retired from medicine 10 years ago, to move to the west country to immerse herself in her large garden and cottage, from where she also occasionally writes gardening articles. She has been free of drinking problems for ten years and now strictly controls her intake.

JANE, 49, was brought up in a large working class family in town in the Midlands. She left school at 14, to work in a series of shop positions, until she married and had one daughter. Her husband's work took her to a variety of locations, sometimes living alone with her young daughter for long periods. Whenever possible she has chosen to work outside the home, and currently Jane works as a catering assistant. She and her husband moved to Somerset 12 years ago, and live in a local authority house, on a large estate. She experienced drinking problems for 13 years, and has been abstinent for the last three years..

JEAN, 60, was brought up in the Midlands, one of 8 children in a working class family. She left school at 13 and worked in office jobs, until she married . She then helped her

husband run a small garage and haulage business, before he bought a pub, and Jean moved with him and their 3 children to Dorset. Jean ran the pub almost single handed until her divorce, after 28 years of marriage. She later married a second time, but divorced after 5 years. She now lives alone in a local authority flat in a small Dorset village, where she works as her church organist. Jean had drinking problems for about 25 years, and has been abstinent for the last eight years.

JILL, 23, grew up in a working class family, with 3 older brothers, on a smallholding which her parents rented in the West Country. At 12 she was expelled from school, and at 16 sent to a probation hostel in Cornwall, where an early drinking problem deteriorated. Jill then worked irregularly in unskilled jobs, until at 21 she moved to Dorset to begin work for the Forestry Commission and share a rented house in the countryside. She remains in the same house and job, and is single. Her drinking problems lasted for over 7 years, she has been abstinent for three years.

JOAN, 42, was one of 3 children brought up on a small farm in the North. She left school at 14, to work in unskilled agricultural jobs, until she married a man who was in the army. Thereafter she spent 18 years moving around the UK and overseas with her husband, until they moved to their present local authority house in Hampshire. Joan has not worked outside the home since she married, and has 2 grown up sons. She had drinking problems for approximately 12 years, and has been abstinent for three years.

MAGGIE, 48, lived her childhood and teenage with her two brothers in many locations worldwide, as her father served in the army. At 15 she left school and home, found a small rented room and an office job. After she married in her early 20's, she moved to the North East, working as an office manager. She later divorced her husband to bring up her two small children alone. Maggie moved to Dorset fifteen years ago, to train in youthwork, and then briefly remarried. She has more recently found it difficult to gain permanent employment, and is currently unemployed, single, and living alone in a small local authority flat. Maggie's drinking problems lasted for 12 years. She has been problem free for the last six years, now socially drinking occasionally.

MARY, 44 , was born into a large working class family in Belfast, Northern Ireland. Her mother was semi-invalid and died when Mary was nine. She attended school irregularly until she was 14, and shortly after left home to move to a large hospital in South West England, where she worked as a laundry worker for many years. Mary never married and lives with her daughter, a college student, in their local authority house in a Dorset coastal town. She is now employed in domestic cleaning work. Mary had drinking problems for 20 years, and has been abstinent for the last four years.

SUE, 37, grew up in North West England, one of three daughters in a middle class family. After attending local grammar school she went on to university, and later qualified as a

Clinical Psychologist, the occupation in which she is still employed for a regional health trust. Sue married while still at university and had 2 children, before divorcing her husband 10 years ago, and moving to live with her children in a small Dorset town, near her current partner. She experienced drinking problems for 6 years, and has been problem free for the last five years, occasionally drinking socially.

VIOLET, 50, was raised in a middle class family, with two brothers, in a small country town in Southern Ireland. On leaving school, Violet qualified as a nurse in Ireland, then left to work in nursing posts overseas, mostly in the middle east, for many years. She returned to live permanently in the UK when she was in her 30's, where she worked irregularly in hospitals in London. Violet moved to Dorset ten years ago, to live with her partner in their townhouse. She has never married and now works in a nursing home. Violet had drinking problems for 25 years., and has been abstinent for nine years.

WENDY, 47, grew up in a large Midlands' city, the third daughter of working class parents. She left school at 14, to be employed in shop work, until she married and moved south with her husband and young son. She rented, and worked alone, in a busy post office and shop in a Dorset town for 10 years. She still lives with her husband, who regularly works away from home, in a rented street house. Wendy has not worked outside the home for many years. Her drinking problem lasted over 15 years and she has been abstinent for four years.

Group size

The final sample size of thirteen was decided on during fieldwork, in consultation with my supervisors. Although a saturation point (when no additional data is being revealed to add to categories being developed) is less definitive in life history work than with methods which are using constant comparisons, data was showing redundancy of developing themes around life histories 10 and 11, although I continued to collect a total of 13 life histories, as I had already negotiated with these women to include them in my research. The final number of life stories supplied an abundance of information.

The process of voluntary participation

On receiving an enquiry about my research from a potential volunteer, or a referral from a collaborating agency, I sent a brief letter of explanation about my research, which I followed up a few days later by personal telephone contact, when arrangements were made to meet the prospective research volunteer. At this first meeting further details about my research were discussed, and it was stressed that participation in the research was voluntary and that any participant could choose to withdraw from the project at any stage and, if so, her tapes would be destroyed. It was also pointed out that no information would be collected from volunteers until each felt comfortable about narrating her story.

Sample diversity

A contentious debate within feminist research, which I would suggest to some extent links sampling methods with ethical considerations, concerns diversity. Susan Geiger (1986) stated that oral histories can only fulfil their full potential when they attempt to study the greatest possible diversity between women. In fact, 'women' as an all-inclusive social category has been strongly resisted by feminist perspectives which view differences among women as pivotal to feminist analysis. Race, class, ethnicity, age, sexual orientation and health, as well as infinite individual differences, make 'women' a category which contains countless groups and subgroups of individuals whose experiences and interests have a multitude of contexts. These important concerns require critical challenge of the essentialist label 'women'. However, I also believe it is prudent to avoid unproductive fragmentation within a research study. Questions such as how we can ever judge any research sample to be truly diverse, and whether we can expect women from subgroups to speak for others as well as themselves, are, I contend, very important issues. Perhaps it is realistic to suggest that the feminist standard of maximum diversity may be desirable, but logically and practically impossible, especially within small sample research.

It is clear that all the participants in my study were very different, but they also had many shared experiences and views. I have tried to understand and respect diversity in my small sample, but feel it is equally important not to lose sight of those common experiences and

opinions which can help name, and challenge, the ways in which a marginalised group of women with drinking problems are treated and viewed.

Data Collection : Creating The Right Setting

'Taking time to know another means more than a preliminary interview; it entails meeting for an extended session or more ... the meeting is an opportunity to promote congeniality and to engage in mutual self-disclosure. For feminist researchers, questions flow both ways. Narrators have the opportunity to interrogate interviewers about the research project and about the interviewer herself'. (Kristina Minister , 1991 : 36).

Minister's views endorse what I experienced from initial sessions with volunteers - that the careful construction of early interviews is a fundamental part of the research process. Time taken to get to know a volunteer, to establish rapport, trust and mutual respect before engaging in the more formal task of information gathering is an essential process for both the researcher and the researched.

For me, as a researcher, it offered me time to get to know each volunteer - to see her home environment, to gain access to the preparatory information she chose to disclose, which would often be important when later engaging in the life story collection, and also gave useful insights for field notes records. This introductory time also appeared to help volunteers become comfortable and more empowered to feel some control of the research process.

It also significantly offered the opportunity to establish some connections grounded in mutual life experiences and gender, which can be a powerful , essential dynamic within feminist research. This goes far beyond acquaintance rapport, and may encourage a participant to talk more freely and honestly within the comparative safety of possible gender-illuminated understandings. During my past experiences of working with women, I learned that they want, and need, to know certain personal information about the person to whom they are about to disclose personal information. This information sharing gives a context to the similarities and

differences which two women will have, it establishes boundaries and frameworks for the relationship, and seems essential to the establishing of non-oppressive research practice. It may be one of the most influential aspects of effective relationship building, and I suggest may explain why so many volunteers in my research felt able to disclose issues which they had not previously talked of, despite many having had experience of long-term relationships with female and male professionals such as psychiatrists, social workers and community nurses. In simple terms, I feel it is presumptuous for any researcher to ask for intimate personal information from someone without offering at least a little of herself first.

In context, the information which many women asked of me was far from intrusive, but it did sometimes take time before they felt confident enough to pose questions such as: was I married, did I have children, did I have a drinking problem, was I being paid to do the research, what exactly was I getting out of the project. The answering of these kind of questions undoubtedly gave a grounding to our relationship, volunteers could see me as an individual and it gave a more respectful, two-way basis to our personal knowledge.

This important period, when relationships were grounded, obviously needed to be time-limited. To continue for too long within an informal schedule would have set false expectations and made the transition to formal information gathering difficult. The time to move from the informal to the formal was different for each volunteer. Some needed more time to seem fully relaxed, others appeared to quickly build an empathic understanding of the context of our relationship after one preliminary session. The majority had two or three meetings before taping started. As relationships developed over the sessions, some referred back to how our initial contact had affected them, and how the prospect of the research had caused anxiety. These extracts from tapes, underpin the importance of creating the right setting:

> *"I was so nervous about meeting you ... I was awake half the night before you first came. I felt like I'd have to make a good impression, or get it all right or something!"*
> (Mary)

" I was getting really scared about what I'd let myself in for, to tell you the truth. I decided I would give you a cup of tea, then say I'd changed my mind. It was different once we started to talk, but if you'd been pushy or anything, I couldn't have done all this."
(Jane)

Interview environment

During my first contact with volunteers, by telephone or letter, the venue for future interviews was mutually agreed. All requested that I see them in their own homes. Carrying out interviews in the volunteer's own home proved useful on several levels. The volunteer would be likely to feel more comfortable in her own setting. Within her own environment she was more able to take the initiative over preliminary conversation, as she might when inviting any unfamiliar person into her home. Being on home territory at least gave her one advantage over me, which may have aided power-balance. Additionally, home based meetings offered minimal inconvenience for the volunteer in terms of travelling, possible child care etc. Being inside the home environment gave me an insightful perspective of the volunteer's surroundings, home and neighbourhood. This was often used by participants during life story narration :

" Look around the place, this is all I have left."
(Maggie)

" I always try and keep the place clean and tidy, you can see that."
(Wendy)

" Just come and look at the state of the kitchen, he's a do-it yourself fanatic the house has been like a building site for three years- it just drives me mad."
(Jane)

Interview length

The informal sessions, before taping began, usually lasted around one hour each. During these sessions volunteers were discouraged from entering into detailed descriptions about their drinking history, or major life events, as I felt this may have affected their subsequent life story giving. When taping began, sessions generally lasted for around one and a half hours each, which I judged to be the maximum time to facilitate clear concentration spans for both volunteers and myself.

The number of sessions needed to record life histories varied. One volunteer spoke for only about four hours, another for over ten, the average being around eight hours. Time was also taken at the start and end of each session (not taped) to exchange news, or take a leisurely cup of coffee, and this encouraged the continuation of the rapport established during initial sessions.

According to life history research methodology, the length of all my life stories defines them as being of potentially the richest variety, as they are Long Life Stories (Plummer 2001:19). Those categorised as being Short Life Stories are much more common in research work, each lasting up to about 3 hours, but are considered altogether more truncated versions of the Long Life Story (Plummer 2001: 24).

The narration and recording of life stories

During my initial discussions with volunteers about life history work, I became aware that some women were having concerns about how to construct their life narratives. This provided a useful lesson for me, for I had failed to consider the cultural and educational differences between myself and some of the women in the sample. I had simply assumed that they would have knowledge about what telling a life story might mean. In response, I compiled a simple

account, or list, of the possible areas each volunteer may wish to include when telling her life story (see Appendix 1). Some volunteers did ask to see this list of suggestions, and said they had found the sheet useful to read before taping. Fortunately, no one chose to refer to, or follow, the guidance sheet during narration, as I suspect this may have been restricting, and have negatively affected the basis of life history work, which must be to encourage subjects to speak within their own frame of reference. For my own part, I did not use this pro-forma guide when working with participants during lifehistory sessions. To support participants to tell their stories in their own ways, I chose to only offer minimal prompting when necessary, and did not impose structural development. However, drawing on the experience of my research, I would recommend offering a clear life history format to participants of narrative studies, as a useful confidence-giving strategy to read before lifehistory recording begins, although I have not found reference to such practice within research methodology texts.

Audio taping is generally considered to be the most appropriate method of recording long narratives, and I chose this method for my study. I decided that note taking would be unreliable, in view of the vast amount of information to be collected, and would also inhibit spontaneous interaction and my observation of non-verbal behaviour. I additionally felt that note taking may give rise to volunteers feeling interrogated, and not in control of the information which was being recorded. As the aim of the project was to truly record and listen to women's words, and the feelings connected with those words, note taking would also have reduced accuracy in my analysis.

I explained to each volunteer why I preferred to tape their stories, and each agreed to this method. Many stated initially that they felt rather embarrassed at the prospect of being recorded, but invariably they soon forgot the tape recorder was running, and did not appear inhibited, as one remarked: ' it's much better to have it all done properly'. A small tape recorder with lapel microphone was used, which eliminated the need for attention to sound levels, and also allowed some mobility for the volunteer. This method produced audible, generally high quality recordings which afforded clear tapes to later transcribe.

There is no standard set of procedures for carrying out life history studies (Riessman 1993;

Atkinson 1998; Plummer 2001) but it is imperative that narrators are helped to tell their stories as fully as possible. The role of the researcher here is not of questioner, but of facilitator. Many participants spent time between each session reflecting and planning, sometimes writing themselves notes, and the thematically developed, coherently sequenced life stories I gathered clearly indicated that much prior thought and organisation had been given by participants.

All began their life stories from childhood, and worked through to the present day. At the end of each life history I invited the narrator to reflect on her story, and to talk of any issues or events which she felt may have contributed to her drinking problem. During narration I spoke as little as possible, as I wanted to avoid influencing or directing content. My counselling training certainly contributed to my ability to non- directively probe, and use non verbal interaction and encouragement; this was especially significant during the frequent recounting of distressing incidents for participants.

The use of open questioning helped the volunteer to focus and also to express feelings, not just facts, which added significantly to the richness of the data, as exemplified in this extract from a transcript:

Maggie: He told us what to do ... always ... ordered me around - oh, you know... it's hard to explain *(shrugs shoulders, searching for words*)

Me: ... and how did you feel about that, or behave, you know, when you were so young?

Maggie: Oh, so frustrated ... and frightened . Very frightened actually... made me feel quite afraid of what could happen to me, you know? I just was so dominated by him then ... it's hard ... *(long pause)*

Me: What's the hardest?

Maggie: *(laughs)* ...sorting it out in my head ... it's a long time ago, but the Memories still can feel horrible ... you know, hard to explain ...

Me: Yes ... but now ... well, how do you feel about it all now you're no longer a child in it?

Maggie: Now? .... well, I still feel frustrated, yes ... but more mad as well now, because I can look back and see that I was only a kid! The way I was manipulated, the way he manipulated me ... Like when once he ... *(speaking more confidently, continues to give vivid example of abuse*)

Field notes

I made personal notes throughout fieldwork, which served as a confidential recording of information, perceptions and images which I felt would be important to remember during tape analysis. Observations such as whether I felt relaxed and comfortable, whether I had been rushed to keep the appointment, whether there had been periods during taping when I had felt preoccupied, distant or distressed. I also recorded my feelings about how I felt the session had gone, such as it being unexpectedly slower or longer or more detailed than I had planned. Information about the volunteer was also noted; if she had been unwell, had disclosed new problems , and her general affect on the day.

After every session I tried to complete field notes as quickly as possible, whilst my impressions were still fresh. The taking of field notes have been referred to as being essential when taking life histories, with emphasis being placed on these being written as soon as possible after interviewing (Bodgon and Taylor 1984; Emerson et al. 1995).

At the later stages of interpretation, field notes were useful to refer to; they reminded me of a wide range of important perspectives which I would have inevitably forgotten. However, no less valuable, was that writing field notes also proved to be a helpful personal activity in my

coming to terms with some of the distress I felt during some of the life stories. This experience suggests that regular field note writing may be one of the most positive processes a researcher can utilise when working with harrowing or distressing material (Davison 1998).

Analysis And Interpretation Of Life Stories

Although analysis proceeds in a more rigorous stage during the final analysis of data, this should not be viewed as a discrete phase, separate from the rest of the research process; for interpretation has naturally begun when we meet our participants, during their interviews, or when we guide participants to focus on particular issues (Ribbens and Edwards 1998).

The analysis and interpretation of life history work is always slow and painstaking (Atkinson 2001). Attention to what is said, as well as what is not said, or is implied, requires much time and analytical skill (Riessman 1993) My collection of 13 life stories, a comparatively high number for a life history study, did pose problems of both material and time management, but generally proved to give distinct analytical advantage. Thirteen stories allowed for significant inclusion and interpretation for theory development. The comparison of these detailed narratives allowed me to make linguistic and thematic connections, and to make it easier for me to assess how individual meaning and experience can often be echoed across many stories. These meanings represented the connecting themes from all participants, and provided well grounded, core or representative views.

Methods of analysing qualitative research are well represented in research texts in general terms, but little has been specifically written on analysing life histories (Atkinson 1998). This may be because life histories pose a dual challenge for analysis, owing to the very large amount of unstructured information which is collected, as well as the difficulties inherent in respecting and validating individual as well as collective experiences. Jones (1985) also suggests that the analysis of depth interviews is a highly personal activity, involving processes of interpretation and creativity which may be threatening to make explicit, with no definitive rules to be

followed which will ensure identical, replicable conclusions about a set of data.

A narrated life history represents a sequence of interrelated themes which form a dense network of cross references and this complex form and structure needs to be developed into a thematically ordered context (Rosenthal 1993; Plummer 2001). This analysis of life history does not subscribe to the kind of ongoing analysis of data, advocated for use in Grounded Theory (Glaser and Strauss 1967) . Grounded Theorists test and develop concepts and theories through successive interviews, with data collection and analysis proceeding in parallel.

In life history work each narrative is valuable because of its individuality, and initially each history needs to be analysed in isolation from other data. In a deliberate attempt to diminish the risk of analysing dominant themes during fieldwork, which could have affected my interaction with subsequent participants, I decided to leave data analysis until completion of fieldwork. I was, of course, aware of broad categories emerging during my collection of life histories, but it was only during the final in-depth analysis that consistent themes could be presumed.

Each life history I collected contained a significant amount of unstructured information. Jones (1985) states that the transcribing of all tapes from long interviews is unnecessary. She suggests that using tapes alone for the analysis process is often sufficient, her preference being to code data directly from tapes. I was initially attracted to this method of not transcribing all tapes, for it would have saved much time. However, I soon assessed that every narrative would need to be transcribed in full and verbatim, to allow me easier access to the vast amount of data I had collected, and to importantly uphold the contention of Riessman (1993) that analysis should always privilege each teller's experience in detail.

Transcription is itself an important interpretative process. The way we move words from tape to paper, the way in which we define a voice will be affected by our social, cultural and ideological positioning. Meaning, as Mishler (1991) has stated, is constituted in different ways, with alternative transcriptions often originating from the same extract of tape. Narrators tell their stories in different styles. Not only do they use words, but also pauses, silences, pitch,

emphasis and repetition to indicate what is important, and emotions are strongly constructed in these ways. Transcriptions which ignore these important aspects within life stories risk missing important information and can also misinterpret the taped text (Kleinmann and Copp 1993)

The method I used for transcribing was consistent across my sample. First I listened to the full taped narrative once or twice, making myself informal notes and referring back to any relevant field notes. This very concentrated listening helped me to re-live and recall the telling in detail; it helped to bridge the gap spent between interviews and analysis. If I had not spent this time regaining most of the important essence and value of each relationship, I feel I would have lost much of the value of in-depth, qualitative work.

When I was satisfied that I had gained maximum insight from re-listening to the tape, I transcribed words verbatim and also included as much non-verbal content as possible, to preserve the fullest meaning. Features of conversation I included were short pauses (-); more significant silences (...). Behaviours, feelings and gestures interpreted from the tapes, or recalled during initial listening, were also noted in parenthesis. I found this retained much content of the narrative, these notes and commentary giving much fuller interpretative potential, as evidenced :

> *(long sigh)* - so what can I do? ... oh dear , oh dear ... do I give in? *(distress)* ... do I just give in to it all? (*raised voice*) I feel so – well - well, hopeless really ... Look -(*points to letter on shelf*) .... that's all I ever got back from them - one lousy letter - *(quiet, head in hands*) ... is this all I'm worth? (*statement rather than question)*
> (Jane)

This example from Jane's transcripted life story illustrates how important the notation of non-verbal description, structure, sounds and silences can be to the full understanding of a written section of narrative. Transcribing such detail demanded much time, but also contributed greatly to my emerging interpretations.

Within life history research tradition, I chose to analyse each life history individually (Atkinson 1998). This ensured that each participants' voice was equally privileged within initial stages of my analysis, and also offered a rigorous approach to thematic induction. Categories and concepts were generated directly from every transcript before I attempted to collect comparisons from across my whole research group. As the purpose of my research was to uncover understandings and common features in the lives of the women in the sample, thematic coherence (the important and repeated chunks of texts about particular themes) needed to be established (Riessman 1993). For this I used **Thematic Analysis**, sometimes referred to as Thematic Content Analysis (Burnard 1991). This process has gained widespread recognition in qualitative analysis, and although its potential for analysing life histories has been noted (Winter 1992) little has been written about its detailed practice and techniques (Aronson 1994; Boyatzis 1998). Thematic Analysis codes qualitative information into a list of themes, or a model of indicators from the data, which are constructed through interpretation from within the frame of the individual story teller, to be compared with other stories which have been similarly studied (Rosenthal 1993).

A theme is generated from the text at a manifest level (directly observable in the data) or at a latent level (underlying, or only being implied in the text). This requires the thematic analyst to be able to identify patterns and consistencies in often seemingly random information, and to have the skills to give them relevant meaning and then be able to cluster perceived patterns to higher levels of abstraction (Strauss and Corbin 1990; Martin 1995). Researchers who can use thematic analysis most effectively have been described by Boyatzis (1998) as having the natural and intuitive ability to link and sense patterns, to be able to process both unprocessed and latent information, and to have insights about what to interpret, which can be strongly aided by a grounding or knowledge in the field of inquiry, as is my case with drinking problems.

Boyatzis (1998) summarised the stages necessary for developing thematic analysis:

- developing appropriate codes
- sensing and recognising themes

• doing this with consistency and reliability
• interpreting the themes within the context of a theory or conceptual framework

Thematic analysis is therefore used to develop, then to reduce, raw material into manageable sizes. Codes or categories are selected which summarise or categorise pieces of information in each life history, but as more codes emerge these can also become ambiguous, so these can be extended, re-coded and defined, to assist clarification and interpretation. For example, my analysis of the code word 'childhood' (to signify narrators' references to this life stage), needed to be broken down to represent new, additional codes, such as 'abuse in childhood', 'education', 'parental relationships' etc. This process of coding and subcoding of data was carefully carried out. Selected sentences, paragraphs and words were noted, the key passages in text highlighted, and explanatory notes made in broad page margins. I photocopied all transcripts three times for additional clarity, as selected data often needed to be included in more than one category during the initial sorting . This example from a life history demonstrates the effect:

> ' I *didn't do too well at school.* You see ... I was off a lot with *chest infections and asthma*, that sort of thing. On top of that, I always had so much work to get done at home ... *Mum and Dad said there was no real point in getting an education,* and they liked me staying at home to help out, me being the girl in the family.'
> (Joan).

The above paragraph, concerning childhood experiences, contained data to be identified within the subcodes which I had labelled *Education, Childhood Illness,* and *Parental Attitudes.* When the sorting of data into such provisional subcodes has been completed, these are known as 'clusters', and they can then be developed by collapsing into more major codes. Within these criteria, again using the above transcript example, the two selections initially sorted into the subcodes labelled *Education* and *Parental Attitudes* could be collapsed into the overarching category of *Parental Attitudes.* This emerging code *Parental Attitudes* would include analysis of data within the context of negative messages about education, thus subcodes were merged, but content for analysis was not lost. Major codes were later themselves clustered to contribute

towards themes. Again using the above case for illustration, the code *Parental Attitudes* eventually added to other codes which contributed towards the development of the theme *Other Childhood Memories*, which is a chapter in my thesis.

By the careful comparing and contrasting of data sorted from all life histories the development of significant and connected grounded themes was achieved. I found thematic analysis was a systematic and reliable method of coding, verifying and shifting data, to reduce a huge amount of material into manageable themes. From the beginning of analysis, when hundreds of codes covered my transcripts, the painstaking process of thematic analysis reduced my dominant themes to a core representation.

Identifying and ordering themes and participants' representative quotations

Allowing women's silenced voices to be heard was a core aim of my research and my thesis needed to give a platform for authentic accounts from participants' stories. I remained somewhat apprehensive that the isolated words and sentences which I would select to quote in my thesis may not fully represent the passionate and inspirational accounts shared with me. During analysis of data the significance of my own reflective and reflexive abilities was very important. The breadth of my understanding of emphasis and delivery on tape, and in written transcripts, was heightened immeasurably by the quality of my relationships with participants. I acknowledge that my perception and analysis benefitted greatly from the rapport I had established with the individual women in my research group.

Selecting the most representative passages from narratives, analysing and ordering themes, developing rigorous theory, would require my skill and experience - but would also be affected by my subjectivity. Personal subjectivity of researchers, their hunches, intuition, views of their work, will always have impact on their life history analysis (Merriam 1988). Yet claims-making about absolute 'truths' in any life history research , the ability of any researcher to stand aside from all subjectivity, is limited and partial (see section 3.8) and

this was important for me to acknowledge. For it helped me to focus more clearly on selecting a combination of processes for carrying out analysis, and by consistently using several inter-connnecting approaches to analyse my data, I feel subjectivity, bias or misrepresentation was effectively reduced.

The task of successfully organising the vast amount of disordered material across my collected life histories into logical, sequential and coherant themes was exacting and very challenging. I developed and refined my process for identifying the dominant themes (the final selection of themed chapters), by analysis of the complex and unique wealth of oral, linguistic and written research material available when using life histories. Within that framework I was able to draw on my own analytical capabilities, and also on the important insights of many of my participants. The generation of final themes and quotations used for illustration were influenced by rigorous analysis using the following :-

- using thematic analysis (see page 82) to identify the topics or life themes most often shared across the thirteen transcribed life histories (data analysed from written transcipts)
- identifying shared and dominant themes which were spoken of with most passion, content and importance across life histories (thematically analysed from transcripts and also by directly studying audio tapes, where I found the true essence of meaning could often best be heard – see page 81)
- respecting participants' own personal self-reflections and views concerning what they identified as being the most influential experiences in their lives, spoken about both during their life history giving, and during the invitation I gave each participant to make concluding comments – see pages 88-90 (analysed from transcripts and tapes, with some views also received in note or letter form from participants).
- referring to my personal fieldnotes (see page 78-79) as an aide-memoire, to enhance my analysis of all of above.

As all participants' verbatim quotes included in the thesis were also selected by using this amalgamation of these analytic opportunities, they are offered as representative comments.

There is no one, definitive way to process data and represent different voices in life history work. It is a highly personal task which draws on many resources. In my case, I contend that it was the dynamic incorporation of several processes, skills and methods which gave me the practice structure to best represent the themes, conceptual categories and words of my participants.

The themes represented in the developing chapters in my thesis were ordered to follow participants' stories through their life stages, so making representation sequential, although the actual order of telling in each life story did not always follow chronological development. I felt this would be the clearest way of presenting the data in thesis, within an analysis which reflects the significance of developing life experiences, and the interconnectedness of biographical events. So plot lines were compared across the series of first person accounts to produce representative or important contexts and these emerging themes were then pieced together to form a comprehensive view of the collective chronological experience (Aronson 1994). The themes presented in my thesis therefore begin with childhood experiences, and then sequentially develop the most significant and common experiences through the life-span, until present day. The final chapters consider important shared and analysed themes concerning participants' alcohol-related experiences, their capacity for 'self-recovery' from alcohol problems and their personal strategies for remaining problem-free.

Presenting the data in thesis

Consistent with some researchers who have used the life history method, I chose to represent my participants' life stories in the main text of my thesis by using a selection of quotes direct from their transcripts, with my own additional interpretative commentary and illustrative summaries linking different elements together and underpinning analysis (Bertaux and Kohli 1984). These quotes were therefore used to directly develop chapters around representative,

key substantive themes. This method of writing up life story material has been termed a 'systematic thematic analysis' : '*the point where subjects are allowed to speak for themselves, but where their voices are organised around themes'.* (Plummer 2001: 180).

Issues Surrounding Validity, Objectivity And Bias

The reliability and validity of data in any research study must be carefully evaluated. Wiseman's early standards for judging the validity of information collected using the life history method remains well respected (Wiseman 1974). These principles are: to assume that no one is lying; to accept the word of the individual even if it differs from official information; to believe that everything makes sense from the subjects perspective; to assume that decisions are rational even if they seem initially illogical to the researcher; to accept that all information may be relevant to the study and, crucially, to acknowledge that there is no such thing as an absolute truth. This last principle of validation, concerning absolute truth is an essential aspect of life history methodology, when the participant's version of truth is by definition subjective, self orientated and not researcher defined.

It is also accepted that a personally narrated life history cannot be read as an exact record of what has happened (Riessman 1993; Parr 1998) and that researcher's subsequent reading of that narrative will also be located in personal discourse - mine being radical feminist. Such issues concerning subjectivity and reliability of feminist research are, according to Geiger (1986) familiar ones, where both the subjectivity of the narrator and the interests and motives of the researcher may be questioned. Notions about objectivity, however, can be viewed as androcentric when true 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 makes possible the formation and evaluation of theories directly relating to women's experiences and oppressions. Similarly, traditional notions of reliability do not apply to life history study (Michler 1991; Atkinson 1998), but Riessman (1993) suggests that plausibility (whether

the story is both convincing and reasonable) and coherency (themes reoccurring across the sample) can offer validation of reliability. Both plausibility and coherency were repeatedly demonstrated in my collected life stories.

I feel that just as researchers interpret data, so the narrator has usually analysed her situation before speaking of it. Total reality and validity are impossible, when, as human beings, we all inscribe into our stories our own interests and personal truths. Meanings also come, I contend, from the very subjective and individual nature of each research relationship. Certainly some life stories affected me more than others. This was because of the content (the words and description) but also the way the story was constructed (the emotional, sometimes non verbal content) which was more powerful when I felt close to the narrator.

In the thesis only brief excerpts from narrations can be included. I have tried to privilege these narrators' true experiences, but am aware that my own interpretations will have impacted upon my choice of these selections. This involves issues of power which must be pivotal when assessing possible bias and personal value stances which influence deduction. As the researcher I hold the power of representation, and in that position I edit and reshape narrative (Behar 1993; Edwards and Ribbens 1998). This element of power and possible distortion in research needs, I believe, to be acknowledged. How truly researchers let voices speak will be reflected in the quality of our analysis and self awareness, whether or not we work from feminist perspectives.

Several feminist scholars have suggested that we involve participants in data analysis, so that it is collaborative and negotiated (Lather 1991; Reinharz 1992) but I feel this is not without difficulties. Not all participants may wish to be involved in such a way, and there is a risk that researcher and participant may strongly disagree in their interpretations (Thompson 1992; Riessman 1993), and that this could lead to participants belatedly refusing permission for a researcher to use their stories (Liebow 1993). It is also very relevant that when theorising across a number of life narratives, as is the case in my study, that it is not easy for an individual narrator to draw collective interpretations, especially when these may not represent her individual experience. Collaborating with participants when analysing across a sample may not

only raise dilemmas when interpretations were not shared, but could also represent a real threat to personal views and coping strategies. We cannot assume common perspectives or political viewpoints with our participants, just as inequality of educational opportunities may pose a distinct form of difference. However, I did feel it would be most valuable to encourage participants to share with me any personal observations they might be developing about the significance of their own life experiences and their drinking experiences. During fieldwork I encouraged participants to talk of their interpretations as they told their stories. When life history narration was completed I also gave each the opportunity to reflect back on their lives and offer observations and conclusions. These insights from participants gave me very useful additional data for analysis and also think provided an important way of helping them to understand the severe constraints within which many were forced to make life choices. However, it was not feasible to discuss a more general analysis of the sample with individual participants as I believed they did not have sufficient access to all the data I had available to me, much of which was confidential.

In the final analysis, I agree with Riessman (1993) and Plummer (2001) when who stresses that our 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. I support those feminist viewpoints which contend that that researchers need to become involved with, and concerned about, the people they study - and that having a strong opinion about the subject of research does not mean that research outcomes need be more biased than if these opinions were not held. Perhaps the key issue may concern the importance of the researcher to recognise her own bias, and judge how this could affect the study, both positively and negatively (Holland and Ramazanoglu 1994). Certainly methods need to be rigorous and accountable in all research, but a commitment to politics of feminisms should not mean that the research will be biased. Indeed, perhaps the openness of a researcher to state her ideological stance, to lay herself open to possible criticism because of this, may indicate that she is also more likely to be prepared to face the challenge of having to defend her objectivity, and consequently be more rigorous in her method and self-critique.

Writing up

Dilemmas may occur at most stages of the research process for feminists, and these are perhaps most difficult to resolve when they concern our challenge of established bodies of knowledge, theory and methodologies, and speculate how these may be judged or accepted. There are particular dilemmas about acceptability when we are being assessed by others, such as PhD examiners (Ribbens and Edwards 1998). By accepting traditional academic conventions we can gain credibility, but may also risk losing important feminist ideals such as reprocicity and accessibility (Parr 1998). These dilemmas may be especially challenging during both the writing up of research and the eventual choices to be made concerning the publishing of research findings. With this in mind, I intend to strive to publish not only in academic journals, but also in literature more accessible to a wider audience, such as 'mainstream' women's journals and magazines.

It has been suggested that academic language and writing serve a powerful purpose - to exclude others from taking part in academic discourse (Madoc-Jones and Coates 1996). It has also been said that for research to be feminist it must not only adopt non-sexist language, but should also be presented in a non-exclusive and understandable way (Eichler 1988). Bell hooks (1994) argues that academic language reproduces the white, male, middle class intellectual hierarchy, where any respected theoretical work must be abstract, difficult to read and include obscure references. This way, only certain discourses are heard and rarely challenged outside of academia. Although she concedes that feminist research questions many dominant research assumptions, hooks criticises it for reproducing hierarchies of knowledge when it uses complicated, male-stream, academic language.

I agree with such criticism. If a role of feminist writers is to challenge the conventions which marginalise less powerful groups, the way we share our research insights must demonstrate commitment to non-elitist language and we should strive to write in a way which demystifies research and academia. Admittedly, compromise is necessary for the writing of research which is to be examined. Academic rigour is essential, but I have endeavoured to write in a manner which can also hopefully be understood outside of the

immediate academic body.

Chapter Four

The Impact Of Childhood Sexual Abuse: *The Child Alone*

Experiences of sexual abuse in childhood represented a powerful and influential opening theme for my research. This emerging picture, which was collectively drawn from participants' life histories, presented strong links between a history of childhood sexual abuse with alcohol misuse later in life. Whilst respecting this association in the stories of my research participants, it is also important to recognise that other women who have had similar experiences in childhood may be guided to use alternative coping mechanisms. This will be discussed in Final Discussion and Conclusions chapter, section 11.2, at the end of the thesis.

This chapter, as in subsequent chapters, will develop as a set of sub-themes which have emerged from participants' life stories. For this chapter concerning experiences of child sexual abuse, these sub-themes have been developed in the causal chain : minimising or repressing memories; self blame; secrecy; fear; hopelessness and loneliness. All participant quotations which are included have been taken directly from the life history transcripts to reflect some of the short and long-term impacts of child sexual abuse on these women's views of themselves and others, and how these may have affected their subsequent alcohol misuse as adults. A section is also included on participants' personal reflections of connections between their childhood sexual abuse and their later alcohol problems.

Minimising

> **It happened ... so you have to forget, carry on ... get on with your life as well as you can ... and I could always reassure myself that it could have been much worse.**
> **(Frances)**

Although several participants were able to relate the extreme trauma and long term effects of being sexually abused as children, many also minimised the seriousness of these experiences, and the effects this may have had on them, especially at the time of the abuse. They often compared their own experience of abuse to that which they imagined others had endured, and, by suggesting a set of hierarchies of damage, the significance of their own abuse was theorised and distanced. Frances' statement, above, like many others, shows how she tried to reassure herself that her abuse could have been worse. Yet as Frances made this statement during her life story narration, there were strong non-verbal suggestions that she felt neither reassured, nor had been able to forget and carry on. Similar under-statements have been recorded in research with other groups of women who have suffered physical, sexual or psychological violence (Kelly and Radford 1996). In fact, denying and minimising have been strongly associated with both alcoholics concerning the seriousness of their drinking problems, and with adult victims of child sexual abuse surrounding their abuse (Bass and Davis 1988).

Sue had been sexually assaulted in a frightening attack by a stranger, when she was seven. In her life history narration she initially minimised the kind of abuse she suffered, and the effects of that abuse, attempting to rationalise that her abuse was not so very damaging. Through comparing her own experiences with those she perceived as being 'worse', or by minimising the severity of her own experiences, it was possible for her to reduce or try to

deny the reality of distress:

> **But you know, when I hear of what has happened to some children, I think, well, it could have been much worse. I mean, I wasn't killed or anything. So I've tried my best to put it behind me so I can get on with living ... maybe I've made that a habit ... what I'm trying to say is that you can get used to not facing up to so many bad things, and I'm not sure that's always a good thing in the long run. You get filled with unexploded bombs and just hope they won't go off!**
> **(Sue)**

Her interesting choice of metaphor, which contemplated the explosive risk of avoiding the real depth of her emotional distress, showed the beginnings of Sue having insight into the potential negative impact of adopting such defence mechanisms. Significantly, much later in her narration, Sue was able to talk of how her recurrent memories of her assault had probably significantly contributed to her clinical depression which she believed had promoted her need to misuse alcohol. This suggested that the telling of her life story may have increased Sue's ability to reflect on the complexities of her childhood abuse, and how these may, even indirectly, have affected her problems with alcohol.

Aged 14, Maggie had been raped by a teenage acquaintance, when she left a church social club on the estate where she lived. In her narrative, she recalled the incident with distress, and then proceeded to minimise the real impact this had on her life:

> **Of course, I wasn't the only one - it happened a lot, and to some younger than me. They even had a special name for it on our estate ... it was called 'the forced fuck'. It wasn't called rape at all, I mean it's part of growing up for a lot of girls, isn't it? That didn't mean it was any more pleasant ... I mean it was disgusting, just horrible. But we had to get on with our lives, what was the point of always complaining ... so in a way, it was accepted as a girl's lot.**

(Maggie)

Maggie remembered sexual violence as being a common event for young women in her neighbourhood, something that they felt they had to accept as part of their lives. This revealed the oppressive experience of socialisation into sexually subordinate and abusive situations for some women, and also perhaps, her reluctance to fully acknowledge the individual impact of very personal trauma. Several feminist writers have analysed child sexual abuse as a complex process of socialising and preparation of the female to accept the subordinate role, to feel guilty and ashamed, and to tolerate, through fear, the power exercised over her by men (Rush 1980a; Russell 1998). Early radical theorists have further suggested that the sexual abuse of girls prepares them for a life of compulsory heterosexuality, and so compounds the propertarian nature of heterosexual relationships (Rich 1980; Ward 1984).

Every experience of abuse will inevitably have its consequences, and these cannot be simply inferred from the particular form the abuse may take. Some women recalled being subjected to sexual threat, innuendo or voyeurism in childhood, rather than contact abuse. Russell (1986) suggests that a non-contact act, which is perpetrated by a trusted adult, can sometimes have more devastating long-term effects than a physical contact act. Such trauma is articulated by Alex, but then carefully minimised as she observes the non-contact nature of her experiences:

> **He** (close family friend) **had always seemed creepy. I once told my parents that he smiled at me in a creepy way, and they laughed and said what on earth was I imagining, he was a kind man and he loved me ... so I shut up about him. When I was about 10 he started on about how he'd let me know all about what it meant to be grown up one day, when I was old enough. He didn't say anything specific, but I knew what he meant, and he knew I knew that too. He continued to taunt me like that for years. He never laid a finger on me though, I mean, never actually touched me in that way. I think I almost wished he**

had, so I'd have known for sure that I wasn't imagining it, or that then he'd stop all that creepy talk. I still wake up at night, really frightened, dreaming

that he's come to get me at last. But in the end, I was very lucky ... I was, because I mean he didn't actually do anything to me.
(Alex)

Alex had made efforts to protect herself from the abuse by trying to appeal to her parents for help. She also described, in her narrative, how she spent considerable energy trying to ensure that she would be alone with the family friend as little as possible. Her efforts were not successful, and this appeared to add even more anxieties to her young stressful life, as other sections of her narrative outlined.

The contention that the consequences of abuse will invariably be less severe if it has involves no penetration or physical trauma has been maintained in much research (Beitchman et al. 1992). It has also been suggested that more severe forms of sexual abuse, occurring early in childhood, are likely to have more impact on a woman's alcohol misuse (Moncrieff and Farmer 1998). Such beliefs were voiced by several participants who underestimated the implications of their abuse if they felt direct physical trauma had not been involved, or if their abuse had taken place in teenage, rather than in early childhood. However, degrees of fear, terror and powerlessness characterise the nature of all forms of child sexual abuse, and feminist analyses argue 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 non-contact act did not minimise the powerlessness of the girl's situation, nor 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. Although Jean had suffered a horrifying rape by three of her older brothers when she was only eight years old, her memories of another abusive incident concerning non-penetrative abuse by a brother appeared to remain as disturbing to her as the contact abuse:

He came in, no clothes on, and stood looking at me from the end of my bed, then he turned the light off and he came over, and I can't remember what then, except after a while I was kicking and biting him and after that he must have known I'd make too much noise, so he never touched me again .... but he didn't need to now .... the fear, the sheer terror of knowing he was there, what he was maybe going to do, that they all were there, well that was almost worse. Terrifying...
(Jean)

Voyeuristic abuse also caused considerable trauma. Maggie discovered her father secretively watching of her when she was showering; her narrative also suggested that she 'was probably old enough to know better'. She was a child of 14 at the beginning of this abuse, which lasted around two years:

I could never look him in the eye again, knowing how he had watched me, looked at me naked ... thinking about what on earth might have gone on in his dirty mind. It was ... it shattered my life ... although I was probably old enough to know better ... but he was someone I'd always trusted and looked up to. I was so ashamed .
(Maggie)

The rationale for minimising had different foundations for victim-survivors. As a professional now working with abused people herself, Alex found it very difficult to accept the significance of her experiences of sexual abuse from her older brother, when she compared this with the histories of abused people with whom she now worked. But this strategy of minimising her negative life experiences has developed into a rather defective coping mechanism, which Alex herself was able to comment on:

It was abuse, looking back. Well, a kind of abuse. But I've worked with so many people who've been abused so badly, that I feel I have no grounds to ... well, my abuse was minimal ... um, I'd call it minimal abuse, if there is such a category ... but then I do always make as little as possible of the bad things in my life, don't I? ... Is that why you're smiling? ... Yes, I pretend if they weren't too bad I'll forget them! Sometimes it works, sometimes it doesn't ...
(Alex)

Repressing Memories

A more extreme adaptation of the minimising of personal experiences of child sexual abuse is amnesia, or the repression of all, or most, memories concerning the abuse. Frances had struggled to stay in control of her memories, although she feared that one day the disturbing images of her abuse would return, as they have in the past:

I don't remember so much about it any more, and I'm pleased. The details have faded a little over time. When I do try to remember I get a tight knot in my stomach, a physical pain, and I think that's a warning to me. I don't want to remember all the disgusting details, I really don't think I could live with them. If it all does come flooding back I'll be desperate to drink to blank out the memories again. At the moment that doesn't bear thinking about.
(Frances)

Claire talked of the complex disinhibiting effects of alcohol which she thinks facilitated a confused memory, and then an intense physical reaction, which suggested possible abuse in childhood to her. Such experiences, known as flashbacks, are known to be alarming for victims for they occur unpredictably and are beyond the control of the woman herself (Hall

and Lloyd 1993). It is perhaps ironic for Claire, that the alcohol which she felt she had misused to try and displace her fear of being out of control in her life, was the facilitating factor in promoting a new area of confusion and distress:

> **When I was drunk one night I got lots of horrible, jumbled thoughts. Memories I'd never had before ... I'd been molested by a man when I was little ... it was very, very disturbing. I couldn't put the memories in any order, they didn't make sense. I became almost hysterical, I just wanted to stop those awful thoughts. I still don't know if it really did happen, but deep down I think it did, I get a reliving of those thoughts quite a lot ... I don't expect I'll ever know the truth, and I don't think I want to ...**
> **(Claire)**

Understandably, many women, consciously or unconsciously, try to bury or forget their abuse, or the feelings those experiences invoke. Disinhibited thoughts and the unwanted intrusion of incomplete and fragmented memories when under the influence of alcohol may cause severe reactions. Yet the increased susceptibility of flashbacks for women who have drinking problems appears to have received no attention in major literature, although I believe this is likely to have important implications for work with women problem drinkers.

Inaccurate flashbacks of childhood memories have also been implicated in allegedly untrue reporting of child sexual abuse, known as 'false memory syndrome', sometimes said to be caused by the persuasions of dangerous and exploitative therapists. Yet evidence available from much research suggests that cases of false claims of child sexual abuse are insignificant (Page 1999). It is probably more far more appropriate to acknowledge that figures of reported incidents are under represented because survivors are known to seriously under disclose, and in many cases may have repressed memories of the abuse altogether. For women who have drinking problems, who also present memories of sexual abuse from childhood, the emergence of false memory syndrome may have additional repercussions. As alcohol misuse is sometimes associated with the clinical symptoms of memory loss, and short term confusion, such women may be at particular risk of being

projected into a possible labelling of presenting false memory syndrome. Here their voices, and their pain, may be silenced or trivialised, and the support they so badly need be denied them (Cowburn and Dominelli 1998).

Self-Blame

For some participants, the fear and trauma surrounding their sexually abusive experiences in childhood was to some degree avoided by those who blamed themselves for somehow being responsible for their abuse. This appeared to have offered some an illusory sense of safety in terrifying and powerless situations. The rationalisation of being in control, or consenting, featured as a strong defence for Jill, who could not face her abuse by naming it as such, and who additionally implied that she may have had the power to have stopped it. She also maintained distance by speaking of it in a matter of fact, almost objective way:

> **Anyway, I didn't see it as molesting or anything. I knew it was what he expected in return for being a friend to me. I know I was just about 13, and although he was the first man who I'd gone all the way with, he was often very kind to me. I expect that if I'd refused he would have taken that okay. But I didn't stop him ... I needed him to be my friend ... going out in the car with him was the only way I could get out of the house, so I went along with what he wanted. There wasn't any force that I can remember, so were probably both benefited.**
>
> **(Jill)**

Although she was persuaded to regularly have sex by an adult over twice her age, Jill found it hard to label the experience as child sexual abuse. She defended it as being a pay off, or reward for her abuser, for helping her to escape from the family home she hated, where her father was physically and psychologically cruel to her mother, herself and her other siblings. Yet she had not consented to the abuse. For consent depends on an individual having enough knowledge and maturity to know exactly to what they are consenting , and also for them to be entirely free to refuse consent (Bentovim and Vizard 1988). In the case of a child, neither of these conditions are fulfilled. However, later in her life story, Jill

was able to make connections between her experience of the child abuse and the subsequent way she acted and viewed herself, even though this narrative is also strongly self denigratory:

> **I was known as the village whore, the bike, so that gives you an idea of the kind of girl I was. I went out with lots of boys and men .... yeah, and I knew what they expected of me. I did it for friendship, like I had with Steve** (adult abuser). **It makes you feel good to think you are wanted. So I went along with it, thinking, well if I do it with them, they'll still want to see me after .... God, it's awful isn't it ... that I'd give myself like that, just because I thought that's what men wanted me for, like my own feelings didn't matter ... still, it sounds bad now, but I don't suppose it was at the time. I was a little slut, the name was right.**
> **(Jill)**

Self-reproach about having accepted rewards or privileges which were perceived to be exchanged as some kind of payment for the abusive acts, was also acknowledged by Alex, a victim of abuse by her older brother:

> **I also have this nagging ... well, it's guilt ... that I only agreed to do those things in return for being able to watch television late. If I did what he wanted, he'd let me watch the late programmes when he was babysitting me, you see. I colluded with it to some extent by accepting those treats afterwards.**
> **(Alex)**

Alex had questioned her own motivations within the abusive relationship and later sought to justify the behaviour of her older brother. Her rationalisations are not surprising, given the widely held assumption that brother/sister abuse may be mutually consented, or less damaging than other sexual abuse (Itzin 2000). In fact, sexual relationships between sisters and older brothers perpetuate many features of abuse of a child by an adult. The effects are likely to be equally traumatising; the victim has been exploited, and the use of coercion and

abuse of power are still central features, as Alex's narrative confirms:

> **Well, looking back I expect a lot of it was about him being of an age when he wanted to experiment with sex. I know he knew it was wrong, because he made me swear I'd never tell anyone, or else... but I was available to him in a kind of way, you know, in the same house. He used to say 'you like this too, don't you'. Well, I didn't, but I was beginning to have sexual awareness too, and maybe the attention was quite nice, being looked on as a teenager, rather than a little kid.**
> **(Alex)**

In addition to her belief that she may have contributed to the abuse by accepting favours, Alex had also projected doubts about teenage sexual experimentation, by questioning her feelings as a pubescent girl. By exonerating her brother's motives, and by feeling partly to blame for what happened, Alex also avoided having to accept that she was being manipulated and used by someone she loved:

> **I'm really undecided about my feelings towards him now. We've never talked about those things we did. If I did begin to think about the feelings I have about it, I think I'd find it hard to ever see him again, and that would be very, very hard. He's my only brother, after all.**
> **(Alex)**

Two other participants, Frances and Jean, were also abused by their brothers. Sexual activity between brother and sister has received relatively sparse attention in research on child sexual abuse, compared to abuse by adults (La Fontaine 1990). Abuse by siblings is often viewed as being the result of mutually agreed sexual experimentation or a mistaken mutual attraction. The consequences for both are often viewed as being equal. Of course, this assumes that female and male siblings are equal, and that sexual experimenting is there by mutual consent. Differences of age, sexual development and strength generate

inequalities, as does the higher family and social status for boys than their female siblings, factors clearly endorsed in the three life stories which included abuse by brothers in my study.

Reasons why victims of child sexual abuse may blame themselves, both at the time of the abuse, and later in adulthood, are complex, and need to be viewed within each individual context. For example, as an adult, the victim may blame herself for not having stopped the abuse:

> **I still have dreams, nightmares about it. That I shouldn't have been there, or that I should have run faster, screamed louder. I keep persecuting myself, trying to think of all the different ways I might have stopped it. It's not logical, any of it, but I still blame myself for not being able to stop it ...**
> **(Sue)**

For the child, guilt can also be directly linked to the abuser telling her that it is all her fault, that she really enjoys what is happening. The power of adult suggestion was highlighted by Wendy's experiences. She was seriously sexually abused for many years by her father, and also by members of a paedophile ring which was serviced by him. Both the paedophiles and her father consistently told Wendy that the abuse was her fault, that she enjoyed it, that what they were doing was for her benefit because she was a bad girl. Her feelings of intense self blame were clearly linked to the accusations made by her multiple abusers:

> **I was only three when it started, so I don't expect there's that much I could have done ... but the thoughts are always with me that I should have refused - somehow resisted more. My conscience tells me I should have stopped it. They all told me it was what I wanted. When you are told that over and over again, over so many years, you begin to believe it yourself. When you're little, you believe what grown ups tell you ... especially when one of them is your Daddy.**
> **(Wendy)**

Taking personal responsibility for the abuse took a variety of pretexts, usually presented in terms of intense guilt or self blame. 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. Jean spoke of the rape by her brothers with a strong message of apology for allowing it to take place, and an implicit request for forgiveness:

> **I sometimes think of what happened, and what I should have done ... how I could have tackled it ... but they were so strong, you see? I was such a little girl, only eight, not knowing what was happening and why they were doing it to me ... and it hurt, it hurt so much ... what more could I have done? (Jean)**

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. These are distressing lessons to be learned in childhood and are likely to have significant influence on subsequent adult beliefs and behaviours.

Maggie's abuse began in her early adolescence, when she discovered her father had been watching her in the shower through a bathroom window. Her guilt is exacerbated by concerns about whether she may have colluded with the abuse because she did not have the strength to confront her father:

> **The worst part of it all is the constant guilt. That it was all my fault for allowing him to look, that I didn't put a towel over the window, even when I knew that he would be there watching and waiting. So I didn't do anything to stop him, did I? Maybe it was fear? I was so sickened and humiliated, but also terrified that he'd know I'd seen him there, that would have been even more humiliation. So I never did anything, I just pretended he wasn't there ... some people might think I encouraged him by not stopping him? (Maggie)**

For Frances, self-blame surrounding her abuse was complex, and demonstrated the many ways in which the eroded self-worth of victims can contribute to self-doubt and blame. She was fourteen when her brother, home from university, raped her. Her feelings of self-blame at the time, intensified by her brother's threats to prevent her telling anyone, have now transferred to a deeper level of self contempt for ever allowing herself to feel responsible for what happened. Her negative judgements about her part in the attack relentlessly continue; she now castigates herself for the guilt she previously felt, for her own 'stupidity':

> **He had a terrible temper, and it was quite usual for him to beat me... when he lunged towards me and hit me, I expected that. But when I fell onto the floor ... he ... he, God, he raped me ... I felt so dirty. I cried and cried and blamed myself for not fighting him off ... I actually blamed myself for years for allowing my own brother to rape me - hard to believe, isn't it? I actually blamed myself for it all - how can anyone be so totally pathetic and stupid! (Frances.)**

Violet's reasons for blaming herself were very different. When she was twelve she was raped by a well respected teenage boy living in her village. She did not report the young man because she thought no one would believe her, this was confirmed by her perception of a change in the attitudes shown towards her by significant people in the neighbourhood:

> **After he'd raped me, he never spoke to me again. It was a small village, so we often met up, but he completely ignored me, acted like I was beneath his contempt. Then gradually, his friends started ignoring me too. They sniggered together and I knew the kind of things they were saying about me. It was a dreadful, dreadful shock ... I was a good Catholic girl, I didn't think I'd done anything wrong, I'd tried to stop him ... but then I began to doubt all that ... I**

saw it as being my fault, and that is what he was telling other people. The community we lived in was so close knit, I thought everybody must have heard about it and know what I'd done with him. I believed that my reputation, and my life would be tarnished forever ... in a fashion, that's happened. I still feel to blame for almost everything that has been wrong in my life, even when I don't understand how some thing could possibly be my fault! Yes, it's interesting to think of it like that ... I do still feel that I am a tarnished person.
(Violet)

Her abuser had distorted what had happened to protect himself, but at the time Violet did not realise this, and she was engulfed by shame of what others may have thought of her. For three months after the attack she also feared she may be pregnant, and her anxiety and shame almost caused her to attempt suicide. The abuse had many repercussions for Violet, who believed it changed her personality from outgoing and trusting, to being retiring, fearful and timid. It also established an enduring fear for her of being labelled and stigmatised, a fear which would later affect her motivation to seek help for the alcohol problem which may have been influenced by the original abuse:

Admitting I had a problem with alcohol took a long time. More than anything, I couldn't stand the thought of people thinking of me as an alcoholic, that's a very low place to be, and I didn't think I deserved to be looked down on and judged by people who didn't know what was going on for me ... that had happened before, remember.
(Violet)

Sexual abuse in childhood, like the rape of adult women, has often been viewed within a punitive context of victim blaming. Just as adult rape victims can be accused of somehow 'asking for it', female children can also be judged to be provocative, seductive or tempting to men's sexual desires (Scully 1990). These views can be internalised by victims who try to find explanations about why their abuser selected them:

I often wonder why me, why did he choose me? I wasn't even pretty or anything - very plain in fact, everybody said so. Maybe I was precocious, you know? .... without even knowing it, did I attracted him in some way? Maybe it's possible for some young girls to be precocious without knowing it. Do you think that might be possible?
(Sue)

Yet sexually abused children are no more precocious, pretty or sexually curious than other children. They do not ask for it. They do not seek it out. They do not usually understand it. They certainly do not want it. Like the rape of women, the rape and molestation of children are the most basic acts of violation, power and domination (Bass and Thornton 1991).

After Mary's mother died, and her father abused her, Mary questioned the motivations for her father's action:

I felt he had picked me out. I wondered about what I had done to him to get this. And then I left, and I'm not sure what happened to little Fiona then, but I can guess ... we didn't talk about such things. When he killed himself I shouted 'hooray!'. I was relieved that he couldn't get at us any more, and I thought he deserved to die for what he did. But I do wonder if he was driven to get us after Ma died. Maybe it wasn't his fault, maybe he couldn't help himself ... maybe I should find it in my heart to forgive him? But I can't. So I'm just left feeling sick with myself for not doing more to stop it at the time ... he's dead now and sometimes I feel guilty about that too. I just wish all the memories could have died with him.
(Mary)

Mary was still tormented by doubts about whether she had been in some way responsible for the abusive experiences, that she may have been perceived as being an easily available

outlet for her father's possible sexual frustrations. Her anger about her own treatment has therefore been complicated by abuser exoneration, and confusion on her own part about whether she should have recognised his possible sexual frustrations. She also expressed guilt about leaving home and possibly leaving her younger sister to endure the fate that she had escaped from. Mary talked here, and in another section of her narrative, about her father's later suicide, which she believed was linked to his fear of exposure as an abuser of his daughters. Death of the abuser has been noted as being especially difficult for a survivor to come to terms with (Hall and Lloyd 1993). This additional, powerful dynamic caused unresolved shame for the hate Mary felt in childhood , and still feels, for him. Mary believes she has been left embedded in a sense of distorted blame, self doubt and inverted anger, which alcohol sometimes relieved for her when she was drinking heavily. But Mary also displays much insight and strength, and, following our life story work, she reached the courageous decision to explore her feelings further through a counselling helpline for sexual abuse victims.

Terrible Secrets

There were many pressures placed on victim-survivors in my study to maintain secrecy about their abuse, some consistent with literature on the topic (Jehu 1988; Bifulco and Moran 1998). The primary reasons participants said they remained silent were:

fear of being blamed and getting into further trouble;
fear of retaliation by the abuser;
uncertainty about sex as a taboo subject which was too embarrassing to talk about;
having no one trustworthy to tell;
a fear of not being believed.

Similar reasons for maintaining silence were central for Violet, although her immaturity and lack of sexual knowledge intensified her extreme confusion. But she understood well that something bad had happened to her, when, aged four she was seriously sexually

assaulted by a Priest whilst she was playing on a beach, out of sight of her mother:

> **I remember knowing instinctively that what had happened was bad, very wrong. I was only a very small child, but even in my innocence I knew this was a very bad thing to have happened ... very serious. When my mother found me crying she pleaded with me to tell her what was wrong, but I couldn't bring myself to tell her, nor have I in all the years since then. I've always kept it secret ... it's too embarrassing and humiliating to talk about, and probably the fact that he was a Priest, and I was such a tiny thing, makes it all the more distasteful.**
> **(Violet.)**

Similarly, Wendy, who had resigned herself to the continuing of her abuse, saw no point in either resisting or telling, for whom could she have told of 'such terrible secrets':

> **I tried to run away the first time, but he caught me easy enough, and after that he held my coat hood tightly as we walked towards the house with the men, where it always happened. So what could I do? As a child I daren't say anything to anyone, not a soul. I've only very recently been able to talk about it as an adult, but as a little girl, who could I have told such terrible secrets?**
> **(Wendy)**

Finding someone trustworthy to tell was a difficulty for all victim-survivors. Although Jill had been visited by a social worker for many years, she believed that even this supposedly trustworthy figure was not safe:

> **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. What a joke she was. He'd** (father) **definitely have blamed me for it, called me a whore. It was just so much easier to say nothing and just spend time planning how I'd run away**

soon.

(Jill)

Maggie often desperately wanted to do something to stop her abuse, but her father who abused her was a popular, and highly respected member of the community:

> **I just longed to be able to tell someone who might be able to stop him. But who could I tell who would have believed me? I was already seen as a bit of a naughty kid ... and him, well he was like a tin god in the army, respected, worshipped almost. He'd definitely have been seen as being above anything like that ... so I kept it all locked up inside, I would never have been believed against him, I still know that. If you were to have met him, you'd never believe me either. I'm pleased I didn't tell anyone, because I can see that it would just have made things much, much worse for me. I did the right thing by keeping quiet.**
>
> **(Maggie)**

Maggie's father was a violent domestic tyrant, as had been both Wendy and Mary's fathers. These three men who had sexually abused their daughters all presented mild, ineffectual and courteous images to outsiders, characteristics noted in other studies on father-daughter incest (Herman 1981). These conflicting images made it all the more difficult for the three girls to feel they would be believed, against the word of their respected fathers. Maggie's assumption that her disclosure at the time of the abuse would have resulted in negative consequences has been upheld by evidence from literature (Finkelhor 1986). Telling others certainly does not always offer future protection from the perpetrator, and it can significantly bring new hopelessness for the child. Clearly, Maggie's story would have been strongly contested by her father, who had much experience of manipulation and lying. Her situation highlights how the effects of secrecy or disclosure need to be evaluated to take account of the individual circumstances of the child. Telling may well invoke worse trauma.

For instance, there were strong testimonies given by participants that when they had tried to tell, many were not believed, nor supported, and that their desperate hopelessness was more intensified than if they had remained silent. Sue reported a sexual attack by a stranger, but soon regretted having done so. Her attacker was never found by the police, and she felt responsible for the resulting distress of her family:

> **I really soon wished I'd kept quiet about it all. All the interviews, telling all those embarrassing details to the policemen. Seeing all the pain on Mum's face, the anger on Dad's, it really was not worth any of it. Even if they'd caught him, what would have been the point? The damage had been done to me and my family by then, and I don't expect a short prison sentence would have stopped him doing it again ... he'd probably still out there at it, attacking little girls ... oh, what's the point? No, I wouldn't advise any child to tell, after what happened to me...**
> **(Sue)**

A sense of family loyalty, wishing to protect her parents from the shocking news of her rape, plus the fear of retaliation by the brother who had attacked her, were Frances' reasons for remaining silent:

> **I had such a low opinion of myself that I was pretty sure Father would never believe my word over one of his beloved sons. Mother would have been devastated, so either way I'd have lost out. Also Richard (** brother **) got me the next day, when I was still terrible shock and told me that if I ever told anyone what had happened he would shoot me. That seems far-fetched now, but at the time I knew he had a rifle, and he was crazy - certainly capable of any cruel act, and I did believe him. So ... if I'd told, there would be bound to be a family crisis, and me probably murdered too. So there wasn't any alternative .**
> **(Frances)**

Just as children are fearful of receiving disbelieving or insulting responses if they try to tell of their abuse, adult survivors also experience the frustration of disbelief and ridicule, or are told to forget old memories (Bass and Davis 1988). Because of the frequently negative experience of telling, or trying to tell, it is not surprising that silence surrounding abuse is perpetuated and sanctioned. Jean, as an adult woman, had finally summoned up the courage to talk of her abuse to a chosen, trusted health care professional. His response only served to reinforce her shame:

> **I did say something only last year ... I thought it had all passed, that I'd forgotten it, or that I could manage it. Then it came up again, suddenly. I told a little bit to my physiotherapist, but he told me to 'dump it and leave it there'... his exact words, I'll never forget them. I couldn't even think about telling anyone else about it after that, until you, that is.**
> **(Jean)**

In adulthood, Maggie had tried to discuss her childhood abuse with her psychiatrist whom she was seeing because of her depression. She hoped he would offer understanding, but his opposite response concurs with the research of Russell (1995) who found there are deeply resistant and defensive responses to reported child abuse by the medical profession, including scepticism, disbelief and victim blaming. The psychiatrist's rejection was humiliating to Maggie, and as she describes, convinced her that alcohol was her only alternative:

> **It was so hard, trying to have the guts to say anything, you know ... but I felt like I needed to tell someone, after bottling it up inside me for all those years ... I was so badly depressed, I probably needed to hear someone say that it couldn't have been my fault, any of it. I thought he'd be the right person to tell, because he was a psychiatrist, after all. I began, really clumsily, trying to tell him, then he realised what it was about, and he dived in and completely changed the subject. Then he went on and on about how I needed to remember**

positive things in my life, not just dwell on negatives in the past. I could hardly believe my ears - I felt insulted and belittled, I could have run out of the office! So, I went home and downed half a bottle of gin. I'd learned a real lesson that day ...
(Maggie)

Hopelessness

They told me that if I told anyone at all about it, I would be sent straight to a school for naughty girls, and I would never ever be allowed to see my Mum or my sisters again ... not ever again. I was very young when they started telling me that. I couldn't face a future without my Mum and the girls, so I did exactly what I was told. I had to, I had no other choices. I don't know if I ever doubted what they told me. My only thoughts now are adult ones, and the only words I can remember were said by the men and my father ... I never remember my words .... I just look down on it all ....
(Wendy)

Feelings of hopelessness and powerlessness and were referred to by all victim-survivors. Occasionally, depersonalisation of the memory was suggested, as in Wendy's description, above, when she could not remember what she said, or how she really felt during the abuse. Even her painful memories are recalled as surreal; looking in on experiences, as if in a dream. This has helped her to be able to remember, whilst also distancing and protecting herself from some of the most traumatic aspects of her experiences . Depersonalisation or desensitisation has been associated with victims of child sexual abuse, and many aspects of their abuse can be seen to directly contribute to these dynamics (Bass and Davis 1988). Powerlessness inevitably occurs when the girl's body and childhood space are invaded against her will, but this can be further reinforced by the coercion or manipulation which prevents her from telling of her abuse. Threats command the child's participation, and

frame her belief of what will happen if she resists or tells. For Wendy, the threat that she would be separated from her mother and sisters deterred her from telling of her experiences; the prediction that she would be sent to a school for 'naughty girls' reinforced that she was both bad and culpable. Threats from her abusers exacerbated Wendy's undeniable powerlessness and added to her confusion about her guilt surrounding events she did not want, but was manipulated to feel responsible for. She was trapped, helpless, unable to find any way to try and stop the abuse. Slowly, yet systematically, she emotionally withdrew and had to accept her fate.

Wendy's father also abused her at home. She described the powerlessness and fear of having to wait for each abusive incident, and of the satisfaction her father derived from wielding such terrible power over her:

> **Oh that dreaded dark allotment shed. Every time I'd hide under the filthy sacks in a corner of mud. He'd send me in and tell me to wait. That could take a couple of minutes or be an hour or so. Each time was different, it kept me more unsure and more frightened. That waiting was the worst part. He knew that, it was part of the game, his enjoyment. He knew how frightened I was of the dark. Sometimes he'd open the door, and I'd think he's here now so it'll get ended, then he'd call, in a happy voice, " I'll be a little longer, you stay there till I'm ready". It was all part of the torture, you see. Not all just physical and sexual, it was the never ending emotional torture too.**
> **(Wendy)**

Others also remembered the hopelessness connected with waiting and powerlessness:

> **Listening, waiting ... I still remember those terrible fears at night when I can't sleep. To live with that was worse than being dead, death would have been a release. I wish I had died, or something, rather than have that to carry on and put up with it. My life's been ruined because of it, so what's the point of having such a life?**

(Mary)

Mary was not alone in speaking of the futility of living a life which she believed had been destroyed in childhood. Other participants, Violet, Frances, and Jean also remembered feeling death would have been a welcomed release during or after the abuse. All would go on to attempt suicide in later life, an expression of distress prevalent among women who have alcohol problems (Russell 1995). However, without the knowledge that these women may also have been abused in childhood, a secret most would never have easily shared, their self harming behaviour is likely to be associated with their alcoholism, rather than being identified as being a possible symptom of child sexual abuse, where the incidence of suicidal behaviour is also very high among adult survivors (Beitchman et al. 1992; Motz 2001). This raises important challenges concerning current knowledge about women's alcohol misuse and suicide, which will be further discussed later in my thesis .

Still Living With Fear

Overwhelming fear was mentioned by all the victim-survivors of child sexual abuse, and fear is interconnected with all the sub-themes in the chapter. Significantly, it was an emotion which, for many, was sustained into adulthood, sometimes being implicated as being a cause for low self-esteem and lack of confidence which alcohol temporarily alleviated:

> **I grew up being afraid of every thing, grew up with that terror, after what had happened. It was hard to know who, or what, to trust. Now everything is still frightening ... I am still afraid of everything, that's me! I just have no confidence in myself ... so drink helped. I felt so afraid of so much, drink gave me courage for a few hours.**
> **(Wendy)**

Mary also talked at length about the fear which over-shadowed her childhood. She had been fearful about the deteriorating condition of her mother, who suffered from a heart condition. She also feared her father's violence, and continued disharmony at home because of this. When her mother died, love and protection within the home also left, and Mary's world spiralled into the situation she had most dreaded:

> **After Mum died ... well, lots of things changed then ... I knew I wouldn't be safe after she had gone. One morning my father came and got into my bed and ... after that, I was so terrified that he would still come and get me again . I lived with that fear every day I lived in that house with him, about another six years, because I was only about nine when he did that. That's when my sleeping problems all started ... lying awake in bed wondering, waiting. After a year my nerves were so shot that I went to the Priest. He didn't seem shocked or interested, he said all I could do was call the police in, and that would mean Dad would go to prison. I wanted him out of my life, in prison, or anywhere away from me ... but I kept quiet, because I knew he'd get out sometime, and then I'd really be in for it. And Father, the Priest, he never mentioned anything about it to me again ... it was like it really didn't matter compared to other things, like whether I'd saved a penny from my pocket money to give to the poor box for all those poor children he said were worse off than me.**
> **(Mary)**

In her family, when her mother died, Mary's status and circumstances as a developing young woman would make her especially at risk of abuse by an incestuous father (La Fontaine 1990). Her feelings of powerlessness and vulnerability to invasion included not only the dread of abuse by her father, but also fears of retribution if she had reported her allegations to the police. The trauma of child sexual abuse induced overwhelming feelings of anxiety, guilt, anger and fear for Mary; it also served to keep her feeling victimised, powerless and silent. Her feelings were confirmed by the trusted Priest in whom she confided, who did not help her find the protection she needed; the safety which Mary said

she had previously been given by her mother when her father threatened physical violence. This compounded a devastating loss for Mary, who later explained that she had never come to terms with the death of her mother, and that the abusive experiences with her father had ended not only her childhood, but also her hope of future love or happiness. Death of a parent before teenage has been occasionally linked to subsequent alcohol misuse in women (Lindbeck 1972). In my study only Mary had suffered bereavement of a parent when in childhood, and this did have a profound effect on her. However this was clearly compounded by the threat of now being cared for solely by her abusive father, so her primary enduring loss centred around not only loss of love, but, significantly, loss of protection and trust of an adult.

The Child Alone

The life stories in my study confirmed that the sexual abuse of children thrives in an atmosphere of silence and fear, often maintained by methods of control and dominance applied by the abuser. For all victims, the enduring consequence of their abuse has been extreme loneliness, both in childhood and also extending into adult years. Once the abused child had lost power over her body, over her sexuality, over her self, she would rarely tell; not only had her physical self been violated, she also felt her integrity has been lost (Sanderson 1995). As Wendy explained, a penalty for having to keep this most dreadful of all childhood secrets, was a deep sense of feeling totally alone:

> **I was confused, terrified ... I just withdrew into my own world. That's when I first learned to keep things to myself. He said it was my fault, that I enjoyed it, that I was such a bad girl. I had to accept that ... what was the point of arguing with him about anything. The worst of it all was the dreadful loneliness ... I couldn't tell anyone ... I just felt so alone, so bad ... I had no one ... I can't get rid of that, I grew up with it, I had no other option, I was just hopelessly ... alone.**

(Wendy)

The patterning of loneliness and silence became integral to Wendy's life . In an attempt to cope with her memories of childhood abuse, she later explained how alcohol itself became a coping strategy, which for many guilty years she kept as secret as her childhood abuse. As an adult woman she often remembered herself as a bad girl, who probably had only herself to blame for her loneliness. Such aching loneliness was referred to many times by the women who had been sexually abused in childhood. Little girls who had no one to confide in, no one to ask for ask for help. They learned to adapt their lives in an emotionally, and sometimes practically, solitary way. Alone, self-contained, almost aloof, they survived by expecting little, and often receiving little from those around them. They had learned very early in their lives that their worlds were not dependable, and they retreated further into lonely, isolated existences:

> **You have to try, somehow ... to manage it all on your own, even when you've grown up. It makes you feel so lonely ... but you have to get on with it. So I've told myself: ' it's your shit, Maggie, you've got to be strong and learn to lie in it'. That's how I've handled my life ... sometimes I feel I'm the loneliest person in the world ...**
> **(Maggie).**

Making Personal Connections

After hearing each participant's narrative, I invited her to reflect on her life story, and, if she wished, suggest how she felt past events may have influenced her problems with alcohol. Participants identified child sexual abuse, more than any other life experience, as having had a direct impact on their later alcohol misuse:

> **I've sometimes wondered in the past, and more recently, since I've been seeing**

you ... well, just how much the rape affected me - my adult life. You see, there was this huge need to try and stop the memories. Alcohol hides it all away for a while ... and I hated myself so much ... it was a kind of punishment as well.
(Frances)

I ask myself if the abuse thing is just one more excuse which I can use ... that's what they say, isn't it, 'don't just find excuses'. But after what's happened, the abuse, you're never the same again, never normal, never a whole person ... that's bound to affect you and your drinking, isn't it? Especially when you're drinking to try and block all that out of your mind, when you're drinking to try and get some peace from it all. Getting a few hours of peace was how I used it ... I didn't have any other alternatives
(Maggie)

The abuse is so deep ... it's hard to explain. You are what you are because of what has happened in your life ... I grew up believing that I was no good at anything ... nothing but the sexual things, he told me that all the time. So I grew up feeling worthless and , yes, depressed. I was so depressed for so long that I didn't even know how it felt to feel normal. I'm just beginning to feel that now I've been stopped drinking for two years. The drinking was probably because of the abuse, but then the drink made it all worse. It all turned in on me ... like I was on an escalator with no way off ... the drink only helps you block it out at the start really ... I called it the perfect anaesthetic!
(Wendy)

Women alcoholics I've met always seem to think: 'why me?' Children who've been sexually abused say: 'why me?' too, don't they? When I think of my childhood, and then the drinking later, there are lots of similar feelings. You get the same kind of emotions with both things ... you also think both things

are your fault. The drinking keeps you hurting myself, keeps up all that guilt and hate and badness you felt about yourself when you were a child.
(Violet)

The abuse followed me ... I never could forget it. When it got too much, with everything else I had going on, I'd drink to block everything out. I am certain I drank because of the abuse, I know I did ... it affected me more than anything else in my life did, and then it nearly killed me in the end, through the drinking.
(Jean)

Discussion: Alcohol Use and Sexual Abuse in Childhood

Before starting fieldwork I had identified in the available literature some links between alcohol misuse in women and having been sexually abused in childhood, but this connection was not always outstanding in the aetiology of addiction. As I worked with research volunteers in my random, self-referred sample, ten of the thirteen women spoke of their experiences of sexual abuse in childhood. The types of childhood sexual abuse experienced by these women had often involved physical violence, and most girls had been penetrated orally, anally and/or vaginally. An additional, and disturbing factor, was that so many women had experienced multiple abuse, from different male adult perpetrators, at different stages in their childhoods. One participant spoke of the bizarre, sadistic victimisation by multiple male perpetrators in a paedophile group, and then of the later abuse by her father throughout her teenage years. These kinds of abuses concur with results from previous research which suggests that child sexual abuse is often a violent, physically intrusive and brutal act (Bass and Davis 1988; Briere 1992; Russell 1998).

The collected life histories also included accounts of voyeurism, extreme innuendo and other sexually threatening behaviours, which, although constituting 'non-contact' sexual

abuse, were still associated by some with their later alcohol problems. This challenges findings of some previous research which suggests that it is the more 'serious' child sexual abuse which will result in the most severe psychological repercussions or drinking problems in adulthood (Moncrieff and Farmer 1997). Although sexual abuse often occurred before the age of 12 years for victim-survivors in my study, the age of onset of the abuse, or whether perpetrators were inside or outside the family unit also appeared to be insignificant in predicting the severity of later alcohol problems. Other studies have suggested such factors are important of these for the development or severity of drinking problems in women survivors (Jarvis et al 2000).

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 (Wilsnack and Beckman 1984; Breire and Runtz 1986). It may be significant that these traits are also thought to be prevalent among those with a history of child sexual abuse (Bifulco et al. 1991; Wilsnack et al. 1997). Studies on women who misuse alcohol often suggest 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 may have affected the coping strategies of the adult victim-survivor.

Furthermore, I would suggest that the effects of alcohol intoxication often mirror the psychologically dissociating patterns used during and after some sexual abuse, as described earlier by participants. Continuing to look for, and adopt, such dissociative techniques, to try to manage distressing personal situations, may additionally raise vulnerability levels of future alcohol misuse for child abuse victims . The possibility of misusing alcohol as personal punishment, rather than for relief, also cannot be discounted, when taking account of the self denigration and self loathing reported by many victim-survivors in my study.

The views of most participants was that alcohol had initially provided important 'self

medication' against the distress of the invasive memories of abuse; that alcohol had been used as a strong short term coping mechanism. Strategies of coping are different for each individual, and undoubtedly these strategies may change, both during the times of the abuse, and in the subsequent struggle to cope with its consequences in later years. The psychological coping strategies which are used, consciously or not , during the abuse and after, are developed and refined, to provide complex defensive strategies, such as those outlined previously in this section. Within this theoretical framework, which has important implications for theory generation, alcohol can therefore be seen as being part of the wide context of an overall pattern of dependence on coping strategies which may initially help numb the memories and pain of childhood sexual abuse.

However, for the all victim-survivors in my research, alcohol misuse resulted in new and additional difficulties - alcohol misuse, just like their child sexual abuse, soon became another guilty secret to endure, which intensified feelings of loneliness. With growing feelings of hopelessness, 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 has invariably made matters worse.

The association between child sexual abuse and later substance misuse has received some empirical support (Herman 1992; Moncrieff and Farmer 1998; Macmillan 2001), but some research has contested such claims (Sedney and Brooks 1984; Fleming et al. 1988; Wisdom 1995). In fact a qualitative study, which explored the major factors which contributed to women's alcohol misuse, failed to uncover any histories of child sexual abuse from participants (Long and Mullen 1994). This research was described, by the authors, as being 'respectful and exploratory' which was judged to: ' *enhance the richness and quality of the overall findings*' (Long and Mullen 1994: 629). However, I consider that it may have been rigidity in the chosen interviewing method, which used semi-structured techniques, which failed to uncover information about intimate sexual experiences. It is perhaps notable that participants in that research did report childhood psychological and physical abuse, especially by fathers; it could be suggested that these experiences may have been less stigmatising and less difficult to disclose by participants,

than any sexual abuse.

Therefore, by examining available literature, and drawing on the experiences of my own study, it may be that it is the methods of investigation chosen in much research which could result in current lack of conclusive evidence between consistently high rates of sexual abuse among women with drinking problems. Several women told me details of child sexual abuse which they said they had not spoken of before, and I believe this was a direct result of the use of the life history methodology which enabled women to feel confident that their long narratives would be heard and believed (as outlined in methodology chapter). The relief of at last being able to tell someone about their abuse was voiced by many, especially those who had not before disclosed their abuse, or had not previously discussed it in detail. Because of my ethical and moral fears about the possible increased vulnerability of participants in research, I noted with much relief this unanimous welcoming from all survivors that their stories had at last been heard.

The amount of addiction research which has specifically investigated connections between child sexual abuse and subsequent alcohol misuse may be considered sparse, in view of the potential treatment advances which such research may uncover. Maybe addressing the double stigma of women who drink, who have also been sexually abused are powerful disincentives for researchers of addiction or child sexual abuse. Or perhaps it is the 'medicalisation' of women's alcohol misuse which reduces researchers openness to pursue such findings. Yet the experiences of many recognised experts in the field of sexual abuse strongly indicate that more research and subsequent literature should illuminate this topic (Kelly 1994).

However, there is no lack of studies which link alcohol misuse and the perpetrators of child sexual abuse. An established body of knowledge has confirmed that child sexual abusers are often heavy drinkers, using alcohol before or during their abusive acts (Parker and Parker 1986; Finkelhor 1986; Gladstone 1999). The prevalence of such research which views alcohol misuse from the male abuser perspective is significant on several counts. Alcohol is being explained here as a cause or contributor of male abusive behaviour, and

alcohol as a disinhibitor regularly features in this rationale, suggesting that alcohol misuse can be blamed for aspects of male sexual abuse of children. Similar arguments have been used and contested in the theorising of domestic and sexual violence against women (Scully 1990; Hague and Malos 1993; Mullender 1996). Additionally, a research focus which centralises the alcohol use of the abusers colludes with the construct that alcohol problems are gender-biased, that alcohol misuse is a male problem. This traditional, 'malestream' nature of addiction research has also both implicitly and explicitly condoned the capacity for choice and control by perpetrators of sexual violence towards children. It may also have diverted interest and funding from the exploration of a valuable research area, of the use of alcohol as a coping strategy for the victim-survivors of child sexual abuse.

The naming and remembering of child sexual abuse can be a traumatic task for survivors. It takes both courage and trust to do so, especially for women who have been silenced in the past. But the uncovering of the memories, if shared in a believing, caring environment, can be part of a healing process; the healing process which several participants named as being an essential aspect of their fight towards freedom from alcohol misuse. The telling and sharing of painful experiences and emotions may become a more positive coping strategy than alcohol abuse. If women who have suffered child sexual abuse do not receive support and non-judgemental understanding, their past abuse may lead to a lifetime of victimisation, and alcohol misuse may play a leading role in that recurring oppression. If victims are not able to tell of their experiences, if professionals in health and social care agencies do not understand the far reaching need for these stories to be heard, many treatments for alcohol misuse are likely to remain temporary and ineffective. The journey from victim to survivor must be encouraged and supported. For the countless thousands of women victims of child sexual abuse, the potential for revictimisation by alcohol dependence can only be alleviated by an unequivocal commitment to try to understand the complex influences of child sexual abuse on the drinking behaviours of adult women.

Alcohol treatment services urgently need to recognise this, and target resources towards the investigation of, and subsequent support of, women whose behaviour may indicate a

history, disclosed or not, of abuse in childhood. Exploring the possibility of abuse, and recognising the probability of differential or confused diagnosis which has been based on categorising presenting symptoms, should form a routine part of clinical and social enquiry for women problem drinkers. Knowing some of the consequences of abuse will not work directly in the essential arena of prevention, but will at least be offering support and recognition to the many victims who would like to make their journey towards becoming survivors without the continued misuse of alcohol.

The question of why some women who have been sexually abused in childhood go on to misuse alcohol, while some may not, is of major importance for understandings of women who have drinking problems. Through exploration of other themes in the lives of my participants, further factors will now be examined to illustrate how and why a progression or culmination of certain life events may make certain women especially vulnerable to developing drinking problems.

Chapter Five

Other Childhood Memories: *The Unhappiest Times Of My Life*

The childhood and adolescent years of my research participants contained various complex and inter-related experiences which were likely to have influenced their adult lives. Through positive experiences and relationships in childhood, all women are known to gain a sense of worth; but if they fail to have the love and respect of others, if their early lives emphasise lack of protection, neglect or alienation, as they were for many of my participants, they are more likely to feel incompetent and inferior as adults (Allen 1995).

All the narratives included, to varying degrees, prolonged unhappy experiences in childhood. The previous chapter has outlined some implications of sexual abuse for participants, and this chapter will continue to develop other childhood stories, which so often portrayed emotionally bare or hostile worlds in which there was little sense of belonging, or support from adults. Unhappy or harmful childhood experiences rarely came singly within a narrative, but did usually exist alongside some happier memories. This section represents the mainly negative experiences, for these were recalled as being more pervasive, unalleviated and influential, often being implicated by participants themselves to their later alcohol misuse.

Experiences at School

The influence of school, and lost educational potential, is almost invisible in literature on women with alcohol problems. This fails to recognise the potential impact of education on developing positive self worth and self image, characteristics frequently noted to be absent among female problem drinkers (Plant 1997). Uncovering the possible origins of such influential traits in women problem drinkers is important. This section documents how schooldays had great influence on developing self-image and self-worth for participants.

> **I hated school so much, I have very few good memories of it at all ... school days were the unhappiest times in my whole life.**
> **(Sue)**

Sue's recollection of school was representative of many. School, and associated issues surrounding education and lack of opportunity, was a significant source of childhood unhappiness, and often extreme distress. Not one life history contained dominantly positive images of school.

From very early in life, many participants in my study realised that they were gendered beings, and school was one of the important places which reinforced this message. The kind of gendered and social biases which school often endorsed was frequently embedded within the hidden and unconscious dimensions of education. Termed 'the hidden curriculum', it is from within the informal curriculum that gender subordination is most effectively perpetuated (Clarricoates 1987; Thorne 1993). Previous research has noted that the pervasive expectations of many schools, teachers and parents for girls' education still focuses on stereotypical and traditional gender roles which prescribe standards and future potential (Cockburn 1991; Measer and Sikes 1992; Tweedie 1993). Such expectations appeared to have affected several participants in my study, who became aware early in their school days that academic or career achievement should be sacrificed by girls:

School was awful ... mostly because of feeling hopeless about how I was held back ... you see, I was naturally quite clever. I had no encouragement from my family, or the teachers, but I passed my 11 plus. I was so proud! But my father said he would never waste money for bus fares or uniform on a girl, so I had to go to the local secondary modern. It didn't seem to be worth trying, if you were a girl. We were brought up to leave school as soon as possible, get a boyfriend and an unskilled job, then get married, and have children. That's how it was. It just makes me so mad to think that I was stopped from making something of my life. But honestly, I had the brains to do so much more ...
(Maggie)

The contention that girls are socialised to regard marriage, childbearing and caring for family as their main career in life has continued to receive wide academic support over the past three decades (Sharpe 1976; Rich 1987; Delphy 1992; Finch 1996). Such contentions were frequently supported in participants' narratives. For many, being a girl certainly meant being expected to leave school as soon as possible, whatever her educational potential or aspirations:

I didn't get much of an education at all and I hated it. Girls were expected to leave school at 14, and settle down with a boy as soon as they could, we never took any exams or anything. There was no point in trying at school, no encouragement - there was no getting out of how your future would be. We were all the same, even the girls who were quite brainy never really did anything with their lives where I was from. Their biggest expectation was to find a kind, reliable man to support them.
(Mary)

Consistently, feminists have argued that girls are socially disadvantaged in the prevailing social and education system (Rich 1980; Segal 1987; Richardson 1996); it is also there they learn subordinate roles, and are expected to accept dominant ideologies of femininity, masculinity and heterosexuality. Wendy's experiences endorsed such claims:

I was a tomboy. I liked playing football, climbing trees ... doing all the things which girls weren't meant to! I was always being told to behave more like a girl, not a boy! One day our teacher asked us what we wanted to be when we grew up. One girl said " Be a Mummy, have a husband and babies." The teacher said, " That's right. Very good." I thought it was revolting and I said I wanted to be a mechanic and not get married or have babies, and the teacher said, "Oh, I don't think so, Wendy." So that was me told! I never had any encouragement at school at all, at home Father told me I was a stupid girl, as thick as wood, a moron. I believed him, because what he said was the law. I ended up just as he said - a real dunce, bottom of the class, stupid. I've learnt so much from books as I've got older and I love learning, but I think it's all come too late to make any difference now.
(Wendy)

(Some time after giving her narrative, Wendy, now in her early 50's, informed me that she had finally achieved her lifelong ambition, and had gained grade A's in English and History GCSEs. She is now studying A levels.)

The educational careers and achievements of all participants were very varied, ranging from one failing to complete her school education, several leaving at 14 or 15 with no formal qualifications, some gaining GCSEs and A levels, and four carrying on to successfully study degrees in English, Psychology, Social Studies and Medicine. All women, whatever their eventual level of achievement, felt some amount of dissatisfaction and frustration that they had not been supported to reach their full scholarly potential. Negative influences often included the perceived attitudes of parents and teachers, whom they felt invariably reflected a strong gender bias about the importance of education for girls. Such frustrations about aspects of their education was extremely high, and raised many insightful reflections about gender based inequality. Jane reflected on such missed educational opportunities. She highlighted both the limitations of gender stereotyping and social roles, plus, for her, the inequality of opportunity based on social class:

I left school with nothing, but I still had an ambition to better myself ... I knew I'd not done myself justice. I plucked up the courage to go to evening classes and I ended up being directed into the embroidery and cookery classes, with all the other women like me. I didn't argue, I didn't have the confidence to say I wanted to do English and Maths and get some knowledge that might get me off the shop floor! Those classes were for the men, or for the middle class type women, not me. So I did the domestic classes and hated them, not something I'd have loved, like English Literature. My life's been full of lost opportunities - it's no ones fault, it's just the way it was for a working class, plain, shy girl.
(Jane)

Restricted opportunities at school, based on gender role expectation, also affected Jean, Mary and Joan, because, as daughters, they were expected to take over the burden of domestic responsibilities as a result of maternal illness or death. Role reversal, where daughters rather than sons are exploited within the home, has been highlighted in other studies concerning the gendered nature of childhood and adolescence (Bifulco and Moran 1998):

When I was 12 I had to stop at home for over a year to look after the rest of the family. Once the school board man came, but I told him I was too busy to be bothered with him. Dad was on shifts and I had to cook three loads of dinners a day for everyone. Cooked, ironed, fed the baby ... Mum had to lie down quite a bit. So there was no time for school for me.
(Jean)

Bullying at school, both by peers and teachers, was another frequently expressed distressing memory. The consequences of such oppressions were expressed in descriptions of loneliness, fear and desperation:

School was a complete nightmare ... feeling so frightened all the time. I

couldn't concentrate, or learn much, because I was frozen with fear all the time. I felt so self conscious ... my hand-me-down clothes looked stupid. I had no friends, no one wanted to play with me. I was bullied really badly, you know. I think they felt above me ... well, I felt beneath them. The bullying was awful, physical and mental .... I was so withdrawn and scared that the teachers must have known I was upset, but for some of them that just made me an easier target for them to pick on me too.
(Jane)

Jill described how physical assault by several teachers at school mirrored her expectations of much adult behaviour towards her. Although an intelligent young woman, her bad memories have prevented her from seeking further educational opportunities, and have shaped many of her enduring beliefs about her own inferiority and authority figures, which were to influence her later reluctance to seek help from professionals for her alcohol misuse:

The teachers were worse to handle than the kids. Some of them were so nasty, but you had no way of getting equal with them. I got some real cracks from teachers. One day, one hit me across the head with a board rubber, it really hurt, and I just snapped. I'd already had enough of being hit at home. So I stood up and hit him back. I was thrown out of school for hitting a teacher ... it didn't matter that he'd hit me first. I was just pleased to get away from it all, but leaving with no CSE's or anything did hold me back from going for some jobs in the future ... suppose I could have done night school or something, but I couldn't have stood being treated like that again. They just look down on people like me, teachers do. Because you haven't got all the right answers all the time ... just like Probation Officers and Doctors - I try to keep well away!
(Jill)

The women who had achieved well academically often still expressed negative feelings surrounding school and their education. Lack of friends and isolation characteristically contributed

to their memories of unhappiness:

> **I did well at school, but I hated every minute of it. It was the social side, not the school work. I desperately wanted friends, but I was just too shy to make any. I tried buying friendships for a while, by giving other children sweets and presents, but that ended up with me being very badly bullied by the rougher children. No one really ever wanted to be friends with me.**
> **(Sue)**

It has been suggested that women alcoholics may be friendless as children (Gomberg and Lisansky 1984) and this was a strong recollection in many of the narratives. Claire reflected on such isolation caused by feeling friendless at school. Her educational achievements, which were many, could not compensate for the negative effects of bullying and feeling isolated from her peer group:

> **I was good at all the academic work, but generally unhappy at school. I was plump, you see. Not fat, just a bit plump, and so I got the nickname 'fatty', and that was used to humiliate me for years. I longed to be thin, so no one could call me that name. I had no friends and was very, very lonely. They only stopped calling me fatty when I got a boyfriend at about 17, and I'd been slim for over two years by then! But it was only by achieving the status of being some boy's girlfriend that I was accepted, and the bullying stopped. Of course it was too late by then, my self image was shattered, and that's been hard to ever get back ...**
> **(Claire)**

Family Life

Enduring parental conflict has been identified as being a risk factor for various psychological adult disorders, and occasionally has been linked to possible later drinking

problems for women (Jenkins and Smith 1991). Most women in my study witnessed damaging, sometimes extremely traumatic, hostility between their parents and siblings; ranging from withdrawn interpersonal communications, to open, ongoing arguments, and regular physical and/or sexual violence. However, most also reported having had positive relationships, particularly with their mothers, although this often caused them additional conflict if the mother was also being subjected to domestic violence.

The children who had witnessed violence between parents saw the misuse of power within supposedly trusted, loving relationships. They were exposed to growing fear and confusion, as the adults on whom they depended, could not be depended upon. These memories remained dominant and influential:

> **Dad was always fighting with Mum. Things being thrown across the room, fists flying and the constant shouting.... they are what I remember most.. There must have been loving times between them too, but I can't remember many.**
> **(Joan)**

For Alex, violence between her parents was a frightening memory, matched only by her abuse from an older brother:

> **Life with my family? It was emotionally cold, and very lonely. Nearly all of what I can remember is about my parents fighting. I'd lay in bed, crying, frightened, listening to those fights. My older brother was the one who beat me, though. He loved scaring me and seeing me hurt. It made my early years unbearable sometimes. Mum and Dad beating each other up, him knocking hell out of me.**
> **(Alex)**

Retrospective self reports of the early family experiences of women alcoholics have frequently described parental relationships, especially with mothers, in negative terms (Williams and

Klerman 1984; Gomberg and Nirenberg 1993; Spak et al. 1997). Mothers have been pictured as being emotionally distant, difficult to please, dominant and strict, while fathers are often remembered as being emotionally warmer (Lindbeck 1972; Long and Mullen 1994). Yet childhood relationships with mothers of those in my study were defined in quite different terms; generally good, nurturing and protective. Not one life story carried strongly negative memories of mothers. My findings may support allegations about the reliability of the substantial prevalence for women and mother blaming in many previous studies (referred to in my literature review).

Joan's memories of her mother represented the views of many:

> **My mother was the kindest person, the best friend I could have had, she was wonderful to me in every way she could. Without her I would have been completely lost. She was the only dependable person for me as I grew up. She's been dead all these years, but I still talk to her every day in my thoughts, she's still a real support to me. I just feel grateful to have known her and loved her so much.**
> **(Joan)**

There were, however, examples of girls feeling undue responsibility when trying to protect their mothers from domestic violence. Additionally, some mother/daughter relationships reflected an over protective, almost stifling bond of affection, or with gender role expectations of the female child forcing her to take a care-taking parental role in the family when a mother was unable or unwilling to carry out this expected function:

> **From the earliest times I saw him beating hell out of her. If he started on her I'd try and stop him, but then I'd get hit and she'd be even more upset. She had a terrible life, and I wish I could have done more to protect her. She had to stick with him until all of it finally killed her. Then I had to take over, I think it's what she'd have wanted. I was a sort of second mum to them all ... it was such hard work, and I suppose it meant I missed out on some of the childhood I**

might have had.
(Mary)

Feeling guilt about not living up to expectations of mothers was expressed, often associated with the heavy burden of emotional distress which was inappropriately shared by some mothers with their young daughters. This frequently invoked shame and guilt for failing to give back sufficient support to mothers:

> **Mother was the most important person in my life, and most of the time I loved her very much. Maybe she did suffocate me ... had unreasonable expectations of me too. She said I was all she had. It was sometimes all too much ... especially the way she used to confide in me about how my father treated her. So a lot of my love for her got very tied up with resentment, guilt too ... I don't know whether that was her doing or mine, but it did leave me feeling that I could never be good enough for anyone who cared for me.**
> **(Violet)**

> **I had to be an emotional brick for my mother from a very early age. She saw me more of a friend, an equal, than a daughter ... she poured out her problems to me, because I was the girl, she said. I tried to be understanding ... I felt so sorry for her, the sad pathetic life she tolerated from him ... but it's much easier for me to look back on the hatred I had for Father, than to remember the pity, and sometimes contempt, I felt for her. That brings up a lot of guilt.**
> **(Maggie)**

Hostile, malevolent and intimidating relationships with fathers were frequently mentioned. These caused distress, and also associated feelings of helplessness and frustration, because any protest raised against unfair treatment was so often viewed as insolence, punished further or ignored. Many were told, especially by their fathers, that they were stupid, useless, good for nothing. As these girls grew up they shared feelings of inadequacy, under-confidence and lack of self-dignity, self concepts which they frequently associated with their later need to misuse

alcohol.

Some learned that whatever they did to try to please, they could never expect their fathers' love, only their constant condemnation and criticism. Wendy located the source of her father's anger to his resentment and disappointment that he did not have sons. Throughout her life she endured verbal assaults and humiliation from her father which crushed her sense of self-worth:

> **He always said the main problem in his life was that he had three girls and not three boys. Girls were no use to anyone, he said, and he openly hated us for being girls ... especially me. He used to introduce me as: "This is Wendy, if she'd been a boy she would have been called Michael." That's how badly he felt about me. We were hated from the word go because we weren't sons, and I still feel second best, a disappointment.**
> **(Wendy)**

Differential treatment of sons was described in many ways. For Jean, Maggie, Alex and Jill male siblings were given superior family roles, and were disciplined more liberally their sisters. Mary recalled how her brothers were allocated more food and material comforts. Frances felt blamed and hated by her father because of her intellectual superiority over her brothers. Despite constantly high achievements, her father's disparaging remarks guaranteed that she could never feel full pride in her achievements. A sense of failure stayed with her in later life, where she was constantly haunted by self-criticism:

> **I could never be good enough, simply because I was a girl. That remained with me ... could I ever be good enough? Father thought women were weak and should be submissive. Being an intelligent girl who was much cleverer than my brothers was unexplainable in my fathers mind, and he never forgave me for it. He resented all the qualities in me which he could have been proud of, because they overshadowed his boys.**
> **(Frances)**

Frances progressed to medical school and qualified as a doctor, but still was not spared the derision of her father, also a doctor:

> **It hurt terribly when he belittled what I achieved at school, and later in my profession. My mother encouraged me as much as she could, but she was very dominated by my father. When I got a place at medical college, Father could hardly bare to congratulate me. When I eventually qualified as a doctor he said, "Stick in and you'll become a reasonable GP, or even a psychiatrist. You've always been a bit of a neurotic, so psychiatry will probably be your best bet."**
> **(Frances)**

Wendy remained bewildered about why her father should have been so cruel to her. Her guilt for in some way deserving the hatred, for being unlovable, was an enduring concern, which has continued into her adulthood:

> **Father ruled the family, and he was the cruellest man you could imagine. He hit us all the time. I don't know why he was like that, we really didn't deserve it. So why did he do that to us? Occasionally Mum would sneak us a quick cuddle, but never if he was around. When he was there she had to be only for his needs. We were all too terrified to show any emotions, so we grew up not showing love, even to each other. I grew up believing that I was unloved and completely unlovable. I still feel that way about myself, that I don't deserve love from anyone. It's been instilled into me ... but why did he hate me so much ...**
> **(Wendy)**

The physical and emotional abuse from fathers was sometimes, but not always, exacted by the fathers who had also sexually abused their daughters. Jean explained the effect non-sexual abuse had on her self image, and on her developing beliefs about gender inequality. As with Wendy, she is also left with the additional betrayal of not being able to understand the reasons for her father's behaviour:

He used the leather belt. Yes, it bloody hurt ... but it didn't knock us into shape or make us perfect ... just gave me a huge inferiority complex for not ever being good enough. He made it clear he didn't want me - but I never really knew why. I got so many good hidings from so many people that I think I just got used to them. I thought they were normal, or deserved, or something. The worst were from the boys and my Dad. Always the scary, awful ones from them. You see ... how can I put it ... men were Gods, and to be feared! They were always the bosses, always.
(Jean)

For Jill, the fear she felt about her father was magnified by the potential threat of his physical strength. She felt helpless and frustrated, yet resigned to the fact that what ever she did to try to please she would be victimised:

I was terrified of him. I'd cry when he hit me, through fear and anger more than pain. Then he'd hit me for crying ... I just couldn't ever do anything right for him.
(Jill)

Although lifestories regularly included conflict in relationships with significant family members, usually fathers, two participants also described times of important companionship with fathers, even if these paternal relationships were otherwise inconsistent. Although Anne's relationship with her father, reflected in other parts of her narrative, featured strong elements of control, she also was able to recall very positive images:

I was the boy substitute for father for a long time while the boys were babies and with their Governess. I'd stand for hours in the woods watching him shoot pigeons, go to Point To Point with him, all that sort of stuff. We got to be best friends when I was about 15, and it's remained that way ever since ...

mostly he's been a lovely Dad.
(Anne)

Similarly, Sue spoke with much warmth about the very positive relationships she had with both her parents, although she felt that this very dependent relationship may have contributed to isolation and her lack of social confidence:

> **Actually my family life was very happy indeed. It was the world outside that was frightening. My parents showed me nothing but unconditional love and caring, they still do, even though I've caused them so much worry over the years. I felt completely secure with them - almost too secure, if you see what I mean. When you are so loved and wanted, the outside world can appear very threatening ... I think I became frightened to face the world away from the security of my Dad and Mum. That left me insecure ... unhappy.**
> **(Sue)**

More Punishment

Christianity, as a religious phenomenon, has been critiqued as being a traditional site of women's oppression (Sawyer 1996; Anderson 1997). Religion can be an insidiously powerful influence on girls and women, because it exerts and creates controls on their behaviour and self-perception. Although religion can be a great source of comfort and motivation, the perceptions of some participants indicated that it can additionally inhibit and induce great fear, especially amongst girls whose lives lack safety and support. For Jean, and several others, God was an unforgiving, punitive, frightening image:

> **God was a tyrant who waved his big stick....**
> **(Jean).**

Many restrictive effects of Christianity for women were articulated by feminist philosopher

Mary Daly in 1973, when she challenged sexist belief systems about proper gender roles and female duties, and obedience and passivity towards men and God (Daly 1973). Since then, women's subordination through religion has been further explored, usually through its functioning of moral standards and sanctions which exert a strong controlling influence on lives and beliefs. Most established religions have been criticised for projecting a negative identity for women, and for endorsing male values and superiority (Hampson 1990; Sawyer 1996, Anderson 1997). The effects of Christianity, especially Roman Catholicism, and the fear and punishment surrounding religious doctrine, caused significant distress in the young lives of several women in my research. The socialisation of many was highly influenced by religion and God fearing, often used by adults to instil discipline in children at home and at school.

Brought up in a strict Irish Catholic community, Mary remembered her religious upbringing as being oppressive and patriarchal:

> **Being an Irish Catholic girl instils a lot of things. When I was young everything revolved round the Priest. He was God and you feared him terrible. He stood in that pulpit and shouted and judged, told you what was right or wrong, and we all believed him. He had more influence than any policeman. He kept a big flat stick and he'd come round church and crack all the kids who had no money for the poor box. Well, we rarely had any ... we were so poor it was us who needed the poor box collection! Oh, it was so belittling, I got some awful bad bruises from him, and in front of the whole congregation too. Lots of dreadful things happened because of religion ... the Priest put it all into action. He ruled, his word was the law, no other rules counted ... and the ones I remember most are those telling us how bad and wicked girls and women are. You grow up feeling guilty, even if you don't know what about. It's a bit like being brainwashed ... but I still pray to the Holy Father every night and say my rosary, I wouldn't dare not to ...**
> **(Mary)**

There has been very little reference to the impact of religion in the lives of women with drinking problems, although one early study drew attention to the significance of religion in some alcoholic women's lives, especially those religions which accentuate judgement and punishment (Jones 1971). This theme of fear of God and waiting for punishment for real and imagined wickedness were Maggie's prevailing memories:

> **Religion was very, very important in my childhood. It remains ... that awful fear of God, and what he might do to me. As a girl my life had routines around being good for God ... pray at a certain time, or else ... keep pennies for the church collection, or else. Oh, so many things, all because of the fear of God, not pleasing him, and what he would do to me if I got it wrong. God was the final judge on my badness. I was told he could even read my thoughts. Whatever was going on in my life, the main fear was how God would punish me for it. Someday, somehow, God would get me for all my terrible sins. He was rather like my father, but worse, because God could constantly watch me, he knew all my bad thoughts, and there was no way of hiding from him.**
>
> **(Maggie)**

Punishment and self-denigration were also remembered by Alex, who was sent to a Catholic boarding school when her parents found her behaviour at home too rebellious:

> **Religion gave me something to hang on to, belong to, but mostly it gave me something to punish myself with. It confirmed that I was a bad person, and would be judged as that by God. It fitted in well with how much I loathed myself. Isn't that what a lot of religion is about ... feeling bad, feeling punished and put down?**
>
> **(Alex)**

In contrast to the experiences expressed by several participants, two more recent studies by Prescott (1997) and Dixon (1997) have both suggested that a history of Christian religious affiliation is associated with fewer drinking problems for women. Certainly, religious

association later in life proved to be positive emotional and social supports for Jean and Wendy. However, participants' recollections of church and organised religion during childhood invariably emphasised a punitive, intolerant and puritanical culture which induced elements of self-denial and self-mortification, so often revisited when these women experienced stress and problems later in life.

Violet's views of the potential negative effects of insular religious codes for women who develop problems with alcohol were resolute:

> **You can only understand if you've been there ... like being an alcoholic ... but religious doctrine can be really dangerous to a young, open mind. The fear it brings far outweighs the good. You see yourself as evil, not a little innocent child. And once you've felt that fear of God, I don't think you can ever lose it, however much you might like to pretend that you know better now. The self disgust and the awful fear of punishment fits in well with the alcoholic personality. A good partnership. That's probably why AA use it so successfully ... and why I couldn't fit in with AA!**
> **(Violet)**

Feeling Different From Others

Alongside all the expressed experiences of unhappiness and exclusion within education, in family groups, peer groups and in communities, were other examples of participants' loneliness and social isolation. Many negative early experiences undoubtedly exacerbated loneliness, but an additional, common perception emerged from life stories, beyond just feeling friendless and lonely. Specifically, there was a strongly expressed belief of 'feeling different' from others, of being extremely distanced from the rest of society. In fact, for some, this became a most disturbing and hopeless childhood unerring belief of personal failure in life, which usually developed into similar self-perceptions in adulthood:

I just always felt so odd, different from the other kids. I couldn't fit into the world at all ... like there was no place for someone as strange as me. I didn't know what it was like to feel close to another kid, so I probably didn't miss them. Don't think I did as I got older either ... I always knew I only could count on myself. That's how I've always been ... different
(Jill)

Early research has shown that women alcoholics reported increased feelings of social isolation in childhood, of being more friendless and shy (Jones 1971; Goodwin et al. 1977). Women have also been reported to use alcohol to combat the negative feelings of enduring loneliness (Annis and Liban 1980; Long and Mullen 1994). Within life histories in my study these perceptions have been verified and widened. For, encapsulated in the strong belief about feeling different, these women usually reported feeling unworthy of friendship. Peers were superior, never equals; other children were more likeable, more popular, more deserving of friendship and acceptance:

I was very unpopular, always on my own, and I hated it. But whatever I tried to do I couldn't change myself to be more, well likeable ... I was so different from everyone else, withdrawn into myself. The kids used to call me 'weirdo'. My earliest feelings were about desperately not wanting to be me, hating who I was. I wasn't a nice child, you know ... not endearing or attractive in any way. Not loveable ... a sort of inadequate misfit, I still feel a bit like that, it's what I grew up believing about myself.
(Alex)

Feeling a failure, thinking that she was constantly letting others down, not living up to expectations, and generally feeling inferior to others were strong self-concepts during Violet's upbringing:

My childhood and teenage times were so much to do with feeling different. I just knew I was always so very unlike other young people. Of course, most teenagers feel different, or special, but this was much more so ... relationships,

mixing, well life itself, was really difficult. I never seemed to live up to how I thought I should be, or what I thought people expected me to be. I felt odd, and that I was a failure ... yes, my younger life was very grim. There's still lots of guilt and unresolved issues for me about not feeling part of life ... of being like a fish out of water ... I've heard lots of other women alcoholics say the same. (Violet)

Family environments were often connected with feeling and being different from other children. Some parents would discourage their daughters from having friends because of parental disinterest or hostility. However, Sue and Claire both spoke of how their caring, if over protective parents, may have influenced their perceptions about feeling different from other children:

It was a struggle, growing up feeling so unpopular, such a social failure. All I wanted was to feel part of what was going on, to feel included. But I was so distant and different from children of my age. Even my parents thought I was different, well better, than other children, I think. I was never encouraged to bring people home ... just to stay apart. It was odd, I just never fit in. It was lonely ... it still is. I've never been able to shake it off. I am different. (Sue)

Claire's parents were in their mid-forties when she was born. Fiercely determined that their only child would break free of their working class roots, they discouraged Claire from socialising with children in their neighbourhood:

We lived a very isolated existence. I hardly met any other children, I didn't know how to mix. I used to cry and cry and feel terribly miserable. I was still very lonely until I left home at 18. I felt like an alien, you know. I just didn't know how to be a child like the rest. My parents never suggested I should have friends - I honestly believe they thought no one was suitable. We didn't have much money or status, but they had real ambition for me, they thought I

was very special. But I didn't feel at all special ... just different and peculiar. (Claire)

Feeling different was also expressed within practical constraints, such as living with poverty. Several women commented on the humiliation of feeling materially different from peers, and this was often compounded by associated bullying. Lack of material possessions and comfort also led to a complex sense of personal guilt about the disloyalty of feeling ashamed of home and family:

We were very poor. I was picked on a lot because all the other children had more than me, because I looked different. I could never have invited someone home ... I felt too ashamed of having no carpets, no decent furniture. I shouldn't have done that because Mum did the best she could. I suppose I was ungrateful. Anyway, why, I don't know, but I always felt odd, in lots of ways, unlike other children - I can't explain exactly how, but that was the very strong feeling I had.
(Joan)

Lack of food, clothing, hygiene and education have sometimes been linked to the kind of childhood experiences of poverty for women who may develop drinking problems (Reed 1991). However, not all who encountered this kind of neglect in my study lived in materially deprived circumstances. In some instances, income was adequate, but poverty was imposed for other reasons. Maggie's father was a Sergeant Major in the Army, who refused to allow his wife sufficient money for housekeeping, resulting in inadequate clothing for school and a general lack of any extra comforts. Like several of the narratives, Maggie's story outlines how she felt her mother tried her best to provide for the family, but that her position of subordination within marriage affected all in the family group:

She did what she could, I'm sure she did. But a mother's affection doesn't buy you the latest pop record, or help you feel as good as the rest in your class. I was humiliated by the ugly clothes I had to wear, by looking so different all the time. I just wanted to merge into the crowd, not stand out.

Father was well paid, we should have had plenty of money, but he used money for control of mother. She had to have sex with him whenever she wanted extra money for clothes or shoes for us ... she had to sell sex to her husband. That's how she had to live, the responsibility of getting things for us ... but what a price to pay ... it was wicked.
(Maggie)

Similarly, Mary's father was also in secure employment, but kept the rest of the family living in dreadful poverty:

Oh dear, those times were very, very hard, because he always kept mother so short of money. He really liked to see us all struggling, or hungry, while he would go and buy himself some fish and chips! Where we lived, most families were poor, but we were the worst of any of them. I stood out ... it made me keep myself to myself, be a loner.
(Mary)

Family poverty caused by long term unemployment was not present in any of the narratives, and, surprisingly, in view of previous research findings to the contrary (Bifulco and Moran 1998), only one participant suggested that financial insecurity and hardship may have been contributed to because of paternal drinking:

In some ways family life was all right ... we managed okay together really, inside the home. The constant problem was having no money, Dad used to gamble a bit too ... I was so self-conscious. I always looked different, my clothes were old and worn or the wrong size - any hand me down that might fit. The other children were really cruel about me being poor, some teachers too, one called me ' Janey Hillbilly' ... I was always the poorest in the class and no one wanted to be seen with me. I lived in a kind of daze, I didn't function properly at all. I was so different from the children I met, I couldn't fit in anywhere.

(Jane)

Jane's life narrative endorsed that it was often the discrimination received from others, especially childhood peers, which created destructive and humiliating situations, rather than necessarily the immediate practical or emotional effects of family poverty. Within family groups, financial hardship often was managed with great resistance and resourcefulness. Children experiencing poverty did not enjoy their deprivation, but some spoke of a subsequent need to form alliances, closeness and bonding with members of their family, which to some extent may have compensated for some material disadvantages. Yet poverty, harshly judged by others, marginalised and excluded; this undoubtedly intensified feelings of being different, being disliked and failing mainstream expectations.

Discussion: Alcohol Misuse And Unhappiness In Childhood

There is an acknowledged lack of longitudinal work which has analysed the long term influences of childhood on women's drinking behaviour (Wilsnack et al. 1998). However, the literature which is available concerning the early backgrounds of female alcoholics regularly highlights areas which have not been supported by life stories in my study. Previous studies have often focussed on familial transmission of alcoholism, suggesting that daughters are likely to be heavier drinkers if a parent, especially the mother, is alcoholic (Blume 1992; Kendler et al. 1992; Turnbull 1994). However, participants in my study do not lend support to such claims. Evidence of maternal drinking was rare; only one participant spoke of occasionally suspecting that her mother may have secretly drunk. Several others recalled their mothers being teetotal. The only regular drinking was among some fathers, yet even this was recorded as not being especially heavy or problematic.

The associated use of alcohol by physically abusive fathers and mothers has also been noted in research (Crewdson 1988; Reed 1991) . Although some paternal drinking bouts were linked to violence and aggression by my research participants, this was uncommon. Maternal physical

abuse did not feature in any narrative. The alleged strongly negative view of parents by alcoholic women, another consistent theme in literature, again often assumes the mother as being most negatively perceived (Gomberg and Nirenburg, 1993). This was challenged by evidence from the narratives, although poor relationships with fathers were frequent.

For children already enduring dysfunctional or unhappy family situations, the result of lost educational opportunities because of gender based inequalities represented long-term loss of power and potential, with much associated bitterness and frustration. Yet there is a paucity of empirical work to underpin my findings that negative school and educational experiences could have had lasting effects on women with drinking problems, especially affecting personal feelings of failure and social disengagement.

The impact of the patriarchal elements of Christian doctrine, and the fear and shame which were parallel experiences for so many who had strict religious influences, has also been absent from work on women with alcohol problems.

Happiness is a subjectively felt emotion. The determinants of what experiences were considered unhappy in childhood were defined by the participants themselves, who, through their narratives, described experiences of deprivation, ill-treatment, neglect and general unhappiness which they found painful and unacceptable within their childhood domains. These were often recounted with very detailed recall, embracing a wide diversity of experience. However, there were adequate indications within narratives to endorse that negative childhood experiences were perceived by participants as being likely to have had a persistent effect on their later lives. Such a view is supported in research by Humm (1998) who found that girlhood experiences are central to women's adult lives; that women ' *use the tension of childhood experiences as the basis of their adult analysis'* (Humm, 1998: 43-4). The collected analyses which emerged from the life stories showed many childhood and teenage years as having been de-stabilised by abuse, neglect, erratic or poor parenting, particularly by fathers; and by unhappy school experiences, and victimisation and isolation. These women remembered feeling unloved and unlovable as children, disengaged and different from others. The kinds of insidious, unrelenting types of mistreatment they often

talked of would usually have remained unnoticed by the outside world, and a sense of hopelessness and futility inhabited many young lives. Central to all these key areas explored from childhood were, for some, the additional influences of social class and poverty.

Childhoods were generally remembered as times of missed opportunities, rejection and disapproval. Participants knew that the potential within them as children had often been crushed or limited, that the expected possibility of a carefree, happy childhood had been denied. As their resentment and negative feelings in childhood often could not be expressed safely within their disfunctioning family or oppressive social environments, many women appeared to feel powerless to move out of the rigid gender role expectations and oppression which had shaped their earlier lives. Their anger, resentment and regret also seemed to have resulted in much self-reproach and mistrust of others. The pressure to conform and accept was overwhelming for several participants, yet the cost of having to adhere to these frequently oppressive experiences and expectations may have later prompted their reliance on alcohol, which helped to numb the pain of memories of much powerlessness, lack of freedom and limited personal choice in their lives.

Maggie's comments offer insight into the sense of injustice and betrayal felt by several participants who had been denied a carefree, happy childhood. Additionally, the opportunity to openly express some of her distressing early experiences appears to have enabled Maggie to move towards an emerging analysis of the powerlessness of her position as a child. This offered a vision of a new understanding which would help her reframe her self-blame to the more positive resolution that she did deserve more, and that she has the right to have expected that:

> **After talking to you last week about my childhood, it's beginning to make more sense now. You see, up to now I've always thought what a wicked, terrible girl I was. But now I can see that I was a victim as well. So many people let me down, and did I really deserve all that? ... On Saturday I sat in this chair and broke down and sobbed and sobbed for that little child, that poor little darling ... how could I have blamed her for so much?**

(Maggie)

In conclusion, it is important to note that although participants were often brought up within environments which were hostile and denegratory, there was much evidence of remarkable personal resilience and courage by these girls. Their determination and ability to cope with, and to learn from, the most difficult of circumstances would resurface many times in their future lives. The contexts of their early lives may suggest not only the underlying causes of some later alcohol problems, but also some of the origins of the many personal resources these women were able to draw on when they decided to stop misusing alcohol in their adulthood.

Chapter Six

Marriage & Heterosexual Relationships: *Equal Partnerships?*

Experiences of marriage or heterosexual cohabitation had been shared by all women in my study. Some rejected this model at certain stages in their lives, and in between there were differing degrees of conformity, which reflected the great diversity in the way women choose to have relationships. However, even the women who were later to reject heterosexuality, had experienced relationships with men. Living with men caused conflict for many participants, and this chapter will explore some of the relationship difficulties which featured most commonly across the life histories, and consider some possible consequences of these on drinking behaviours.

Marriage, as has been outlined previously, is one of the social norms of western society. To be successfully married is to acquire social status for many women, who tend to still be defined by their relationships with others, with men in particular (Stoppard 2000). The status they achieve by caring for men and children is said to remain a major contributor to self-esteem in women (Williams 1987). Yet the institution of marriage, and the nuclear family, have also been strongly criticised as being primary conditions of patriarchy, encouraging gender hierarchy and the exploitation of women (Delphy and Leonard 1992; Rowland and Klein 1996).

Women marry or cohabit for many reasons. The effects of socialisation, the ideology of living appropriate gender roles, economic security, the wish for lifelong companionship, having children and gaining independence from parents, are among the numerous influences which may make made marriage an attractive option. Hope for a better future also featured for many in my study.

Hope For The Future

> **I used to joke about marriage with my friends when I was a kid ... We called it the great escape - after the film, I suppose ... tunnelling to freedom and romance. We saw it as some exciting thing that would bring us freedom and happiness in the future. Well, it might be that for some. For me it turned out to be far from great, and it certainly wasn't an escape.**
> **(Sue)**

Many participants, like Sue, had anticipated the passage from teenage to adulthood as a chance to build a happier, more self determined life with a compatible life partner. Marriage was seen as the obvious vehicle to accelerate the journey from living at home to the attractive freedom of adulthood and independence. But contrary to individual hopes, frequently marriage became a site of dissatisfaction and inequality. The majority of participants in my study had been married, and their narratives suggested that being wives often placed them in oppressive, subordinate positions, reflecting ideologies of the family where women's roles are subordinated to serve the interests of male partners. Such unhappiness within marriage was termed 'the problem that has no name' by Betty Friedan (1963) early in the second wave of feminism, since then marriage has been regularly exposed as being an institution deemed most desirable by women, but that which often becomes the most disappointing (Stanley and Wise 1983b; Gittins 1985: Giddens 1993).

According to several women in my study, the crucial decision about choosing a life partner, which would have far reaching effects on future happiness, was often influenced by societal and family pressures. The interrelated pressures of gender socialisation and feeling unwanted and unattractive as a young woman, affected Jane's decision to marry. Within marriage, she experienced rigid gender role expectations which contributed to her dissatisfaction with the relationship:

> **I didn't think any man would want gawky old me. When I had the chance to get married I just jumped at it. I was so relieved ... there was hope for me at last! There was no lovely new life I'd dreamed of though. Soon I was working**

full time and trying to look after a baby and demanding husband. It was so hard to work all day, and then begin again every evening when I got home. He never helped at all, he sat there while I hoovered round him. He's very traditional, thinks all housework is only for women.
(Jane)

Pressure to marry came later in life for Frances:

I had always enjoyed being single, I liked the independence. But by the time I was in my late 30's everyone I knew was married; I was left out, in a way. I met another doctor, a widower, 22 years older than me. We got married, but I don't think either of us were really in love, we just needed some company. We stayed together for six years, we weren't really happy, and I knew I couldn't keep trying to fit into his lifestyle and expectations. The rules of marriage didn't suit me - I wanted friendship without the constraints ... an equal partnership, which is, of course, not possible.
(Frances)

For Frances, and several others who had long term relationships with men, the search for a 'companionate partnership' had been a major attraction. As other studies have shown, when anticipated friendship and companionship are not achieved, despair and isolation are frequent consequences for women (Finch and Summerfield 1991).

Marital Violence.

Violence in marriage is a powerful mechanism of control and fear which was experienced by several participants. This violence encompassed physical or sexual assault, but also included emotional and psychological behaviour designed to oppress and intimidate:

An unspoken war ... he'd spend days and days not speaking, just glaring at me

or grunting orders. I dreaded those moods ... he acted like he hated me, for no reason. If I said anything he'd hit the roof, so I kept quiet ... but it made my nerves so bad.
(Wendy)

In her first marriage, Maggie also described psychological, rather than physical abuse:

He didn't want me to have anything. I kept rabbits, they were my pets, my only friends, and I loved them. One day, for no reason, he went out and killed my favourite rabbit and brought it in and said I had to cook it for my dinner ... anything and everything I loved, he took from me.
(Maggie)

Such revengeful, psychological control is not uncommon within violent domestic relationships (Kelly 1988). Several studies have shown that within marital relationships, high levels of negative verbal or emotional interaction, or psychological violence, are strong predictors for problem drinking among women (Frieze and Schafner 1984; Kantor 1993) although alcohol treatment programmes insufficiently screen for such spousal violence (Miller 1998).

Various experiences of male violence often resulted in rejection and helplessness for the women who spoke of marital cruelty. Although many asked explicitly for help from a wide variety of professionals, this was rarely given. The helplessness of their situations was intensified by frustration, powerlessness and humiliation. Jean's experiences of trying to find help so she could leave her violent first husband were not unique:

People might say I had a choice - but I had no choice. Sometimes I was so frightened I'd call the police. They'd come and say they viewed 'domestic situations' as six of one and half a dozen of the other. They told him to behave himself, then they'd leave. As soon as they'd gone I got a worse hiding. I ended up worse off every single time ... Once I tried a Marriage Guidance counsellor who sat in silence while the kids drew pictures. He referred us to a

Probation Officer because of the eviction order hanging over us. " Thank God." I thought, "he'll do something." But John (husband) **- he was always good with words - said there wasn't a problem, that I'd over-reacted. The Probation Officer went off and we never heard from him again - I mean, he didn't even say quietly to me " come and see me on your own if you need to". Oh no, John had said there were no problems, so that was it. Despair and hopelessness all over again ... I don't suppose they know what it does to you, every time being knocked back further and further. Experience soon taught me there'd be no help.**
(Jean)

With two young children, and no social or financial supports, Maggie was also subjected to physical violence from her second husband. She did not know who to go to for help, any avenue she tried failed her:

You soon find no one wants to know. I was at my wits' end ... I went to the GP, and he told the 'social.' So eventually a social worker appears, all smiles and friendly at first. He said " right at the start I'll explain there's nothing I can do unless the children are in danger. Has he hit them?" I said, 'not yet, I try to keep them out of the way' ... so that was it . He wasn't interested in helping me at all. He stayed an hour, drank my coffee, and told me all about domestic violence. Things will only change if YOU want them to, he said. I could have killed him. But I was just so ill, so tired that I just said 'Thank you for coming'. I never heard back from him, and I never asked for help again. You soon learn ...
(Maggie)

Maggie's experiences with statutory welfare services reflected the view that some practitioners see working with adult victims of domestic violence as peripheral to their statutory work duties, and additionally endorses unenlightened woman-blaming attitudes (Mullender 1996). Such attitudes are likely to compound isolation and secrecy. Yet, contrary to the myth that many

battered women will suffer in silence, or do not want to try to find outside assistance, literature has consistently documented how little help assaulted women often receive from the welfare and medical professionals they do contact (Dobash et al. 1985; Abrahams 1994; Davison 1997). Other difficulties for women who try to leave violent men have also been documented (Pahl 1985; Mullender 1996). Apart from obvious factors like child care and housing, economic, social, ideological and legal systems can all act as disincentives for women to escape violent partners.

Jean's story is illustrative. She was desperate to find temporary escape from her violent husband, and pleaded for refuge at a psychiatric hospital . Evidence suggests this may not be an uncommon method of seeking safety ; psychiatric in-patient facilities have been shown to have consistently high rates of female in-patients who report a recent history of physical abuse from spouses (Warshaw 1989; Lent 1991):

> **Begging to get into psychiatric hospital - 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. So that gave him another card to play against me ... whenever I tried to get help, it backfired ... I'm not surprised I just gave up - you do, you know - you just bloody give up**
> **(Jean)**

Like others in her position, when Jean felt she had unsuccessfully explored all other avenues to escape her domestic violence, she reluctantly turned to her family for help. But, as she suspected, the ideology which blames abused women for their own situations maintained that even her parents would refuse to help her:

> **When I went home, of course they saw my bruises, black eyes. I begged them to let me move back in with them for a while, to get away from him. They said I'd made my bed, so I'd have to lie in it ... well, Dad said that, Mum said nothing.**

(Jean)

Physically and mentally exhausted, Jean's final effort to try and find protection from constant physical, emotional and sexual abuse, was with the legal system:

> **I started divorce proceedings; another big mistake because he turned into an even bigger swine ... terrorised the girls, even threatened to kill one of them. The house was in his name, the only way he'd have it, and he refused to give it up. I tried for an Injunction Order and he broke in at midnight, raped me and left me injured. He collaborated, did some kind of deal with my solicitor, so I never did get the injunction. I felt totally powerless against them all. He even managed to get MY solicitor on his side. It was hopeless ... I lost any little fight I had. Totally defeated ... if he was going to kill me, so be it ...**
> **(Jean)**

And, because she felt so 'totally defeated', alcohol become Jean's only accessible means of protection against the physical and emotional pain she was forced to endure. It did not take away the experience, but to some extent she felt it protected her from the unrelenting anguish and pain of the marriage in which she seemed totally trapped.

Others talked of different obstacles which had prevented them escaping violent partners. For many, economic dependency in marriage was enforced when husbands kept control of the family finances; these women felt especially vulnerable and trapped when they needed to try and leave unsatisfactory relationships. Although already living in virtual poverty their eroded self worth often prevented them from believing that they may be better off leaving and living on welfare benefits, a frequent dilemma for abused women (Graham 1984b). However, Maggie's determination to try to escape her marriage, and her resourcefulness in managing to save small amounts from her meagre 'housekeeping', finally enabled her to leave:

> **Coldness, cruelty, other women, you name it ... but what can you do? I had two babies, no money, and no way out. After six long years I knew I was going mad. So I left, with two small children, and £80 I'd scrimped over three years**

from the housekeeping. I got two disgusting rented rooms and juggled two jobs. No support, no friends. It was hard, but I knew anything was better than going back to him.
(Maggie)

Even when Maggie did leave, her husband still viewed her as his possession, and viciously intimidated her:

He constantly bothered me, threatened, hounded me. He said I was his, and no other man could have me. He'd park his van outside my flat and wait. When I came down he refused to talk to me, but he'd point the barrel of his shot gun in my direction. I was convinced he would shoot me, but I was almost beyond caring ...
(Maggie)

Maggie continued to explain how her drinking increased markedly during this period when she believed that what ever she might do, she would never be able to completely escape from her ex-husband.

Others also spoke of the humiliation of financial dependency, and the determination with which they fought the poverty imposed by their partners. Without the economic resources to leave such relationships, they explained how they often put their own needs last to give their children basic comforts. They went without clothes or luxuries, sometimes even food. Other researchers have also noted how women are likely to put their own needs last when family money is limited (Abbott and Wallace 1990; Payne 1991):

Most weeks I didn't get any housekeeping, especially if he was in a bad mood. I'd go to the butchers and ask for free bones for the dog, which we didn't have. Then I'd stew the bones and we'd eat off them for a few days. In the summer I'd find nettles for soup, or look for wild fruit in the hedgerows. I'd manage to feed the kids somehow. And I made all our clothes ... I was proud, didn't want people to know how poor I was.

(Jean)

Sex As A Duty

The essential characteristics of sex within marriage have, according to Jackson (1994) largely been constructed around reflecting and promoting the sexual interests of men; consequently women's needs have been marginalised (Smith 1996). Within many life histories, sexual relationships, particularly with husbands, were described as unpleasant, problematic and sometimes violent. Reasons for unsatisfactory sexual relationships were varied, although common experiences were sometimes shared. Several participants mentioned that lack of sex education in childhood had contributed to sex being shrouded in mystery, being a bad thing for a young woman to do:

> **Sex was all hush, hush. Taboo. All my mother told me was that I nice girls never let a boy touch them above the knees. You'll not believe this, but for years I thought a girl got pregnant from her knees! But I wasn't any different from most of the other girls. You just weren't told about sex.**
> **(Mary)**

> **I was a virgin when we married, I knew very little about sex. It was just all shrouded in mystery - but there was a strong message that it was bad ... so I took a lot of anxiety about sex to my marriage.**
> **(Jane)**

Additionally, sexual awareness could be based on previous negative influences. Maggie's first knowledge of sex was formed from overhearing her parents' sexual behaviour which often involved violence and rape:

> **Sex at home was dirty and vicious ... I only learned what I heard through the bedroom wall from my parents, and that was horrible, cruel. I grew up thinking that's what it would always be like ... and when I got married that's mostly how it turned out to be!**

(Maggie)

Previous exploitative or frightening sexual experiences also, understandably, left fear of sex:

> **So when I eventually did have sex I was very, very frightened ... by then Father had tried to get me, and the drunk man outside the dance hall when I was 14, and then my brother in law when I was babysitting. That all put me off sex a bit .... well, it would, wouldn't it?**
> **(Mary)**

Experiences of sexual abuse in childhood were particularly severe for Wendy, who had been abused from a young age, and for several years, by members of a paedophile group, and by her father who 'supplied' her to the men in that group:

> **Most of what I knew was from the abuse with my father and the other men. I was made to believe that I was good for nothing but sex, but that was the perverted, disgusting kind. I had no idea about what normal sex might be.**
> **(Wendy)**

Inadequate sex education and negative sexual experiences in childhood often combined to cause confusion, and result in a fatalistic view of sexual choices in adulthood. Expectations about sex for women who married were usually clear; many had been socialised to believe that there were no choices about sex for a married woman, and the rights and needs of husbands were unquestionable. Thus the assertion that male sexuality traditionally serves as the only model for all human sexuality (Smith 1996) appeared to further marginalise the needs and rights of several women. Feelings of powerlessness often led to those of humiliation and disgust:

> **Sex with him was disgusting ... awful ... a duty that I knew I had to put up with. It made me feel cheap and used.**
> **(Maggie)**

Sex was something a woman had to do for her husband. You didn't say 'no' or 'how' or 'when' ... you just hoped it'd get over with quite quickly. I didn't like it much ... and I never have ... but I know it's something a married woman has to do.
(Jane)

It was just like a dog peeing up a lamp post ... him the dog and me the post ... it was disgusting and degrading. So this was what being married was going to mean ...
(Jean)

Sex was not referred to in all life histories, and not all those who did mention it spoke of it as cruel or totally unloving. However unsatisfactory sex was cited as causing much personal unhappiness and as being one of the reasons for the eventual breakdown of some heterosexual relationships:

He was ... not a natural lover. Sex doesn't matter one bit in a relationship if it works, but when it doesn't, well it causes lots of problems ... worries I couldn't get over.
(Anne)

Sex was always an issue ... a pressure ... it wasn't the only thing which broke the marriage up, but it certainly didn't help.
(Sue)

Looking back, the beginning of the end was a total breakdown of the sexual side of the relationship
(Claire)

In literature women alcoholics have frequently been described as 'sexually disfunctioning', because they have expressed lack of sexual satisfaction, or low interest in, heterosexual sex. This disfunctioning has been identified as both contributing to, and preceding, their problem drinking (Wilsnack 1984) . Personality characteristics, such as low self esteem among women problem drinkers, have also been judged to interfere with the formation of satisfying sexual relationships, so increasing their risk of turning to alcohol for relief (Richardson 1981). Early studies even declared alcoholic women more likely to be 'frigid' and suffer from 'poor sexual adjustment', compared to male alcoholics (Kinsley 1968; Scarle 1977). However, many researchers have failed to recognise the possibility that women's sexual partners may contribute to their sexual problems, and this appeared to be the case for many in my study. This may be especially pertinent for women who misuse alcohol, as they are more likely to have alcoholic male sexual partners, who are known to experience more sexual problems than other men, or engage in sexually and physically abusive behaviours (Van Thiel and Lester 1979; Cornel et al. 1995).

Some women in my study also described sexual abuses and rape by their partners. Marital rape is thought to be the most common form of sexual abuse of women, with rape occurring in an estimated 10% of all marriages (Finkelhor and Yllo 1985; Anderson 1997). However, because of the expected intimacy, duty and sexual access within the marital relationship, many wives are said to be less able to name this forced sex as rape (Russell 1982; Kelly and Radford 1996). Within descriptions of marital rape in my study, because many women had not been given a concept of choice regarding sex with their husbands, they also often had difficulty in describing it as rape. Some women 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). Anne mentioned her rape by her drunk husband in objective, distanced terms, disallowing herself from showing distress. This presentation in lifestory narration was very similar to some of the distanced, emotionless ways which some other women had described their sexual abuse in childhood:

We'd had a damned grim 6 to 8 months, and by the end of it I couldn't stand

him touching me. One night he got drunk and forced sex with me. I deeply was hurt about that ... it was ... but that's of no significance ... he was drunk ... I had to forget about it ...
(Anne)

Heavy alcohol use has frequently been cited as a major contributing factor in males who sexually abuse their partners (Ptacek 1998) and alcohol use by partner-rapists was mentioned in my study. Maggie's second marriage was even more volatile than her first. Her new husband was a heavy drinker and sometime drugs user, and subjected her to regular physical and sexual violence:

He raped and beat me up when he was drunk or stoned. He kept saying after each time that it wasn't his fault ; that the drink had made him do it, and he'd stop. To begin with I did believe he would change. I couldn't accept that this cruelty would continue happening by my husband, who was supposed to care about me ... I'd already been raped when I was 15, you know, outside the Youth Club, and that made me ill for years after. This was as bad, and it was stirring all the other memories too .
(Maggie)

It is understandable that women may try to deny the humiliation and degradation of such attacks by their partners. They can be dismissed as not being 'real rape', despite the very real and serious nature of the crime, and the personal impact of this. However, for Jean, who suffered almost 30 years of sexual abuse from her first husband, there was a clear definition about the naming of marital rape, and a willingness to convey some of the emotional impact of such relentless 'torture':

He just wouldn't take "no" ... and if I struggled or cried, or if he had to hit me to get me to lie still, he just liked it even more ... he was always drunk and constantly raping me. I'd go to bed, totally exhausted after over 16 hours a day working, then he'd come up and force me, rape me ... just wake me up and do it, like I was his property or something . It's terrible never getting a decent night's sleep, being so afraid ... it's a kind of torture.

(Jean)

Research has frequently suggested that alcohol facilitates male sexual aggression (Abbey et al 2001) and makes rapists and others feel they are less personally responsible for their crimes (Abbey et al. 2001). In my study, within life histories which contained experiences of male abuse while the perpetrator was drunk, there was a tendency, as with Anne (above) to suggest that alcohol was a reason for the release of unacceptable behaviour. However, there may be little evidence to support the belief that alcohol can be excused as being a primary cause of male violence towards women (Scully 1990). Several studies have shown that alcohol only acts as a function of expectancy. In other words, that aggressive personalities will act into expected behaviours connected with alcohol, but that alcohol should not be seen as a drug which releases new violent inhibitions (Gelles 1993). Alcohol has also been cited as being the reason for 'uncharacteristic' aggressive acts in domestic violence. It has been used to excuse male violence, almost as if it makes a previously non- aggressive man suddenly become aggressive. Challenging the power of alcohol as a disinhibitor has far reaching implications for cases of domestic violence and society's attitudes towards the abuser who drinks, then seeks , and often receives, vindication because of this.

Occasionally other studies have also reported high rates of rape among alcoholic women, although the relationship of the woman to the rapist is not always specified (Murphy 1980; Wilsnack 1984). Rape within marriage was mentioned by some in my study who had also experienced childhood sexual abuse, and/or rape by strangers. This continuum of traumatic sexual violence through life spans, and the regularity of this within my research group, suggests a key connecting category, which will be explored in later chapters .

Sexual problems described by women in my study usually preceded their drinking misuse. These difficulties often involved unloving or abusive relationships with partners, and alcohol was then used to anaesthetise some of the emotional distress and physical pain of sexual distress. Of particular interest, in view of previous literature to the contrary, no participant complained of impaired sexual functioning during periods of her alcohol misuse, as long as she felt she had choice in her sexual situations. Feeling in control, and having power within sexual behaviour and

decisions, was pivotal.

Isolation

Just as isolation had featured so regularly in the childhood stories from participants, desperate loneliness was also referred to frequently in connection with heterosexual partnerships. Loneliness presented in many ways. For Claire, an unplanned pregnancy resulted in her marriage. She talked at length of the loneliness of her marriage, of how this contributed to her increasing drinking problem, and of her guilt for seeming to put her own needs before her childrens':

> **Most of my married life was terribly lonely. Two small children, him at work, or his evenings at college, and me trying to make ends meet to send him to college, teaching part-time at a pretty rough school. I was exhausted all of the time, without any support or friendship from him. I felt more isolated living with him than I'd ever been when I'd lived on my own ... I just couldn't stay any longer with all that tension, and that awful draining loneliness. I was becoming really ill, and my drinking was on the up ... so I had to leave. Of course it was selfish, I've not done right by my children, I know that. But it's too late now. I'm not proud of myself ... I'm ashamed.**
>
> **(Claire)**

Shame is intensely disempowering for women (Bartsky 1990). In order to overcome shame and feelings of inadequacy, alcohol can be used, and this, in turn, can intensify and invoke even more shame. This vicious cycle was illustrated in Joan's story. She felt she had a basically stable marriage, however, her life history also strongly suggested her subordinate role in the marital relationship, beginning with her lack of confidence about her perceived lower social status, and continuing with expressions of gratitude that her husband had stayed with her. She mentioned the loneliness of her marriage, of how family life revolved round the needs of her husband, but did not speculate that this may have contributed to her own 'personal problems', about which she felt so ashamed:

In truth I haven't been good enough for him. I've tried my best, but never managed to measure up. I've had a , well ... a good life with him. I can't complain. Of course the Army brought so many separations, so much loneliness, so much having to cope with all the personal problems on my own ... I'm not strong, you see, mentally, and we've always had to make decisions to fit in with Fred's job. I don't resent that, but it has made me very unhappy sometimes. But when you think of the wife I've been, the depressions and then all the drinking , he's given me more than I ever deserve ... oh dear, I feel so guilty about that.
(Joan)

Wendy's description of the acute loneliness of her marriage included her intense frustration and feelings of failure as she realised her attempts to change her husband's attitudes were pointless. She felt criticised and isolated, but has stayed in a loveless marriage, for she feels she had no other practical choice:

His work was always the most important thing in his life and after a while that really hurts. He never did anything with us or ever shared the child care responsibilities or decisions. It was like being a single parent. When I married him I thought he'd change, learn to be more loving and caring. But after 25 years, the penny finally drops and you give up trying. It's very lonely, but I've grown to stop fighting it. The frustration was eating me up . I now think life's about accepting the ways things are, and not expecting to try and change them. I have to stay with him because I have no financial independence, everything we've worked for over the years is tied in with him. Not the best reason to spend 30 years with someone, but it's mine ... of course, I wish things could have been different ...
(Wendy)

Partners' Influence on Drinking

Alcohol literature still focuses heavily on examining genetic predisposition and the influence of role modelling for people who develop drinking problems. Family vulnerability towards alcoholism is strongly supported (Hill et al. 1991; Gomberg and Nirenburg 1993;), especially parental alcohol problems (Poikolainen 2000) and substantial resources have pursued the quest to place alcoholism within the family, individual, pathological domain.

In my research, no significant evidence or patterns were established which could link parental or family alcoholic role modelling or vulnerability. There was also lack of supporting evidence to substantiate the influence of peers on drinking consumption. However, in the wider exploration of the influence of relevant others on drinking behaviour, several women did reveal the direct influence by some others, significantly, male figures. The men who had most influenced drinking were in positions of comparative power over these women, usually being their sexual partners or husbands, who had sometimes previously misused this power over these women in a variety of ways.

Anne spoke of the influences placed on her to drink by the two men she married; both were heavy drinkers themselves:

> **Thomas (** first husband **) had quite a reputation for heavy drinking ... we were bad for each other in lots of ways ... it was with him that my drinking started - it was always impossible to say 'no' ... he was persuasive. To begin with I joined in with his drinking, but then I found I was getting as bad as him. He didn't do my drinking any good - my fault, of course, not his ... after we split up I hoped the drinking was behind me, and I had almost stopped. Then I met Johnny** (second husband) **by the time I knew he was probably an alcoholic, I'd fallen in love with him ... but they do say alcoholics gravitate towards others who drink anyway. Soon I was drinking again and the best times we had always involved alcohol. The disease hadn't**

got hold of me at this point, and drink made everything better, even our relationship. He was extremely volatile - real challenge to live with. We had some very tough moments, but with Johnny there'd always be a drink at the end of it, and then I'd be forgiven.
(Anne).

Anne's relationships with her husbands suggested coercion around the central feature of alcohol. She defended her first husband, taking sole responsibility for what happened: 'my fault, of course, not his', despite also noting 'he didn't do my drinking any good' . Her view that alcoholics gravitate towards other drinkers, implicitly absolved her second husband of responsibility for their turbulent, 'extremely volatile' periods, which would be resolved around the recurrence of drinking and her being forgiven.

Such relationships, with strong investments of control and compliance, with heavy drinking as a central feature, were described in other life stories.

Maggie and Claire wanted to please, not feel they were being judged for constantly criticising their partners' heavy drinking. They also wanting to spend time with them, and this invariably involved drinking environments. It was increasingly necessary to collude with their boyfriends:

He was a very heavy drinker, and although I didn't like that side of him – it scared me actually – I wanted to please him and try and make a go of the relationship. I wasn't a drinker and to begin with I didn't go with him on his drinking sprees, to clubs and parties. But it's hard to keep saying no to someone you love. He said drink would make me relaxed and more sociable – by that he meant more interested in sex, I think! So I began drinking with him, and it delighted him, he'd never been more pleased with me. After some months it began to get out of hand, I said I was going to stop, but he persuaded me not to. I really was a fool! By the time I had the sense to start to stand up to him, it was too late and I was addicted as much as he was. We split up, but I took the drinking with me.

(Maggie)

When I met Peter I thought he was wonderful and I did anything he asked me. Embarrassing to admit that now, but it's true. He drank a lot, I hadn't. He kept buying wine and whiskey and telling me to drink more as it would take away the worries I had about my children. The more we drank together the closer we seemed to get for a while, then it got out of control and it all turned in on us. He was accepted at some alcohol clinic shortly after he left me ... unfortunately I did a lot more damage to myself before I got sobered up (Claire)

Some studies have drawn attention to the influential role male sexual partners can have on problem-drinking women, suggesting that alcoholic women tend to have alcoholic partners much more than alcoholic men, and that these partners appear to play a role in encouraging and maintaining the women's alcohol misuse (Wilsnack and Wilsnack 1993). More recent research has indicated that alcoholic women are more than twice as likely to have an alcoholic spouse than non-problem drinking women, and that spousal alcoholism should be considered a significant predictor of alcohol problems in women, but not men (Windle 1997).

Jean's experiences capture how it may be possible to feel considerable pressure to drink with a strong male partner. Her married life of violence at the hands of her alcoholic husband had led her to believe alcohol was her enemy, and she chose not to drink. However, years of abuse and loneliness eroded her confidence and self belief. She was eventually persuaded by her husband that he needed her support, not disapproval, and that she should drink with him. Their GP's views reinforced Jean's feelings of guilt:

I could see how over the years he used drink as a weapon, and how I resented it ... whether I then followed or copied his behaviour, I don't know. The GP told me John was very sick, that I had to be patient with him. All I ever said was that I wanted to leave him, but he said John needed me, that I should stay with him, give him support ...

(Jean)

When her husband's psychiatrist suggested that Jean should start drinking with him, that this may support him to drink less, she felt intimidated, confused and blamed:

> **Then the consultant said if I went to the pub, and shared some drinks at home with John as well, it would make things better. He said, quite clearly and seriously, that if you live with a drinker but don't drink yourself, then it can't ever work. But if you drink with him, it keeps him company and he might drink less. These were the experts ... it was like I was making his problem worse or something. So I took the medical advice and went to the pub ... I needed company too. I didn't like it in many ways, but I followed him. By his side for the first time - but only if I went to the pub. He soon began bringing me bottles home as well. He got me started on it. It took him some time, because I was so anti drink ... I hated it, what it had done to my life. But when I drank I was better for him - I went along with his crazy ideas, didn't refuse him sex ... he used to become very vicious if I refused to drink.**
> **(Jean)**

So Jean had been advised, by the people she saw as experts, to drink with her husband. The advice implied that Jean's attitudes to alcohol had exacerbated her husband's drinking problem. She was placed in the role of caretaker and carer, her own needs were denigrated to accommodate the perceived responsibility of being the wife of an alcoholic. Other writers have made similar observations (McConville 1991; Ettorre 1992, 1997). Such persuasive advice, and the temporary improvement in her husband's attitude towards Jean when she did drink, placed the enemy alcohol in a new role of potential ally. The start of Jean's serious drinking problems had begun.

Overall, there were clear affirmations from five participants, that they had received pressure from intimate male figures to begin to use alcohol, and that this occurred before they had established their drinking problems. The collected life stories suggested that heavy drinking

male partners were most influential during the start, or establishment of participants' drinking careers. It appeared that these men felt they had much to gain by encouraging their female partners to drink with them. They hoped to avoid disapproval around drinking, they would be more able to spend time in alcohol related activity, and some appeared to hope that drinking would make female partners more sexually available. For some women compliance with heavy drinking may have initially made them feel closer and supportive of the men they needed. They wanted to feel less blaming and judgmental, and less rejected by their male partners. As women's socialisation into sex role behaviour reinforces dependency, compliance and approval by men, it follows that they may be liable to drink with, or for, heavy drinking male figures in their lives. The impact of women's social and sexual roles on their drinking, particularly the influence of subordination and dependency in sexual partnerships, and within family units, is an important area of research, which my study suggests deserves more attention in the future.

Discussion : Alcohol Misuse, Marriage And Heterosexual Relationships

Much research concerning the effects of alcohol misuse on marital relationship has examined the context of male drinking behaviours (Leonard 1993; Gomberg 1998; Greenfield et al. 1998; Ptacek 1998), where heavy drinking in men often proceeds domestic disharmony and violence. Fewer studies have linked women's drinking to dysfunctional marital relationships (Estep 1987; Jacob and Seilhamer 1991; Fagan et al. 1998) and these studies do not reach 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.

In my study marital problems preceded alcohol misuse for many women, although for some, their new drinking would exacerbate this marital disharmony. Most women were only able to stop alcohol misuse when they had left unhappy relationships, often then choosing to live alone. These findings challenge much literature which contests that women who are divorced, separated or living alone are more likely to have higher rates of alcoholism than are married women

(Ferrence 1984; Clark and Hilton 1991; Hanna et al. 1993; Wilsnack and Wilsnack 1995); or that performing multiple roles as a wife and mother may be a protection against heavy drinking or relapse for women (Hatsukami and Owen 1982).

Marriage and intimate relationships with men left several women in my research feeling deeply ashamed, because they felt they had failed. Even those who had been able to talk frankly about the unhappiness or abuse in their relationships often commented that they may have somehow contributed greatly to their relationship break up. It has been suggested that women may be particularly vulnerable to loss and guilt when a relationship fails, because they are socialised to place so much self-worth on their relationships with others, and their affiliation to, or acceptance by, others helps form their female identity (Richardson 1993). When participants' drinking had started during marriage, this was cause for additional shame, and persistent self reproach often ran parallel with profound feelings of worthlessness and of not being worthy of others.

Loneliness was a common link among memories of relationships with men. When these relationships began, 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 grief that many had experienced as children. Even though most tried repeatedly to make their relationships work, to change and be changed, they felt their attempts were hopeless, and many intimate relationships became a time of feeling total loss of control and failure.

Several in my study had felt trapped in the kind of violent relationships which are known to cause poor self esteem and high levels of clinical depression among women (Orava et al 1996); conditions regularly linked to women who have drinking problems (Walitzer and Sher 1996). Victims of domestic violence have also been said to internalise their anger and distress, which can lead to self destructive behaviours such as alcohol abuse (Blair 1986; Miller 1998). Additionally, some participants believed that the most significant persons to influence their drinking habits were male, heavy drinking partners.

Stereotypes of women who suffer from domestic violence, or who feel they are trapped in unhappy relationships, suggest they may be weak and passive (Dobash and Dobash 1992). But reflecting on the narratives in my study, these are myths which deny the complexities of women's responses to domestic disfunctioning. Corroborated in their stories, these women have not been silent victims, functioning within the self perpetuating context of learned helplessness. They all tried many means to leave unhappy relationships, and have often used alcohol as a substance of self medication to try and cope with the unmanageable. 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.

Chapter Seven

Depression: *The Black, Bottomless Pit*

It's hard to describe just what it's like. Sometimes huge ... like a shadow hanging over me, which can suddenly turn into a black, bottomless pit, which I fall into. It's something I seem to have no control over ... a bit like when I felt addicted to needing more and more drink.
(Sue)

Self-identified periods of depression were spoken of frequently by participants like Sue, above. This is consistent with previous research which has also associated depression in the lives of alcoholic women, who appear to have increased rates, compared to both male alcoholics and non-alcoholic women (Glass 1991; Kendler et al. 1993; Crum and Pratt 2001).

The periods of depression described by my participants were generally remembered as being different from transitory periods of sadness, as they caused prolonged disturbances in daily functioning. In many narratives, cognitive, somatic , affective and behavioural aspects of women's lives were affected. A wide range of symptoms were described, such as reduced concentration, guilt, self-depreciation, hopelessness, lack of energy, sleep and eating disturbances, withdrawal, suicidal thoughts and low self-esteem, all known to be among the core indicators of clinical depression in women (Worell and Remer 1992). However, viewing clinical indicators in isolation from individual and collective causative factors, promotes a directly medical or biological view of depression. This denies the experience of depression as a protest, an unwillingness to go on, or as an expression of the extreme frustrations inherent in the restrictions of many women's roles in contemporary Western societies (Chesler 1972; Irigaray 1993; Ussher 1994; Russell 1995).

The reasons why women with drinking problems appear to present high rates of depression are not clear, yet are important to uncover (Nixon and Glen 1995; Dixit and Crum 2000). In this chapter, by resisting the negative pathological, essentialist connotations surrounding much established theory on women and depression, and by listening to how and why depression may have entered the lives of women in my study, a clearer picture can be reached. By viewing depression as a severe level of sadness, and by re-directing a focus on a more positive questioning of the oppressive conditions and relationships within which some women in my study have often been immersed, a wider understanding of the role of depression for women with drinking problems may be uncovered.

In my research all the life histories included occasional periods of deep unhappiness during adult lives. For some, a diagnosis of clinical depression by G.P. or psychiatrist had been made, others chose not to seek medical help. Some had received medication, some had been hospitalised, and some had attempted suicide. Periods of depression, which were often richly described, were frequently of a very serious and prolonged nature. Most of the life histories also included descriptions of more than one period of severe depression, and, significantly, these self identified depressions often began very early in life, in childhood, teenage or early adulthood. This indicated that depressions were the most commonly shared experiences among women in my study, suggesting that depression should be considered an important vulnerability factor among women who misuse alcohol.

Depression In Childhood

Joan believed her depression had started in early childhood and had been unlike the experiences of other children she had known:

> **I never had any confidence, I kept separate. I remember crying a lot, not being able to sleep. Even as a little child I felt so miserable and wretched ... not like other kids**

(Joan)

When considering the experiences in her childhood, Claire also realised:

> **I was desperately unhappy and depressed throughout most of my childhood and teenage. There's no doubt in my mind about that. That's when the black periods really started for me**
> **(Claire)**

Jane explained:

> **The fear of life was probably worst in my childhood, and that's when I remember feeling most alone, most frightened and most depressed. I mean really depressed, not just a bit unhappy, but like life was just not worth living ... terrible memories**
> **(Jane)**

Alex and Jill had both suffered depressions in their teenage years. Their stories described desperate unhappiness and loneliness, which presented itself in dangerous self-injurious behaviour. Jill remembered:

> **I was still quite young, 13 or 14 ... I felt so low, and thought what was the point of going on. So I decided to take a bottle of paracetomol. I was sent to hospital for a washout and I remember my Dad arriving. No sympathy, he was just mad. I was only in hospital a day, then back to school the next. They gave me a social worker then, who was just awful. I had no one to talk to at all, and I was depressed all through secondary school ... then I started cutting up ... anything I could find, knives, bits of glass or tins, anything to see the blood running down my arms ... it gave me some relief somehow ... took my mind off other things. I liked hurting myself, it really relieved some of the tension.**

(Jill)

Alex also spoke of how she had withdrawn into a disturbed and desperately unhappy way of life in her childhood. Eventually, like Jill, she began seriously self-harming, and felt additional rejection by being sent away to boarding school where she further isolated herself and her low self image and depression continued:

> **I'd always felt lonely, inferior, but by the time I was about 13 I'd become seriously withdrawn ... disturbed. I spent all my time alone in my bedroom, and that's when I began self-harming in a big way. My arms were a real mess. Deep cuts and scar tissue ... I was a shitty kid, you know ... my behaviour in general was pretty bad! My parents couldn't handle me - or didn't want to - and they sent me to a boarding school which segregated me from the other girls ... I had to live in the sanatorium for two terms on my own ... that was so, so miserable. Even when I got older I think I'd been depressed for so long that it felt normal to me - crazy, eh?**
> **(Alex)**

By the age of sixteen, Frances had become depressed. She experienced anger and rejection from her father, disinterest from her G.P. and she soon believed her illness was her fault:

> **I became very depressed while I was still at school. Father said I was attention seeking, told me to pull myself together and remember how lucky I was ... but Mum was very concerned and took me to the G.P. who didn't seem to know what to do with me. But he gave me some sleeping tablets which at least made me feel less exhausted, but I became quite dependent on sleeping tablets, and that's been a struggle ... I felt that all of the depression was because I was such a hopeless person.**
> **(Frances)**

Some located the sources of their childhood unhappiness to specific traumatic life events. Life

events and losses, such as death of a parent or close relative, or sexual abuse in childhood, have been associated with depression and drinking in adult women (Turnbull and Gomberg 1988). Indications of the possible depressive impacts of such early life events were included in certain narratives:

> **It hit me so hard when Ma died. She was all I had in the world ... I was only 13 and I went to pieces. I've never recovered from it - not properly.**
> **(Mary)**

> **I didn't know just how depressed I really was until I was about 20, but it started long before that ... when I was raped outside the youth club. I couldn't talk to anyone about it, you see, and I was only 16.**
> **(Maggie)**

> **I was about 12, a couple of years after my rape, and I heard my brother'd suddenly died, and my world crumbled into living years of depression and desperation. Overdoses, wanting to die. Totally without hope and not knowing how to get any help**
> **(Violet)**

The probable causes for such desperate unhappiness before adulthood, as described by several participants, are not difficult to locate. The effects of sexual or physical abuse, unhappiness at school, lack of friendship groups, alienation from families and resultant extreme isolation, which had been recounted earlier in several childhood stories, are likely to have precipitated such depressions. The self-concepts that often featured for those who spoke of childhood depression frequently linked inferiority and self-loathing. Such feelings of inferiority and worthlessness are readily associated with young people who have suffered abuse and neglect, but also with older women who suffer from depression and, significantly, those with drinking problems (Wilsnack and Wilsnack 1993).

Self-Esteem

Examples of low self-esteem, often co-existing with periods of depression, permeated many life stories, and presented in a wide variety of guises. Statements about self-dissatisfaction regularly referred to how these had begun in childhood, and many commented how they had frequently longed to become someone else:

> **Even as a child I felt bad and guilty about myself. I've never felt good enough, always worthless and unlikable. I've always dreamed of being someone else, someone I could respect.**
> **(Violet)**

> **Most my life has been spent hating myself. I've dreamed of being someone else ever since I was little. Even then, when I look back, I never had any self-esteem, I was shy and inhibited, didn't know how to communicate with people properly ... just pretty useless.**
> **(Alex)**

For others, expressions of low self-image were sometimes voiced in strongly negative feelings about physical appearances, often within the contexts of feeling unattractive to men. Mary, who had also suffered sexual abuse from her father, was sexually assaulted by her brother in law while she babysat his children. Although very upset by the event at the time, the feelings she now expressed concerned her astonishment that she should be considered attractive enough to be pursued by a man:

> **I don't know why he picked on me ... I mean I was hardly good looking, or someone to tempt him. I never was as pretty as most of the others ... I'm surprised any man took a second look at me ... same as now ... there's no point in thinking you're something special when you know you aren't, I always say.**
> **(Mary)**

Similarly, Jane continually referred to her self-perceived lack of physical attractiveness, which had been regularly emphasised over the years by her husband:

> **I've always been very poor looking. My husband is always so smart and well turned out. But not me ... whatever I put on I can't look good ... he just says I'm not good with clothes and things ... oh, even on the day of our wedding, lots of people thought he wouldn't turn up ... that a man would actually want to marry plain old me!**
> **(Jane)**

Joan mentioned her ' inferiority complex ', and the suggestion of her husband's role in reinforcing her lack of confidence:

> **My husband says I have a huge inferiority complex. He's really confident about everything ... can't understand what's wrong with me. It makes him mad - but that makes me even more anxious, and feeling , you know, small, all of the time ...**
> **(Joan)**

Maggie believed her self-esteem, and subsequently her feelings of depression, improved when she made a decision to live on her own, when she was in her 40s. But until then she felt to blame for her own unhappiness, and at the same time unable to alter her circumstances. She believed her dilemma was complete, that she was guilty of both contributing to, and colluding with, her misery. It is little wonder that Maggie, and others, described themselves as 'trapped':

> **I was a complete failure. Trapped in a life I detested, but I couldn't find the strength to get out . Trapped and completely pathetic is how I felt ... it's how I was ... I withdrew into a shell and hated myself even more for not being stronger, less depressed ... for not having some spark of fight left in me ...**
> **(Maggie)**

Other Sources of Depression

> **After the baby was born I became terribly depressed. I had a premature, sick baby to look after, and no family or friends near to help. It was a kind of post-natal depression, I expect, although I didn't see anyone about it. I just tried to struggle on for a few years ... such a struggle ... until I just couldn't manage any longer.**
> **(Wendy)**

The significant life event of childbirth was traced to major depressive episodes by Wendy, Jean and Jane, although none had this depression diagnosed as such at the time. Certain discourse around the experiences of depression following childhood has challenged the myth that motherhood is automatically a positive experience, and has suggested that failure to conform to this ideal, or 'maternal instinct', results in 'abnormal' or depressed behaviours (Beck 1992; Weaver and Ussher 1997). Postnatal depression has also been shown to be most associated with the kinds of social and interpersonal problems which women face around childbirth and early motherhood, and is considered to result from their oppressive and restrictive gender roles (Nicholson 1998). In fact, postnatal unhappiness is far from uncommon, it has been estimated that up to 80% of young mothers experience some degree of serious distress and depression (Blumfield 1992). The three participants' negative views of their behaviour following childbirth were certainly strongly influenced by shame for believing they had failed as young mothers. The medical model of postnatal depression as a distinct hormonal and biological entity may compound such feelings of failure, by avoiding the very real social, cultural and interpersonal factors that may contribute to a new mother's unhappiness (Jelabi 1993). The women who described depression shortly after having babies all spoke of the unsupported domestic situations within which they attempted to cope with a demanding new child. The tangible reality of fatigue and hopelessness was vivid; for all three women, their drinking problems began during, or shortly after, these depressions:

I found it so hard after she was born. I felt numb, didn't really feel part of her. She cried and cried, I couldn't get any sleep and my husband just left it all to me. I ended up moving around on my hands and knees and crying all the time. He kept telling me to snap out of it ... I suppose it was post-natal depression, looking back ... but I didn't know about such things then, I just felt very wrong and guilty. It must have been shortly after then that I began to use drink to try and relax ... I just knew I'd failed her and my husband.
(Jane)

Jane's story endorsed a belief that anything short of perfect bonding with small babies is likely to be experienced as source of shame and personal incompetence (Taylor 1996). But feelings of personal failure are less likely to cause postnatal depression than lack of support from a partner both before, during and after pregnancy (Demyttenaere et al. 1995). Jean's narrative placed her unhappiness long before the birth of her second child, but it was the new responsibilities and exhaustion of bringing up another small baby single-handed which compounded her sense of depression:

I was pregnant again and I felt I couldn't stand it any more. Even before she was born I decided to put an end to it all, but discovered I didn't have a penny for the meter! So I couldn't even afford to gas myself ... terrible. He was off drinking, spending all the money, I was so lonely and depressed ... he never helped, or offered any comfort. When I became pregnant again I just wanted to run or die, or somehow escape ...
(Jean)

Searching for a way to 'escape', as Jean (above) stated, was the reason many participants gave for contemplating, or actively attempting, suicide.

Suicide Attempts

High rates of suicidal attempts, and completed suicides, have been associated with alcoholism and depression, and female alcoholics have been found to have a higher risk of both attempted and completed suicides than male alcoholics (Murray 1989; Glass 1991; Olson et al 1999). Women with drinking problems are also reported to be up to five times more likely to attempt suicide than non-alcoholic women (Gomberg 1989; Merrill et al. 1992). This high incidence of suicide attempts was reflected in my study. Seven women spoke of having attempted suicide, all having taken overdoses of medication which had usually been prescribed by their GPs. For most, overdosing shortly proceeded, or occasionally overlapped, their alcohol misuse. For some, alcohol appeared to be used as an alternative method of 'escaping' to overdosing, as described by Wendy:

> **I took five overdoses in total ... it was all about getting some peace ... thinking that just maybe this time someone would realise how desperate I was ... but they didn't. It was easier to take a bottle of pills and be able to sleep for 10 hours, to escape from it all. If I didn't wake up that didn't matter to me, I knew no one cared if I lived or died. But the last overdose was very serious, you know, seriously life-threatening, and I knew that if I died it might be better for me, but what about my little boy, who would have looked after him? So I had to find something else to help me escape ... and there was alcohol ...**
> **(Wendy)**

Attempting suicide was explained by some as being their ultimate expression of extreme unhappiness; cries for help which so frequently remained unrecognised:

> **I took overdoses over the years I was depressed, mostly before I began the serious drinking. I seemed to overdose when I was in some crisis, when I was at the end of my tether. The hospitals didn't really take me seriously ... I**

had to nearly die before anyone believed that I was seriously depressed and needed help.
(Violet)

Most participants who had attempted overdoses did so many times, and none felt she had received sufficient support from medical services following the suicide attempts. Feelings of severe depression, and stressful life events around the times of their overdoses, were recalled, with domestic violence being a frequent problem for some who self harmed. Suicide was often viewed as the only way out of such impenetrable personal difficulties:

All the rows ... the arguments ... the fights. I couldn't sleep and I was so, so tired. Lots of awful things were happening ... I was on anti-depressants ... I just felt life wasn't worth living anymore. So I took all the tablets and woke up in hospital having my stomach pumped out. They sent me home the next day, and no more was said about it. I don't know if it was, you know, what they call a cry for help, but if it was, no one heard it.
(Mary)

Joan had been abroad with her Army husband when she overdosed. She had regularly tried to tell him how isolated and miserable she felt, but he did not appreciate the seriousness of her situation:

Everyone told me I'd love being overseas, but I didn't. The boys were little and my husband was always away, and I felt so alone. One night I'd been on my own for three weeks and I just cracked up and took a bottle of pills. Next thing I remember I was in the hospital. They let me go home straight away ... well, they must've thought I had a good husband and a lovely home, so why did I need to take an overdose ...
(Joan)

The Role of Prescribed Drugs

> **They keep on about how the only person who can help you is YOU ... don't they realise you wouldn't be sitting there, all that humiliation, if you could sort it out for yourself? Then the pills, pills and more pills ... anything to shut you up ... guilt and failure is already crippling you. So you take the tablets, just like they say. They want to shut you up, not be any trouble .... what do they know?**
> **(Jean)**

Jean's observations emphasised the kinds of pressures she feels are employed to endorse the use of medication to silence women. By placing the responsibility for change wholly with the distressed woman, who may already believe she cannot cope, strong feelings of failure and guilt are internalised. The punishment for her 'failure' is the pills, which Jean knew would 'shut her up'. There was no encouragement given for her to articulate her difficulties, Jean felt silenced once again, and her 'humiliating' cycle continued.

Others, such as Maggie, were also critical of the prescribers of psychotropic medication for using drugs to silencing them:

> **They start writing the prescription before you even sit down at my surgery. They want you to take it, shut up and stop being a nuisance - women with 'nerves' aren't popular, they're just a big nuisance.**
> **(Maggie)**

A major difference between male and female alcoholics is their use of prescribed medications, with women alcoholics using tranquillisers, sedatives and anti-depressants at over twice the rate of their male counterparts (Mulford 1977; Robbins 1989; Corrigan and Butler 1991). The impacts of being prescribed psychoactive medication, usually by GPs, was significant for

several in my study, particularly for those who continued to drink while taking this medication. The mixing of alcohol and prescribed drugs by some participants appeared to result from either lack of prescriber advice about pharmacological dangers, or the personal use of medication to accentuate the mood-altering qualities of alcohol.

Doctors have sometimes been accused of holding notably stereotypical, sex-biased attitudes about their women patients, which may explain their reluctance to diagnose a female patient as having a drinking problem (Carter 1997), but increase their willingness to label a distressed or disturbed problem-drinking woman with a primary diagnosis of depression or anxiety (Sandmaier 1988). This diagnosis will often result in a prescription of mood-altering medication. Consequently, not only may a problem-drinking woman leave her GP with her alcohol problem undiagnosed, but she may also be given a second powerful, and potentially addictive drug. The combined use of alcohol with such medication will make the effects substantially more powerful than drugs or alcohol alone. Another danger is multiple, or cross-addiction, if dependence on both alcohol and one or more other drugs is experienced. Cross addiction may keep a woman drinking longer, and several women in my study switched between their misuse of alcohol and their prescribed, psychoactive medication during times when alcohol caused physical sickness, or when they wanted to hide their drinking from others, or when drinking had impeded their ability to manage their everyday affairs.

Negative, stereotypical attitudes by GPs were frequently linked to personal observations about their prescribing habits, as mentioned by Jean (above) and also by Wendy:

> **They want you out, so they can get the next one in. They don't want you there in the first place - it's all a game, they're just not interested ... I was given more and more antidepressants - they didn't even ask me why I was overdosing, or why I was drinking, they just gave me more tablets. (Wendy)**

Wendy's life story outlined how she had wanted to discuss the reasons why she felt she was overdosing, which in her case included her hopelessness about her drinking problem, but she

was not given the opportunity or permission to talk. Instead she was given more medication, which added to her addiction problem, as she became increasingly dependent on the potent psychoactive drugs she was prescribed. The need for medication, and the apparent willingness of certain GP's to prescribe this, became a significant problem for several in my study, for these medications appeared to exacerbate, rather than relieve, their need to misuse alcohol. Many women had been prescribed psychotropic medication at times that coincided with their heavy drinking, sometimes with the clear knowledge of the prescriber.

Significantly, few women linked their concurrent use of alcohol with medication as having been a dual substance misuse. This may have reflected a supposition that medically prescribed drugs were legitimate and non-abusive, compared to alcohol misuse, which, as a self-administered substance, could attach self-blame and guilt . Additionally, when a doctor prescribed medication, this may have been viewed as a validation that it was likely to be therapeutically necessary, and so should have some beneficial qualities.

Women who are prescribed psychotropic medication are managed in an environment which is widely legitimised by male authority, within this context, often the GP and husband. Some participants explained how their use of prescribed psychoactive medication had been reinforced and even encouraged by their male partners:

> **My husband always keeps an eye on me. ' Are you on edge again?' he'll say, ' well, get back on the flipping tablets, then.'**
> **(Jane)**

> **When I was on the tablets, I might be calmer, more agreeable, or less likely to argue. So it suited him** (husband) **very nicely for me to be on them, made his life much easier, he often said.**
> **(Wendy)**

Some writers have exposed the use of psychotropic drugs to control female patients, and have shown how gender permeates professional thinking to influence both the kind of treatments

offered, and the nature of the patient/doctor interaction (Cooperstock 1981; Busfield 1996). This interaction expects women's passivity and can cause further frustration and even anger, but when in a powerless position, there is a strong temptation to collude:

> **Doctors have always given me the valium to shut me up. You don't want to shut up, but no one ever wants to listen, so the tablets are your only alternative, or you'd go really mad ... what's the point in fighting it, that way you only get more het up and feel even worse ... so you take the pills and are pleased that they calm you down a bit.**
> **(Mary)**

Not all misuse of prescribed medication could be attributed to initial prescriber mismanagement. Violet had easy access to many drugs as she worked as a hospital nurse. After being prescribed analgesics for chronic menstrual pain, she discovered that these strong painkillers also made her feel cognitively distanced, numbed; a sensation she had experienced with alcohol, and one which she enjoyed. She perceived that both substances gave her the similar desired feelings of intoxication, but she appeared more concerned over her alcohol use. Violet described how she believed she controlled her drugs use, whereas alcohol controlled her. She identified alcohol as the most dangerous and disruptive substance:

> **The DF118 I first got from the doctor, made me feel warm inside and much better about myself, they gave me confidence. Using them always accentuated the effects of alcohol, so they were useful ... alcohol was always the real temptation, the problem, it was really damaging my life. DF118 were freely available on the wards then, I didn't feel like I was stealing or doing wrong at the beginning ... but the habit got out of control. My intake became huge, at the last count over 50 a day. I'd built up an incredible tolerance, then I started fitting. I very nearly died ... my heart stopped once. It was horrendous ... and the drinking, as well. The only positive thing is that because of my nursing training I kept off the hard drugs - heroin,**

cocaine. I knew the severity of my alcohol addiction, and I just didn't trust myself ... had I got into hard drugs things would have been much worse. (Violet)

Violet's comments suggest that she perceives a demonstrative difference between the dangers of what she calls 'hard drugs', compared to her mixing alcohol with her prescribed medication. Despite her nursing background, and her acknowledgement that she almost died as a result of alcohol and medication misuse, she still believed that the use of illicit drugs would have been more damaging. This viewpoint, of believing in a hierarchy of drugs harm, reflected the view of several other women in my study, who also had used alcohol concurrently with prescribed psychotropic drugs believing that their prescribed medications were sanctioned, thus legitimised.

At times in their lives when participants may have viewed their positions as extremely vulnerable, they chose to seek medical help. Their narratives have endorsed that many wanted to resist becoming passive patients who were expected to acquiesce to professional judgements and treatments. However, at the time they were functioning from powerless positions and it is not difficult to understand why several felt they had to accept whatever comfort or promise of 'cure' was offered. When asking a GP for help to 'feel better', a medication may have temporarily sublimated frustration, anger and despondency. The use of psychoactive medication obviously offers much benefit in the relief of transient mental ill health, but will rarely solve the underlying reasons for distress, in fact, according to opinions expressed in several narratives, it is likely to exacerbate distress when used with alcohol.

The uses of psychiatric labels and pharmaceutical preparations have been judged to be powerful weapons in ensuring women continue living in oppressive situations while their emotions are pathologised (Ussher 1991; Russell 1995). Women's combined use of alcohol and drugs – especially, but not exclusively, as prescribed medication - could be seen as a consequence of stigmatisation and control in medicine and psychiatry. While women are overwhelmingly viewed from within a patriarchal, traditional, medical model, they will be prescribed relevant medications to control their feelings. Those women who misuse alcohol,

and often report heightened feelings of hopelessness and depression, are inevitably more likely to also have access to, and permission to use, drugs.

Seeking Relief from Depression

Receiving medication from GPs, which was prescribed in isolation from alternative support, was just one way participants expressed concerns about the lack of understanding they felt they had received for their depression. Wendy's comments described how she felt when she was a psychiatric hospital in-patient:

> **You were treated really horribly in there, like you were sub-human, wasting their time ... " Pull yourself together and look at all the good things you have in your life, instead of all of this self pity!"**
> **(Wendy)**

Other participants also voiced much dissatisfaction about a wide range of health care providers, within both community and institutional settings. For some, mistrust of doctors, nurses and hospitals stemmed from these experiences, and it is possible that this affected many subsequent cautious help-seeking behaviours for drinking problems which were also mentioned in life histories.

Mental health workers have been accused as being as representative as any others in failing to address the issues and stresses which confront women who display psychiatric distress (Smith 1987; Motz 2001). The experiences of participants in my study supported this accusation. The narrated experiences of treatment by health care workers towards depression and/or suicide attempts were invariably negative, often remembered with much distress. Wendy spent brief and hostile times in accident and emergency hospital wards following each of her suicide attempts, but was offered no other treatment:

No one enjoys feeling so miserable and worthless that they swallow handfuls of tablets ... don't they understand that? Once a nurse said to another one, right at the end of my bed: " God, not her again, when's she going to do it properly and put us all out of our misery?". They stood there and laughed. Maybe I was unlucky, but the medical people's attitude just made me feel worse ... humiliated, lower than low. I thought that if even the hospital people don't want to help me, and treated me so badly, there was just no hope.
(Wendy)

Others' experiences in psychiatric hospitals were generally equally miserable. For Violet, the unsuccessful treatments she was given only served to emphasise to her that she was worthless and responsible for not only her illness, but also for her lack of recovery:

When I was terribly depressed I had a 3-year spell of being in psychiatric hospital most of the time. The last spell was 12 months solid ... ugh... in all honesty, it didn't help, it just kept me from damaging myself for a while. It was almost like being punished for being a bad person and bothering everybody with my depression and overdoses . Well, that's what it felt like ... I would have done anything, anything, to try and stop myself feeling so wretched, but the treatment they gave me just didn't work. I used to feel guilty about that too! Maybe it was me, not them ... a hopeless case or something ...
(Violet)

Whilst she was unable to leave a very unhappy marriage Maggie lived with a deteriorating depression. Her consultation with her GP reinforced that there would be no way out of her misery. Shortly after she began to seriously misuse alcohol:

I was so desperate. The doctor said very little, except that I was probably having a mental breakdown and there wasn't much he could do about it, because he couldn't give me medication because I was a suicide risk. He said the solution was for me to sort out my life. He didn't even ask me to see him again. I knew then how pointless it was to ask doctors for help ... when it comes to mental problems, most of them just don't want to know. (Maggie)

Frances' periods of depression had originated in childhood, and worsened following her rape by her brother in her mid-teens, but it was not until her mid-20s that she received specialist psychiatric care. Her treatment in hospital conformed to many stereotypical assumptions about women who are perceived to be mentally ill (Stoppard 2000). Only when her behaviour was seen as compliant and accepting was she judged well enough to be discharged:

During my first SHO post, I became so ill that I resigned. I returned home, and must have looked bad, because father arranged for me to see a psychiatrist immediately and I was admitted to a unit. The nurses were quite unpleasant because I was a doctor and had been given a private room, and most of the other patients kept away too. I had some sessions with the consultant, but it was impossible to talk to him. He labelled me "uncommunicative' and recommended ECT. Oh, how I hated that. It seemed like the worst punishment possible for being depressed. I had two courses and it was decided I was much improved. I wasn't, but I was going to agree to anything, as I wanted to leave as soon as possible ... I never disclosed about my rape, or that I was starting to drink too much, or anything intimate ... the environment wasn't comfortable to talk of such matters. I started answering all questions in a simple, submissive way, I basically knew what they wanted to hear. On discharge the consultant said he couldn't offer me a clear diagnosis - I didn't have an alcoholic label to hang everything on then – but he told me I should concentrate on getting

out more, mixing with people of my own age, by which I strongly suspected he meant eligible young men. Like my father, he probably felt that getting married would have a calming influence on me!
(Frances)

Post-birth ill health of both her baby and herself exacerbated Jane's depression. Medical arrogance pushed her deeper into her feelings of utter powerlessness:

After Beth was born I'd become really depressed. My asthma got much worse, and I told the GP that I suspected the baby had asthma too. He went mad, said I was obsessed with getting medication for me and my baby and he stopped all my tablets. I went on feeling more and more depressed, but my doctor just wouldn't believe me. One night she was so ill we had to call the doctor, and luckily another one came out and whipped her straight into hospital. She had pneumonia and was diagnosed badly asthmatic, like me. That's probably why she cried so much. So I was right all along, but she could so easily have died. I never have trusted another doctor again. Then the consultant said asthma was a psychosomatic condition caused by an unhappy home life for children ... she was only a little baby ... I'd always tried my best, even when I was most depressed. Things may not have been perfect, but she was totally loved and wanted ... another doctor had made me feel like a failure , and a liar ...
(Jane)

Sue's description of her experiences in psychiatric hospitals powerfully illustrated an inadequate, oppressive and sometimes abusive treatment regime:

I was about 20 when I spent about two years being moved from one hospital to another. I hadn't started drinking at all then. Those years were awful, terrible ... I could tell you some very shocking stories about the way patients

are treated, the way I was sometimes treated too ... it's those kind of experiences which just makes you feel totally hopeless. ... medication and isolation were used as threats. I was drugged to keep me quiet and constantly threatened with ECT if I complained. I hated ECT the most of anything, so it was a good deterrent. No one knew why I was so depressed. I never had any proper counselling. When I did see the psychiatrist, little was said about my past, or why the depression started, only interest in 'medication reviews' and hearing you say: ' I feel so much better, thank you very much'. No one ever seemed to ask me how I actually felt - treatment was all about discussing symptoms, and judging whether you were safe enough to be discharged. Being in psychiatric hospital was the nightmare of my life. I wouldn't wish my experiences on anyone. Just nurses and doctors in the conveyor system to get you discharged as soon as possible. Psychiatric hospital can be a very frightening and dangerous place to be ...
(Sue)

Claire, a teacher, had been determined to resist a psychiatric diagnosis, as she feared that the stigma of mental illness may affect her career prospects. She avoided psychiatric services, even when she endured times of deep depression in her life. Because of her fear about becoming a patient of mental health services, she had to rely on the only treatment for depression, which she could access - alcohol:

I was having a nervous breakdown of some kind, and in those days you kept quiet about such things because of the social disgrace, and that you might be sent away or something. I've never had treatment for mental illness, although there have been long periods in my life when it may have been considered that I was eligible for it! You see, it used to be something you shouldn't have on your record if you were in teaching, other jobs too, I expect. Terrible stigma was attached to mental illness. Funny, I thought that 'alcoholic' was a much more acceptable category, but that I had to keep

away from any psychiatric label at any cost! So I managed to stay away from psychiatry, or any psychiatric medication ... when things were intolerable I always found I could drown my sorrows reasonably successfully for a while !
(Claire)

Other participants remembered the alienation they had felt when their partners lacked understanding or sympathy towards their depression. Such rejection led to more hopelessness and isolation. Jane linked this experience to the acceleration of her alcohol problem:

My husband gave me no help at all really, just made me feel worse. I did try to talk to him about how bad I felt lots of times, but as usual, he didn't want to discuss things ... I had no one to talk to, I just felt alone and a very horrible person, and all that hatred just went inside me. That's when the drinking began in earnest ...
(Jane)

Wendy similarly felt she received no support from her husband, even after her overdoses, and her reliance on alcohol increased:

My husband's attitude was, " if you're going to kill yourself, do it properly and finish it." He said that to me so many times , he made it clear he didn't want to help me, his whole attitude towards my depressions was very, very cruel and heartless. I felt I only had the drink to try and get me through ...
(Wendy)

Locating Depression within the Life Stories

To present the widest analysis for this chapter, it has been important to be able to select relevant narrated accounts. Several participants were themselves able to confidently state in their stories that they believed they had suffered from depressions, whether or not these had been medically diagnosed. Others were less specific about their experiences and spoke of their periods of sadness or dejection in less detail. Therefore, identifying depression within the context of each life history required careful interpretation of the given data. Such interpretations took into account both the citation of any major symptoms of depression, and also the way words and any accompanying non-verbal expressions were presented. Careful analysis of transcripts, reading the words and listening to the tapes, made it possible to note probable depressive symptoms or behaviours, even if these were contained within the more cautious stories.

An example of this was Anne's rather vague and dismissive description of periods of unhappiness, narrated in her rather objective, clipped style, with considerable control of emotions and feelings. In at least three parts of her life story she suggested extreme unhappiness, although she did not mention 'depression' or even suggest illness. However, the way she spoke, and the non-verbal communication (field notes made shortly after the research taping proved to be useful aide memories) suggested a much deeper level of distress than her words alone may have indicated. She also described having experienced some symptoms which are characteristic of clinical depression:

> (reference to parents divorce) **yes, I was very unhappy indeed about it all ... very unhappy ... I stayed away from people completely. I was very unhappy about myself as well at that time, you see** (long pause, sighs, looking for words) **... I was rather, well, very withdrawn. Only a young person's reaction, of course ...**(following her own divorce) **Well, I wasn't too happy ... not too happy at all for a couple of years or more ... only to be expected ...**(pauses, appears distant, preoccupied, deep in thought) **... it was a shame that my children had to salvaged by friends ... they were very damaged little people ... we were all**

very damaged (raised voice, ironic laughter) (after death of last husband) **I actually went off my head completely for a few weeks. Completely nuts** (pauses, sniffs) ... **then I'd have those irritating little things like not sleeping, crying a lot, feeling totally exhausted, all that sort of stuff ... took at least two years out of my life, that did ... maybe longer ... you pull through though, no other alternative...**
(Anne)

If more information had been requested during Anne's accounts, the 'evidence' of depression might have been more explicit. However, within life history work, it is often the uninterrupted telling of the story which allows the most reticent of participants to safely reflect on some of the feelings which accompanied their descriptive account. Anne appeared vulnerable during some of her narrative, so I decided to avoid any but the most minimal of prompting.

Discussion: Alcohol Misuse and the Significance of Depression.

As stated, research evidence suggests that women with drinking problems suffer more depression than non-problem drinking women, or male alcoholics. However, much controversy surrounds the debate about whether women with drinking problems suffer from secondary or primary depression. Most have argued forcibly that most women alcoholics' depression does not predate their alcoholism; that it is secondary to their heavy alcohol intake, which is believed to have a depressant effect on their central nervous systems (McGovern and Peterson 1986; Turnbull and Gomberg 1988; Petty 1992). It has occasionally been suggested that abstinence from alcohol does not necessarily improve depression, but that the improvements in life opportunities and more positive self-belief, which will accompany sobriety, will reduce depressive symptoms (Turner 1992). Accounts from life histories in my study support the latter view.

There are methodological difficulties in research which proposes to distinguish between depression which results from alcohol, and that which precedes alcohol misuse. But self-reporting, especially from the holistic context of life history narration, although arguably anecdotal, may well be the most reliable method available for theory construction around the co-morbidity of alcohol misuse and depression. Within my study, careful analysis of in-depth narrative has made it possible to interpret when, how and why clinical depression may have occurred. Such life history narration has offered important information concerning this group of women's experiences, within the personal context of how they remember such periods of profound unhappiness. This method of new knowledge generation has been noted as having being neglected in the past (Hamilton 1995; Stoppard 2000).

Whether depression is generally a primary or secondary feature for women with drinking problems is a crucial one, yet the possible use of alcohol as self-medication for psychological problems, primarily depression in women, still remains relatively unexplored (Litman 1986; Long and Mullen 1994). If a woman's depression pre-dates her alcohol misuse, she may be drinking to self-medicate to try and escape her extreme unhappiness. For such women, more emphasis on the reasons for, and treatment of, their depression, rather than their heavy drinking, may be the more suitable initial focus.

The life stories in my study strongly suggest that periods of deep distress and unhappiness, which could be labelled clinical depression, played a decisive role in the aetiology, course and outcome of alcohol problems for several women. Participants cited depressions which occurred before alcohol misuse, and no one spoke of isolated post-alcoholic depression, although drinking often reinforced or exacerbated existing depressive symptoms. Significantly, depression regularly began as early as childhood. Later in life, alcohol was often used to numb the distressing feelings which accompany depression; this evidences the significance of pre-alcoholic, or primary depression. My analysis has also suggested areas of concern surrounding the prescribing and use of psychiatric medication, often used concurrently with alcohol.

Through the opportunities available in life history research sufficient data was collected to draw together clear pictures of pre-drinking life experiences. Within this analytical context, and the interpretative opportunities available, life history work has arguably much potential in the further exploration of the importance of depression in the lives of women who develop drinking problems and the role of alcohol as self-medication.

Many women who remembered periods of depression linked these to times of deep unhappiness in their lives, and to life events in which they had felt trapped and fearful. Several also suggested a marked vulnerability to self-harm or attempting suicide at this time. The unhappiness they described appeared to result from distress and disappointment rather than being products of a biological condition or illness. Significantly, most felt they received little support with their problems and their resultant depressed state. For most, drinking problems escalated as they drank more alcohol to try and cope with the depression caused by insurmountable difficulties, frequently compounded by distressing personal events or memories.

When depression is explained in terms of being inherent in the stages of some women's lives, as for many in my research group, there could be a risk of viewing all 'women' as compromising a homogeneous group; that all women will have similar experiences. These are complex interpretations to present. Not all women who have drinking problems can be claimed to have suffered depression, to do so would be to obscure diversity within the life experiences of all women, and there are no grounds to make such definitive statements. However, the life stories in my research suggest that it may be the sequence of, and the unrelenting nature of life events – such as unhappy childhoods, sexual and domestic violence, unhappy marriages – which may indicate vulnerability to extreme unhappiness (depression) which, if unalleviated, may lead some to relieve their unhappiness through alcohol misuse.

Chapter Eight

Lesbian Women: *Managing Complex Lives*

The only specified expectation of prospective participants for my research was that they should be women who had experienced alcohol problems. Yet within this self referred group, over half were to define their sexuality as not being exclusively heterosexual. Five women, including Sue, below, were living exclusively lesbian lifestyles. They spoke unequivocally, and from personal knowledge, about the serious drinking problems which they believed affected many lesbian women :

> **Lots of lesbians drink far too much - much more so than heterosexual women. Maybe they only feel good about who they are if they're muddled with alcohol ... maybe they can't manage the homophobia. We have to juggle very complex lives, you know. Whatever the reasons, it's very sad because lots of lesbians I know have never faced up to their alcoholism ... it's something like, drinking becomes part of our lesbianism.**
> **(Sue)**

The experiences surrounding, and the possible reasons for, alcohol misuse among lesbian women were often, as Sue suggests, complex. However, although the lesbian participants reflected diversity of social, economic and cultural background, there were commonalities of accounts and views, especially in relation to their alcohol misuse, which may usefully reflect different experiences of lesbians, compared to some heterosexual women who develop drinking problems.

Two general types of risk factors appeared to play a role in the development of alcohol problems among my lesbian participants. The first group of factors, which included experiences such as education and employment opportunities, child sexual abuse, depression or interpersonal violence can affect all women, but arguably may affect lesbians differently from heterosexual women. There has been some supporting evidence from other studies that similar sets of problems will be

experienced differently by lesbian, compared to heterosexual, women (Decamps et al. 2000). Jill had experienced difficulties in the five areas listed above, but she clearly thought that her sexuality had also been an important factor in her alcohol misuse:

> **Having the kind of upbringing I had ... all that had happened to me, all the things I'd done .... in the end I just couldn't stand thinking about it all the time ... and it was much easier when I was drunk. Then how I felt about being a lesbian ... I knew my life had been shit and now I'd have hassle for the rest of it because I'd found something good for me at last. It just didn't seem fair. Drinking was the best way of dealing with all of it.**
>
> **(Jill)**

The second group of at-risk factors for lesbians concerned those which were linked by participants more specifically to their lesbian sexuality, such as being subjected to lesbophobia, or being part of the lesbian social 'scene'; experiences which would not be part of heterosexual women's biographies. The experiences which fell into these latter categories especially concerned the personal and emotional impact of oppression:

> **I felt such stress for so long, a real fear about what people would think of me if they knew I was lesbian – not just family, but old friends, and even my work. I was more desperate to drink to escape from those feelings than any others, on many occasions ...**
>
> **(Violet)**

Lesbianism, like alcoholism, has alternately or simultaneously been labeled a crime, a sin and a sickness (Wilton 2000). Women alcoholics, lesbians and the female population in general share a history of social oppression. A lesbian alcoholic, as a member of all three of these oppressed minorities, may experience the triple burden of social stigma and rejection.

Whilst general health and social care research on lesbians is acknowledged to be inadequate and often prejudicial (Stevens and Hall 1991; Hall 1994), in-depth qualitative research on

lesbian women with drinking problems is virtually non-existent (Bridget 1994; Hughes and Wilsnack 1997). Additionally, the research which has been published often includes both gay men and lesbian problem drinkers, although lesbians differ from gay men in many aspects of their lives, not least because as women they are vulnerable to triple discrimination (Kowszun and Malley 1996; Bergmark 1999).

Available literature suggests that many members of the lesbian community may have serious problems with alcohol, although lack of data, especially in Britain, makes it impossible to speculate precise rates (Wilsnack and Wilsnack 1995) . In the United States, where most studies which have included lesbians have taken place, drinking consumption among lesbians has often been assessed to be consistently higher than among heterosexual women (Swallow 1983; McKirnan and Peterson 1989; Sorensen and Roberts 1997; Abbott 1998; Aaron et al. 2001). However, research which refutes claims of high problem drinking rates among lesbians has also been published. Quantitative research studies from the United States have rejected claims that lesbians are more likely to have alcohol problems than the rest of the female population (Buenting 1992; Bloomfield 1993; Saulnier and Miller 1997). However, it could be suggested that the research methodology, the use of large surveys and questionnaires, when enquiring about such personal and intimate information, may have influenced the findings from these studies.

Coming Out

A major influence on alcohol misuse among the lesbians in my study concerned low self-esteem and self-doubt. Central to the invasiveness of these determinants was the degree of success for participants in the process of finding a positive lesbian identity. The process of 'coming out' or identifying as a lesbian woman, was not an easy or time limited event. It often appeared to be a lifelong process, continually affected by the difficulties of living in a heterosexist society. Lesbian participants invariably explained how they had regularly felt alienated and marginalised from mainstream society because of their sexuality:

I don't know why we have to put up with it ... being made to feel like you're abnormal, that you're wrong. It can ruin your life.
(Claire)

Although feeling isolated and different from other women are common experiences for many women with alcohol problems, these feelings appeared to be more intense for lesbian participants, who carried the perceived stigma of both their sexuality and their drinking problems.

Expressions of distress, anger, confusion and loneliness accompanied lesbian stories of coming out. Ambivalence about wanting to feel confident and open about their sexuality, yet feeling unable to share that identity with relevant others:

All the time you wonder, who can I tell ... what will that mean to them. You have to live a lie to some extent, even if you're quite up front, because every one just views you as heterosexual unless you tell them differently. It's a strain - half the time you just can't be bothered to keep telling ... feels like you're apologising or something. Other times you feel like an outsider, you're not part of everyday life at all ... makes you feel very hurt. Living with all those lies strips self confidence, you feel so ... resentful.
(Sue)

Having to live a lie, as Sue and several others described, requires restriction and oppression of the self. It can involve censoring or carefully choosing actions or words. It endorsed to some lesbians that they were hiding something intrinsic about themselves, about which she should not speak. Just as many women alcohol misusers feel guilty about, and choose to hide, their alcohol problems, lesbian women in my research told of how they had already endured the very negative experiences of hiding their sexuality. Hiding, covering up, had a deeply detrimental effect on self-esteem:

Of course I feel very bad that I can't be myself in every situation. It's degrading ... as if I should be ashamed of who I am. You can get a low opinion of yourself, of who you are. Alcohol helps to hide that for a lot of lesbians. It's easier to be brash and full of yourself when you're pissed, but no one knows what that's hiding.
(Jill)

In Jill and Sue's accounts, above, as with other lesbian participants, there was often a strong sense of anger underlying declarations about low self worth. Because of the stress of societal repression and lesbophobia, lesbians may be liable to experience higher levels of anger than heterosexual women. If so, I suggest that misusing alcohol may help facilitate some expression of this anger, as well as temporarily boosting low self esteem. Although low self-esteem is accepted as being a recurrent, and important, contributory factor for women who have drinking problems (Beckman 1994), questions about sexuality have been omitted from the vast majority of research studies on women and alcohol misuse (Hughes and Fox 1993). Consequently data is not available to assess how any differences in self esteem among lesbians and heterosexual women may influence their risks of developing drinking problems.

Accepting the label 'lesbian' was a threatening, almost defiant act of self naming for some. An 'out' lesbian voluntarily takes on an identity which patriarchal society has taught her to distrust, for she is embracing a life style which prioritises women rather than men:

Heterosexuality was very wrong for me, I knew that from an early age but it still took me fifteen of my adult years to trust myself to make the step to say: 'Oh this is who I am, I can't pretend any longer". Wasted years ... and all that pretending damaged my life ... like the drinking to try and feel better about the bad person you must be ... you just lose good feelings about yourself.
(Claire)

Other participants also highlighted that adopting a lesbian identity was not something any woman chose by chance, or without having thought very carefully about the possible repercussions for herself and her family of placing herself in such a generally disliked minority group:

> **The process of getting there was so long and hard ... I thought about my sexuality for years before I decided that only lesbianism was right for me. Taking on the label is much more than simply admitting to a sexual preference. It's all the negative stuff you have to take on too, the prejudice, you're setting yourself up to be a different, a bit of a social outcast. It takes lots of working out, weighing up all the consequences and deciding whether you're strong enough to go ahead with it ... and as my drinking was really bad at that time too, decisions were very hard to make ...**
> **(Violet)**

All the lesbian participants in my study spoke of how they had fought to combat negative messages about lesbianism, and had struggled at times with an acute sense of invisibility and rejection. During these times, which often endured for many years, their self-worth and confidence was frequently low, and, as Violet, above, has indicated, this was often an time of extreme vulnerability for excessive drinking.

Drinking Culture

Various psychological, sociological and cultural factors have been used to explain possible high rates of alcoholism for lesbian women. These contexts centre on the varying negatory effects of minority group status, and the stigma and discrimination which is attached to lesbian sexuality (Deevey and Wall 1992), as well as drinking culture variables (Bergmark 1999; Hughes and Wilsnack 1997) such as the reliance of mixing in lesbian and gay bars and clubs - which are also arguably a result of lesbophobia.

For many lesbian women, the only place to socialise and feel free about their sexuality is within the drinking-led environments of lesbian and gay bars and clubs, where friendships and affectional relationships can form away from societal scrutiny and prejudice. Although frequenting gay bars has been thought to greatly contribute to heavy drinking among lesbians (Plant 1997) only two lesbians in my study commented on this. Violet spoke briefly of the increase of her alcohol consumption while she was part of the lesbian drinking 'scene' in London. However, Alex's comments, below, add new insights to this theme:

> **When you can only meet other lesbians in places like gay bars, drinking is part of your way of life. It's also an escape, you can forget that people see you as weird and different and wrong ... when you're with lesbian friends, we can all drink ourselves senseless and not give a stuff about the consequences, or what other people might think of us. Drinking too much is part of the scene, it gives a sense of solidarity, or something. You know, most of my friends and I would drink eight or ten pints of lager every night and still make it in for work every morning ... it's just part of the life. I really loved it while it lasted too.**
> **(Alex)**

Alex's account of gay bar socialisation may introduce another reason why some lesbians misuse alcohol. She described how the sharing of alcohol appeared to produce communal feelings of well being, powerfulness and defiance. Her account gives a sense of how alcohol may be drunk excessively as a defiant gesture, challenging the stigma encompassing lesbians' lifestyles. This possible motive does not appear to have received attention in previously published addiction literature on lesbians.

By extending this perspective concerning 'defiance', it is possible to suggest another associated influence which may contribute towards some lesbians being particularly susceptible to alcohol misuse. The regular use of strong defence mechanisms which lesbians may adopt to cope with a lesbophobic society could be readopted to defend against an awareness about impending personal alcohol problems. Jill's comments may support this premise:

It's no big secret among lesbians that we drink a lot. But people should start asking why that happens, and why so many of us screw our lives up with drink. It's simple – a good way to cope with all the bad feelings about us. Most other lesbians do it, so you use it too. It's accepted. You're ail drinking far too much, but no one really seems to see they've got a drink problem. It's part of managing things ... it's part of getting out of your head so you can be free to be your self. The boozing is probably less of a problem than the hassle that makes you want to do it
(Jill)

Jill had spoken, above, of how lesbians use alcohol to aid personal freedom, to allow self expression. This was strongly replicated in other life stories, especially when related to the possible positive role of alcohol in accessing personal sexual needs:

I used alcohol all the time to get up the courage to have affairs with other women ... to allow myself to do what I knew was right for me ... drink was a Godsend then, without it I might never have been able to cross the line.
(Claire)

If I hadn't been drunk there never would have been a first time for me, I'd never have dared to go with a woman. It allowed me to do what I really wanted to.
(Alex)

These insights suggest that alcohol has been used as positive mode of empowerment for some lesbian women, who may have used alcohol to help them to feel liberated and comfortable enough to be able to express their sexuality in a lesbophobic society.

Feeling Blamed

The significance of the attitudes of others towards their alcohol misuse was important for all in my research. However, some issues were confined to lesbians' experience, and these appeared to additionally influence their reluctance to find support with their drinking problems. As lesbian participants had already experienced negative attitudes from others concerning their sexuality, to volunteer information about another stigmatizing part of their lives, could risk further prejudice:

> **Well, I've heard lesbianism blamed for everything from being a bad mother to being bankrupt. I wasn't going to risk discussing my sexuality with the doctor. The last thing I needed was my lesbianism to be blamed for all my problems, including my drinking. It's the injustice and loneliness which makes you drink, not being a lesbian!**
> **(Sue)**

> **I was never asked about my sexuality, and it was certainly not something I was going to mention in treatment. It was all very ... well, everyone was just thought to be heterosexual and I wasn't going to expose myself in that sort of atmosphere. Probably meant that any benefit I could have got from treatment programme was wasted. The depression and confusion and guilt was a big part of my drinking, but if you can't speak up, you keep it inside.**
> **(Violet)**

Previous studies have overwhelmingly endorsed that lesbians perceive interactions with health and social care professionals as intimidating and humiliating (Stevens 1994; Lehmann and Lehmann 1998). Stereotyping and prejudice on the part of professional workers, plus the negative expectations of lesbians themselves, are likely to result in lesbians feeling reluctant to enter health care (Robertson 1992). One study conducted in the United States found that fears about the negative consequences of discussing their sexuality similarly affected lesbians' capacities to seek help for their alcohol problems (Sorensen and Roberts 1997).

Accounts of specific hostility from helping professionals came from two of my participants who had experienced very negative outcomes after sharing feelings about their sexuality:

> **I was feeling so bad and confused about the whole sexuality thing that I went to see a therapist. Well, it turned out to be no help at all. He seemed to be more mixed up about my sexuality than I was, I don't think he knew what he was talking about. It set me back for a long time, just filled me with even more fear, guilt and frustrations, and a lot of suspicion about professional care workers**
> **(Alex)**

> **I didn't really know what a lesbian was - well, no one talks about it, except in a bad or smutty way, do they? I felt alone, like I was the only person who had ever felt like this. I really liked the Probation Officer at the hostel, and I finally got up the courage to tell her. All she said was : " Okay then, if you're a lesbian, how do they have sex, for instance?" Of course I said I didn't know, how would I have? She laughed then said if I didn't have the answers then I was lying, that you have to have had sex with a woman to be a proper lesbian, you couldn't be one just because you thought you might be! That upset me so much. I felt so stupid, you know, really small. I dropped the idea of being a lesbian for about two years and I never mentioned anything about it again to anyone 'official'. You get sick of been laughed at, you see ...**
> **(Jill)**

Reports that proportionally low numbers of lesbians use alcohol treatment services (Kowszun and Malley 1996) is not surprising, based on experiences given in my research. Lesbian women with drinking problems believed they were not well served by social care and health professionals, and while this continues, lesbian problem drinkers are likely to remain a largely invisible group in alcohol treatment services.

The Impact of Gaining a positive lesbian identity

Personal acceptance of their sexuality, with all the associated fears of lesbophobia and rejection, was a difficult process for all the lesbians in my research group. The circumstances and the discovery of a lesbian identity was different for each woman, with self-doubt, shame and fear becoming less disabling as each grew in confidence within her sexuality. As each became stronger and more confident about being a lesbian, there often appeared to be less reliance on alcohol:

> **I don't know what I did with all the guilt I felt about being attracted to other women ... eats you up. It took a lot of soul searching, and a lot of risks, but accepting myself as a lesbian has given me more fulfillment than anything ... and I think it was then when I found that when I could accept who I was, I just had less need for so much alcohol.**
> **(Sue)**

> **Drinking was a real kind of comfort ... which got completely out of control ... you can see how lesbians do get hooked it . It can be such a lonely life, you really can feel totally alone. But when I did live my life truthfully as a lesbian, the effort of getting there was worth it. It makes me furious to think of all the damage which is done to you by society, by bigots. What a difference it would have made to my life, if I'd believed I was free to choose ... I wonder whether I'd have ever have drunk as much as I did ...**
> **(Claire)**

Although alcohol was regularly used to temporarily increase self-esteem and reduce feelings of sadness and depression during the sometimes difficult process of gaining lesbian identity, several women further suggested they had only been able to accept being a lesbian in a truly

positive way once they had stopped misusing alcohol. Such interdependency between sobriety and lesbian self-acceptance has been noted in a previous study (Finnegan and McNally 1987) :

> **Living as a lesbian has meant freedom at last! Now I can get on with life without relying on my next drink ... but it was only when I'd begun to kick the habit that I could really accept who I was. I used alcohol to try to fight it, or ignore it ... but drinking messes you up more than anything, it made me even more afraid to be something I knew a lot of people would hate.**
> **(Jill)**

> **I decided that I couldn't continue trying to pretend I was bi. or het. and I knew I had to get alcohol out of my life. So finally I was a lesbian! I've never regretted my decision, just the agro. you get from other people about gays. But now all the lying to myself and other people has had to stop. It's a relief, I can be who I am, and not feel I need to apologise about that.**
> **(Alex)**

The final commitment to a lesbian life style often coincided with newly achieved sobriety . This brought personal freedom, fulfillment and the promise of self respect, which was an achievement to celebrate:

> **This was the most important stage of my life, coming to terms with my sexuality, trying to ignore what other people might think about me ... believing in myself and my right to find happiness and emotional well being. I'm now sober, and proud to be a lesbian. I've come a long way ...**
> **(Violet)**

Discussion: alcohol misuse & lesbian women

The lesbians in my study shared important insights into the under-researched topic of lesbians with alcohol problems. These women who recognised themselves as lesbians had stepped outside the social norm. It had taken strength and conviction to be able to identify themselves beyond the sexual roles and models consistently presented to them; it had often taken similar amounts of courage for them to choose to live without alcohol.

They described how trying to resist their sexuality, and the pressures of the coming out process, had often started or exacerbated their drinking. Some suggested that they had only found a positive lesbian identity when they were no longer drinking; for others acceptance of lesbianism allowed them to find the self confidence to stop misusing alcohol. Each experience was different, but each was undeniably connected to the misuse of alcohol. These findings raise important considerations for both treatment and preventative programmes in alcohol education; significantly, in training and education, where the invisibility of lesbianism has been marked (Bridget 1994).

Lesbians and non exclusively heterosexual women make up a significant proportion of women who experience drinking problems, and this needs to influence alcohol studies, theory and practice. Not only has there been little formal research, but there is also an absence of lesbians' stories in general addiction texts. Many books on women with drinking problems fail to mention lesbians at all (Gomberg and Nirenburg 1993) or allocate only one page to this significant sub-group (Plant 1997). Such invisibility does little to affect positive images of concern or support either for individual lesbians, or the lesbian community. The contention of most lesbians in my study, that their drinking problems, like their sexuality, was expected to be hidden, continues to be reinforced.

The process of achieving a positive lesbian identity commonly involved enduring the experiences of discrimination, oppression, loneliness, confusion and self-doubt, but there was no shared experience which could be measured to demonstrate how successful lesbian identity was reached. Additionally, many women had experienced the daily conflict of living within the constant turmoil of passing as heterosexual. It is therefore both the self identified lesbian and the hidden lesbian who may develop drinking problems. Both need to be recognised and accepted as at-risk groups within contemporary women's alcohol studies.

To understand the complex issues which affect lesbians with drinking problems, a knowledge needs to be reached of the interplay between the constraints and discrimination in lesbians' lives, and the nature of individual alcohol misuse among this heterogeneous group of women. Alcohol may be used to boost self-efficacy, confidence and feelings of personal power, as the experience of external and internalised homophobia and heterosexism erodes self-confidence and assertiveness. The anger lesbians may feel about years of misunderstanding, guilt, self-doubt and alienation regarding their sexuality is a pivotal consideration, for this accentuates the feelings of powerlessness which they are also likely to feel about their drinking problems.

To establish knowledge of women with alcohol problems without a significant understanding of the impact of lesbianism, is to view only part of the picture. Reflecting on the narratives collected in my research, lesbians who misused alcohol would have benefited from support to help them reclaim both their power as women and as lesbians, for these appeared to be major factors in reducing alcohol intake, or reaching sobriety. The institutional heterosexism prevalent in many health and social care settings needs to be acknowledged and challenged before such women will be supported by formal treatment regimes to rediscover their lost power and self-confidence.

Chapter Nine

Searching For Help: *Nobody Wanted To Know*

All participants spoke of the times when they had sought help from others about their drinking problems. Exploring these experiences will help to illuminate some of the barriers and processes involved in the help-seeking of the group of women in my research. Additionally, it may also give a context in which to understand why many other women with alcohol problems may be judged as being poorly motivated to seek help, or difficult to match the preferred treatment courses which are available.

> **They say the hardest part about alcoholism is the admitting to yourself that you have a problem ... for me the hardest part was trying to get some help for the problem I knew I had. No body wanted to know ...**
> **(Claire)**

As an underpinning to this chapter, it is important to note Claire's endorsement, above, that she knew she had a drinking problem, but had experienced great difficulty in finding helpful support. Her views were echoed by many participants; few suggested that they had resisted to accept that they had alcohol problems. The women in my research had the life experiences and insight to realise when their alcohol consumption had begun to have a detrimental effect on their lives. This challenges much current theory which is likely to shape attitudes of both helping professionals and more general opinion. The belief that women alcoholics are likely to strongly deny their drinking problems has been a major justification in the medical myth that they are resistant and hard to treat (Plant 1997; Walitzer and Connors 1998).

The Role of Medical Practitioners

The key gatekeepers for women's entry into alcohol treatment are doctors, especially general practitioners. Some literature has outlined dominant negative factors which may jeopardise alcoholic women's treatment by health professionals: belief in myths, stereotyped sex-role expectations and inadequate knowledge or training (Vannicelli 1984; Mead 1997). Physicians, and nurses in general practice, have also been shown to believe women alcoholics are sicker, more manipulative, more deceptive, more difficult to diagnose and have poorer prognosis and motivation than male alcoholics (Zankowski 1987; Gustavsson 1991; Rhodes and Johnson 1994; Owens et al 2000). Additionally, women have been seen as being reluctant to admit to having drinking problems to their doctors because of the stigma which surrounds women's drinking problems (Thom and Green 1996). All these factors will be likely to impede many women's route to adequate support and treatment for drinking problems. Jane's story illustrates:

> **I did try very hard to stop drinking on my own, but it never worked. I couldn't stand it any longer, and took an overdose of my anti depressants ... I suppose it was another cry for help, I wanted them to see how bad I was. But after that the doctor stopped all my anti –depressants. I felt even worse, it was terrible. Then he let me go back on them again and he never mentioned my drinking - I'm not blaming him, I just don't think he knew what to do with me. After that I rang in for a repeat prescription every three months, I think he found that easier than having to see me at the surgery ... he didn't like to listen to all my complaints about my drinking ... I heard they don't learn much about alcoholism in their medical training, and they don't seem to know what to do with us ...**
>
> **(Jane)**

Jane's experiences were representative of many participants'. Her initial overdose had shown a desperate need for someone to recognise the depth of her distress, and the spiralling of her drinking problem. However, after her overdose she suffered the immediate withdrawal of her

medication, the only source of relief for her depression at that time. Jane did not feel supported or heard by her GP, in fact she believed he avoided seeing her. Several other participants, like Jane, complained about the lack of interest and knowledge of GP's, but especially about the inability of GP's to listen, when they tried to explain about the pressures which they felt were exacerbating their heavy drinking. This may, in part, be explained by the rigid medical training which prescribes to the biomedical model which locates illness inside the body rather than the social environment (Good and Good 1993).

Doctors have also been accused of believing women should function within their ascribed gender-roles and are likely to view their female patients accounts as emotional, unreliable and subjective; yet their subjective power as gatekeepers gives them the final authority to decide the services a patient will receive (Atkinson 1995). Such moralistic and negative attitudes are easily sensed by women problem drinkers, whose fragile self-esteem and assertiveness may be further diminished:

> **He said I should look at what a nice family and husband I had, that I had enough money, and fewer problems than most people. He said that I should learn to be more satisfied. I felt like crawling in a hole ... it had taken me so long to get the courage to go and see the doctor, and all he did was see me as a complaining, moaning woman who should know better than to drink, because he felt I had no reason to.**
> **(Joan)**

Others spoke of the fears they had felt about asking for help for their drinking problems, and of the frequent disappointment and rejection they experienced after accessing gatekeepers such as doctors. Doctors were criticised not only for failing to listen, but also for tending to prescribe psychotropic medication, usually without supervising its concurrent use with alcohol:

> **I finally plucked up the courage to mention to my drinking to my doctor. He said he'd give me some tranquillisers. I said, but what about my drinking, how will they help that? He told me I had to calm down, then I'd not feel the**

need to drink so much. He said there was no magic cure anywhere, but that tranquillisers would be the best bet. He really wasn't that bothered, he said I didn't have a bad alcohol problem, as that would take years to get. I knew that was rubbish, but what can you do?
(Maggie)

Others also commented about how some GP's were dismissive and disinterested when they disclosed their alcohol problems, or failed to recognise the seriousness of their drinking. There was evidence of some GP's showing concern, but of then being unable to suggest positive treatment regimes. Some GP's admitted lack of confidence in working with alcoholics, and they sometimes transferred full responsibility for change back to their patient. These attitudes and behaviours suggest insufficient understandings and clinical training in the area of substance misuse, and left many women in my study feeling untreatable and more hopeless. Mary's story highlights many of these areas of concern:

The doctor didn't really know what to do with me. In the end he said I'd have to go into hospital. Then he did something I can never forgive - he tricked me. He said that I could leave at any time, but that I should give it a try ... when I got there, the ward door was locked behind me. He'd lied to me. I was locked in with all these really bad mental cases. I mean, those people can't help being ill, but what had all this to do with me ... I was so scared. I was kept there about three weeks, maybe a bit more. I just did everything they told me, so they'd let me out as soon as possible. I was taken off alcohol, of course, and given lots of tablets ... I can't remember anyone talking to me about my problems. Then they said I was all right - but I didn't feel any different at all! When the consultant discharged me he said he'd got such good reports of how I'd behaved, and helped the other patients, that he could give me a ward orderly job. All he wanted to talk about was whether I'd work there. Of course I said no. As I see it, the professionals have no time for you. I wanted to say: ' I don't expect a quick

cure, but please give me some understanding, even some pity' ... but I'm not very quick with words, I didn't complain.

(Mary)

Mary's humiliation at finally having to agree to detoxification in psychiatric hospital, was compounded by her belief that her doctor had lied to her about her voluntary status there. She did not feel she had a psychiatric problem or that she should be in that frightening setting, but she spent her time there passively, without complaint, to ensure she could be discharged at the earliest opportunity. The suggestion that she had been 'good enough' to be able to work on the ward not only taught her that feminine passivity and acceptance was expected and rewarded, but that the helping professionals had no interest in exploring her drinking problem with her. Mary's experience of treatment made her feel determined never to believe her doctor again, nor to agree to residential treatment in the future. It has been suggested that professionals often blame women for their drinking and send them to unhealthy treatment settings which reinforce sexism, with double standards and secondary status for women (Babcock and Connor 1981). This suggestion has been validated through several of the life histories in my study, and may help explain the evidence that although women do more readily seek help for general health problems than men, this is not the case for alcoholic women (Wilsnack and Beckman 1984; Tucker 1995).

The limited knowledge of GP's concerning the range of services which may be available for women with drinking problems was raised. Specifically, GP's often only suggested attendance at Alcoholics Anonymous (AA) . If AA did not proved helpful, as was often the case, feelings of hopelessness and failure were compounded:

When I told the GP how bad things had got, he said I had to go to AA. I didn't like it at all. This big group of strangers you're supposed to talk to, mostly men. Well, I was terrified, you have no idea . Even their drinking stories had nothing to do with me ... my experiences were very different. Anyway, I only went three times and I never heard from them again. The

doctor wasn't pleased. He said: ' was I helping myself? It was like that was the end. I'd failed and there was no where else to go.
(Wendy)

Alcoholics Anonymous

The majority of women in my research had attended Alcoholics Anonymous (AA) at some time, and this proved to be one of their most influential alcohol-related experiences. The importance which many participants placed on their experiences with AA, and the implications of their views, which challenges some fundamental practices of this most widely used helping facility for alcoholic women in the UK, is given representative focus in this section on help seeking.

AA was the most used helping service accessed by those in my study. In fact more women tried AA than had consulted their GP's, or other helping professionals, about their drinking problems. They said this was often because they had felt they could attend AA in an anonymous capacity, avoiding the stigma and disapproval they feared may come from contacting statutory services. There was also a fear of the unknown if they disclosed to a professional, whereas it was generally believed that AA would be likely to offer unconditional support.

Although Alcoholics Anonymous is the largest self-help alcohol network in the world, local groups are self funding and stand outside the mainstream of alcohol agencies. New members find their way to the organisation by a variety of routes, most often for my research participants via their GP's, or through self-referral. AA's central philosophy supports the disease model of alcoholism. Members follow a twelve step programme which is clearly rooted in religious and cultural tradition, described as middle class, white and male dominated (Denzin 1987). No particular theological belief or religion is followed, but the influence of the ' Higher Power' is central, reflecting the firmly American Christian Protestant historical roots of the organisation. Members are strongly encouraged to be completely abstinent from

alcohol, with no recognised place for controlled drinking. Although at least one third of members are believed to be female, there are few women-only groups (Baker 1992; AA 1998).

Experiences and opinions about the effectiveness of AA were mixed, but only one woman, Anne, a devout Christian, spoke of AA as being overwhelmingly positive experience:

> **It's got something special. People there have a spiritual experience, it's a spiritual programme and everyone believes in this. You understand how people have experienced recovery, how they manage, because it's never over when you've stopped drinking, that's only the beginning of living with the illness. At AA there's total honesty and nothing you hear ever goes any further, so you have lots of trust. You have to own up to all your faults and ask God to take them away. I began by going every day of the week, now I go about 4 days, but I expect I'll need to keep going all the rest of my life, without all that love and support I expect I'd be tempted back to alcohol. (Anne)**

Anne had been attending AA for just a few months. Although no one else was as positive about the organisation, many stated that they had found it very helpful for a short time, until they gained the clarity and confidence to question whether the ethos of AA was one they shared. These views are difficult to compare with those outside my study, as empirical data on members are very limited owing to anonymity for members and groups.

Generally, those who had attended AA felt it had been the only service available, or offered, to them. For these women, who felt so guilty and stigmatised about their drinking, there was a definite sense of gratitude that any group had accepted them:

> **You have to use what's there, and there is nothing else, not that I've found anyway. So I went. I didn't choose to go so much as have no other options ... at least they didn't turn me away, like the hospital had ... But for most folks**

it's something to go to. Any support group might have worked better for me. Not ideal, but better than nothing.
(Jane)

Well there was nothing else ... but although I'm grateful to AA, I do have many reservations, many question marks about the methods they use. Let's say, it's good it's there, and lots of people are very grateful for it ... but how many needy people does it turn away because of the way it is ...
(Jean)

The 'way it is' to which Jean, above, referred, is founded on the ramifications of its overtly religious philosophy. Most who had attended AA felt this central doctrine was neither universally acceptable, nor appropriate for them:

The whole philosophy of AA was very hard to accept. When I arrived at my first meeting two people were spouting on about Jesus and I thought, oh no, this isn't the answer, it's nothing to do with me. I'm not going to turn to God just to play the AA game.' I know AA isn't all full of religious people, but the whole philosophy is Christian, God is the all powerful. That's just not for me.
(Violet)

Keeping the steps, trusting in God is hard enough for me and I have a strong faith. They are a religious lot, and if you can't agree to that disciplined kind of religion, then you couldn't fit in ... I've seen lots of desperate people drop out because of that. And it's quite fearful too - all the 7 deadly sins, not allowing yourself to feel pride ... a lot of Old Testament kind of punishment for sins stuff. Some of it's quite bigoted ... I don't think the end justifies the means ... I really don't believe all that fear is good for you ... you become unhappy and your spirit is broken.
(Jean)

Some research which is available has concurred with Jean's comments, above, indicating that a primary reason for women not attending AA is that they find it hard to fit in with its ethos (Kaskutas 1994). Although AA's organisation around processes of spiritual investment, sacrifice, submission to the belief in a greater power and individual disclosure, certainly can be a powerful environment for change for some, there was evidence from some participants that it can be destructive, leaving women more guilty, alone and hopeless:

> **How could I relate to all those drinking stories, all those personal details being given with so few feelings being shown. There was lots of fear there about getting in touch with your feelings. I left AA feeling worse than when I'd joined ... another failure I notched up.**
> **(Violet)**

> **I didn't like it at all, when I stopped going my husband was angry, he said what was wrong with me that I couldn't join something which was there to help me ... I tried to explain, but he didn't understand, he just thought it was my fault**
> **(Wendy)**

For some, AA attendance was not even a personal choice, but a compulsory part of the overall treatment package planned by a helping professional. This is still the case for many treatment services nationally, both statutory and voluntary. Being forced to attend such persuasive meetings resulted in strong feelings of resentment for Jill and Frances:

> **When I was at the hostel it was part of my order that I attend AA. Nobody ever asked me, I just had to go. They were a complete and utter waste of time, especially how I was supposed to stick to a load of rules and regulations they called The Steps. I used to sit there and feel so mad that because of my drinking the courts could force all this rubbish on me.**
> **(Jill)**

The psychiatrist decided all his patients must attend AA. It was part of the therapy, he said, that only with the support of AA would I stay abstinent. The process of admitting alcoholism, telling strangers your intimate life story and then having to listen to other people humiliating themselves in public was not my idea of supportive therapy! And all that religious hypocrisy ... I'd had enough of that as a child, and few things were likely to alienate me quicker than being told to put my faith in a higher power. It certainly didn't do me any good, it only made me resentful ... it really had nothing to do with me and what I needed .
(Frances)

Although AA is very strongly advocated as being the most effective treatment available for all alcoholics (Chappel 1997) it has also been criticised as having little specific provision for women members and for culturing a predominantly male image and environment (Hoffman 1994). However, some writers contend that the shared experience of problem drinking is enough of a common experience to unite and support both sexes in these joint meetings (Rosenqvist 1991). It has also been suggested that there is little empirical data to substantiate the belief that women should be treated separately in single sex settings, or that they require different treatment modalities to men (Vannicelli 1984). This has been refuted by the findings in my study. In fact a recurring criticism of AA concerned its male domination and implicit rejection of women's needs in its agency philosophy and service delivery. Jean clearly believed that women's needs were different from the male alcoholics she had met; she also mentioned the difficulties of raising sensitive topics around male behaviour within the mixed AA setting:

Most of the membership is male. Okay, we are the same when it comes to our addiction to drink, but I feel that is where the similarities stop ... we are so different ... our lives, what we've had done to us, how we handle the treatment. You feel loads of resentment from the men if you start complaining about the way men have treated you ... it's the superiority thing again ...
(Jean)

Important concerns were also raised about security and safety issues for women placed in this male environment:

> **If it had been a small group of women I'd maybe have managed, but I couldn't adjust to all those men and the way they did things, I just found it very threatening really.**
> **(Wendy)**

Wendy's opinions about the large, mixed group setting being 'threatening' and 'masculine' has been substantiated in some research which has suggested that female alcoholics may function better in individual therapy, while the reverse is often true for men (Plant 1997). Isolating and negative impacts for women who have to discuss intimate or sexual experiences in a male-majority or male-orientated treatment regime have also been noted (Lindbeck 1975; Spampneto and Wadsworth 1996) as has the evidence that all-women groups and programmes may provide the best opportunities for women to gain a separate sense of self and to make changes necessary to stay alcohol-free (Burman 1992).

> **To me AA was a fiasco! There were even people there quite drunk ... and it was usually the men who'd be drunk and difficult. I kept at it for as long as I could, I wanted to give it a chance to work for me ... but it was just making me feel ill. . So I saw the chap who ran the meetings and said I was finding it hard to sit there with people being tipsy and sometimes angry and aggressive, especially the men, who did all the talking anyway. I said I couldn't go any more, as it was upsetting me so much, and he said women often couldn't manage the honesty in the sessions, and that I should leave if I felt that way! What a put-down!**
> **(Mary)**

Mary's experience of AA not valuing her differing views was shared by others in my research. Kasl (1990) has suggested that women who question AA have been shamed, called resistant

and abandoned, evidence of the disapproval of women who try to challenge a male model:

> **So many of the men kept this big wall around them, some were even quite aggressive and that scared lots of the women, even if we didn't say so at the time. I felt very, very uncomfortable there.**
> **(Violet)**

The large group environment also proved difficult for several women who felt more stigmatised and believed they were less confident than the men, who were often accused of monopolising the grouptalk:

> **A group of people dominated by the men doing all the talking and getting the kind of help they wanted.**
> **(Wendy)**

Another central premise of AA is the disease concept model of alcoholism. Members are told that they have a disease, that their drinking habits are different from those who do not suffer from the condition of alcoholism, and that total abstinence is their only long term solution. This belief can be reassuring. If someone feels diseased they can abrogate responsibility or blame, feel less guilty about their current or present behaviour and also feel more aware of the risks they take in further drinking. However, for most women in my study the disease concept framework eventually became counter-productive to their continuing recovery and self understanding, and some viewed it as being more appropriate for male needs which, some suggested, responded to strict guidelines and living in the future. Research which has analysed gender differences in treatment regimes has also concurred that men, far more than women, are likely to accept and benefit from a belief in the disease concept of alcoholism (Miller and Cervantes 1997).

> **When AA first told me I was born an alcoholic, and I was diseased, I was happy to believe that. It seemed like a very good excuse - because I was born that way. I was different from other people, something inside me was wrong**

and I couldn't control it. It wasn't me doing it, it was the disease and I was powerless against alcohol. That was a blessing to hear and I drank more in that first six months than ever before, because I couldn't help it, could I! But the more I thought about it, the less sense it made. I needed to get away from the idea of having an incurable disease before I could begin controlling it. I needed to work out some of the reasons which drove me to drink before I could stop it. It was very masculine, the whole programme - forgetting the past, moving on and living for tomorrow, having the incurable disease ... I don't think that's how women are ... that's more suited for men.
(Wendy)

The acceptance of being powerless over alcohol, the core belief of AA, and the first step in their affirmation programme, has been applauded by many writers. However, some critics contend that powerlessness is a source of women's oppression and control, not a liberating strategy. It has been suggested that although AA may intend to empower, it pathologises deficit or defiant characteristics associated with women (Walters 1990; Kaskutus 1996). This, in turn, is likely to exacerbate already low self image among women problem drinkers. The AA programme, formulated by a white, middle class male over 70 years ago, was designed to break down inflated self opinion and ego, and place reliance on an all-powerful, male God. As many women turn to alcohol because they feel powerless in their lives, it would be more affirming to them to suggest that they have the power to choose not to use alcohol:

I know a lot of people in AA believe they are born to be alcoholics ... what has happened to them in their lives is less important. I think this belittles a person's life, events are just seen as an excuse. You're made to feel like you have no control over alcohol, so why bother looking for other reasons. I didn't find that helpful at all. I felt very bad, and very blamed.
(Violet)

I was shocked that people were encouraged to demean themselves like that in public, say they were powerless against the evils of alcohol. I went to a few

meetings, but I hated them and I can certainly attribute none of my recovery to AA. It made me feel even odder, I couldn't even relate to the other alcoholics ... that's a very isolating feeling.

(Claire)

There were many references across life stories, about feeling blamed, or isolated, for having the kinds of problems which some believed had aggravated their heavy drinking. Jean described how she wanted honesty from her AA group, but not judgement. She doubted the advisability of self disclosure in the story-telling process in the group, and, like several others, criticised the AA philosophy of working towards a future without sufficient understanding of the effects of the past:

I don't think it's always helpful to keep being encouraged to live in the future when you know there is a lot in your past which is preventing you from moving on ... AA is supposed to let you talk freely, not to feel judged or bad about yourself ... there's a lot of things I wouldn't feel okay about sharing, and if that's true for me, I can only think it must also be true for others ... at a meeting if I felt 'down' there'd always be the comments about not sticking to the programme - like the fact that I was beginning to get to grips with the bad feelings was wrong ... I think recovery is about being able to feel the bad emotions too. But when things are hard, it's all your fault, and that can make you hide how you might sometimes be feeling, in case you'll be judged as failing. You're not allowed to hurt - you don't always know why you're hurting, but you know you're going through hell, and you don't want to be put down about that ... it's like the doctors, they want you to sort things out, get better quickly, or they get tired of you ... AA says it's not what we do, it's the way we react, and I think 'how on earth are we supposed to react?' I knew I'd been a doormat and I didn't want that anymore, but the minute you put yourself in, you're accused of being aggressive, and that's wrong as well!

If you can't BE yourself, how can you FIND yourself ... I said that at an AA meeting once, but they all went silent. I think it was too much for them!
(Jean)

Whilst the positive effects of Alcoholics Anonymous for many problem-drinkers should not be under estimated, its philosophy and environment can be seen as being inappropriate for many women. Its male-dominated tradition supports re-establishing the male as the head of the family. Women play a traditional, supporting role, and much of its literature supports sexist, oppressive gender stereotypes:

> *'men are meant to be tough and rugged, but if a woman becomes that way, it is pretty hard to get back to the niceties of womanhood'* (Alcoholics Anonymous 1982, p 499).

Finding positive support

In general, my research participants did not feel comfortable in the strict, clinical treatment regimes often offered by alcohol treatment centres and AA. Overwhelmingly, they found that being able to talk about their experiences and feelings in a safe, non judgmental environment was their preferred support. The benefit of being able to talk to someone they trusted, and being given the permission and time to understand their drinking problems themselves, through the exploration of talking, was central. Significantly, the potential of sharing experiences did not always require a directly interventionist approach. The telling of their story to someone, even when no counselling or professional advice was offered in return, was in itself instrumental in the healing process. Mary explained how a friend who had experienced a drinking problem was always there to listen:

The best help I got was from my neighbour who once had drunk a lot herself. She didn't tell me what to do, but she was always there to listen. She had more common sense about it than all the experts.
(Mary)

Similarly for Jane, talking to a non judgmental listener appeared to help her to reach insights about her drinking, which she felt she had not experienced when she visited professionals, or when she attended AA. Once again, the listener did not have to directly intervene. She spoke of how she had found the process of life history narration helpful to her:

> **You see, I've found it so much easier to talk to you than try to talk to a 40 people in a room. I can say things without feeling guilty or wrong, not like when I saw the doctor or the psychiatrist - don't they get any training in, well, how to talk to people? ... it's just so much better to go through things slowly, gently, not being rushed or pushed about. I've done lots of thinking between your visits, and it's helped me - I'm starting to be a lot clearer about my life and how it's all been building up the tension... and you never are shocked by anything I say, I've often seen the experts get shocked and then they start to not believe you, because they don't want to hear it ...**
> **(Jane)**

The experience of life story narration, although very different from an interactive counselling facilitation, was also believed by Jean to have benefits which included being heard and being believed. Additionally, she mentioned the qualitative differences she perceived between the research narration sessions and the life story work she had experienced at AA. She began by reflecting upon the feelings which she felt she had hidden for so long:

> **I've been amazed, just amazed ... I sometimes write down some of things I've told you when you've gone, and that seems to be very good for me. Afterwards, I've read the notes, thought about what I've said, and been - well, amazed is the word - because I was supposed to have done all this before! At AA, step four is writing out your life, so I've done all that. When I agreed to do all this with you, I thought it would just be like that ... but no, not at all! I'd missed out all the feelings before, and so many of the things which happened - well honestly, how could I have told a group of people,**

with men there and everything, all the things I've been able to tell you? No, this time it was different, this time it was true and it was from the heart and I didn't feel bad about telling you either. You didn't blame me - I mean, I'd hardly expect you to sit and be rude ... but you can feel judged and blamed without the person saying a word, and I've had that so many times that I'm sensitive, maybe over-sensitive, to picking up what people are really thinking, to atmospheres. But with you, for the first time ever really, I've felt okay. Felt you were understanding a lot of what I was trying to get through ... it's done me so much good ...
(Jean)

The lack of safety and fear of being misunderstood were important issues for many who criticised AA, doctors, psychiatrists and other professional workers. Some had found informal talking very important. For others, a more formal counselling gave the opportunity to challenge the feelings of despair and self dislike which had made their situations seem hopeless. Studies have suggested that women tend to prefer individual therapy or counselling (Nelson-Zlupko et el. 1995) but the effectiveness of such therapy is highly dependent on the attitudes and anti-sexist practices of the counsellor. The gender of the worker has also been highlighted as being important, as a female counsellor may be able to role model non-stereotypical behaviour and attitudes, a possibility unavailable to male workers, and a female may be likely to possess a degree of empathy impossible for a man (Babcock and Connor 1981; Worell and Remer 1992). Women problem drinkers are also said to be more likely to use, and be satisfied by, services staffed by women (Beckman 1984; Ettorre 1997).

A relevant example was Wendy. She suffered chronic depression because of her traumatic sexual abuse in childhood, but many memories had been blocked. She drank to try and sublimate her feelings of confusion and distress, and when alcohol misuse added considerably to the hopelessness of her situation, she felt unable to draw upon her personal resources to

resolve her problems. She became caught between the strong contradictions of feeling she needed alcohol to survive, but that she had to stop the habit she now termed 'self abuse' . A friend suggested she see a feminist counsellor who specialised in working with adult survivors of child sexual abuse:

> **Just trying to stop drinking with willpower, or doctors pills, wasn't working for me. I knew I had to do something to sort myself out, then I could work on the drinking. You drink because you don't like who you are, or how you are. The more you drink, the more you hate yourself, so you have to come to terms with yourself before you can manage the drinking. My drinking was another kind of abuse that I was inflicting on myself. I don't use my life as an excuse for my drinking, but the counselling really helped me to see some of the reasons why I am and who I am, and it also helped me to like myself a bit more- although that is still very difficult to do.**
> **(Wendy)**

Within a woman-centred, supportive counselling model 'symptoms' associated with surviving sexual abuse, such as depression, self-depreciation and guilt, can be viewed as normal reactions to this most traumatic of experiences. Subsequent behaviours - such as alcohol misuse- can be explored as often being the result of attempting to cope with the overwhelming damage caused by sexual abuse. Guilt and self-blame can be challenged, and deep sadness validated and understood, as new ways of valuing self are explored. Jill and Claire also considered that counselling had contributed more than any other helping service to the control of their drinking:

> **The most useful thing about being in the Alcohol Treatment Unit was deciding to leave and find myself a counsellor. I had no money to pay for it, so had to get any jobs which would get me money, cleaning, shop work, it wasn't easy. . Without the counselling I'd never have been able to sort myself out. I realised what a mess things were, including how frustrated I was about**

not reaching my full academic potential ... it was quite a struggle, but when I went on to get my Masters in Sociology I felt fulfilled, I could believe in myself. That's when I got the knowledge that I didn't need alcohol.
(Claire)

I couldn't stop drinking, in fact it was just getting worse and worse. I was really screwed up about my sexuality in particular. I didn't know what to do, then I heard about Women's Aid. I didn't know what they were, but I was desperate and I went along, and they put me in touch with a counsellor. It made all the difference, she was the first person who bothered to listen to me. It was because of her that I worked out what I was doing to myself, that the drink was just one more thing that was destroying me ...
(Jill)

Groupwork was another treatment approach mentioned by some participants, as it was often used by both voluntary and statutory agencies. Studies have indicated that the use of all-women groups with female leaders can enhance positive role modelling, teach women to please themselves rather than always trying to please others, and teach respect for other women instead of competing with them (Root 1989; Blume 1991). Among the women in my study, the groupwork offered did not appear to offer the kind of therapy which allowed sufficient individual reflection and learning. However, all the groups which had been attended were mixed-sex ones, so the possible advantages of an all-women group environment could not be compared. Violet had been a member of therapy groups in AA and at a treatment unit, but identified the personal limitations of those groupwork process for her:

The groups and all the shared experience stuff just didn't work for me. I knew that alcohol was just another drug, not something special for AA or the alcohol unit to claim to be theirs. Most of all I needed to understand why I was drinking and hearing other people's stories didn't connect to my experiences. Groups gave me no insight at all. I needed to get the personal ammunition to get to grips with why I'd been killing myself with drink, to

find out for myself what was driving me to drink and why I couldn't stop.
(Violet)

Several in my study also spoke of how they thought they had drank heavily as a form of escapism, to try and avoid the difficulties in their lives which seemed unmoveable. Treatment modalities which facilitated understandings of self, and which may have helped women work on strategies towards positive change in their lives, would have been preferred by many. Beckman (1980) reported that women who drink for escapist reasons are more likely to initially feel positive effects from their drinking. Feeling trapped and powerless, having low self image and limited assertiveness skills, are part of socialisation into a traditional female role which hinders women being able to deal with their difficulties, deprivatising gender-related distress for women is more likely to allow them to understand their difficulties, and be more assertive in seeking support (Waterson 2000). It is therefore essential that women find alternative ways of facing, and dealing with, the problems they are drinking to escape from. These paralysing problems are often based on practical life difficulties such as the impact of poverty, poor housing, insufficient child care support, the ramifications of poor health:

Running away from the problems. All the day to day things like managing the bills, getting the shopping and housework done when I felt poorly. I could never cope ... when a problem came along I'd binge badly and try and forget about it. Then a few more weeks, and another problem, and I'd be back on the bottle ... it just went on and on ...
(Mary)

I always tried to run away from my problems, and drink gave me that oblivion. Nothing changed after I'd been drinking .. you learn that never happens, but learning takes time, and you need to face up to that before you can stop. I wish I'd been able to find some help with that before it was nearly too late.
(Maggie)

Escapism was a huge part of my drinking. Escaping from problems and emotional pain - all the big load of things which I couldn't deal with. Alcohol gave me a numbed, fantasy world which I wanted to live in for ever, but sooner or later you have to face reality ...
(Claire)

Learning to 'face reality' with the support of respect and understanding is how some women described how counselling had worked for them. Yet counselling should not be seen as a panacea for helping all women with drinking problems. Some counselling which was offered to participants was financially exploitative, and personally very unhelpful. Other interventions by nurses and clinical therapists which were labelled 'counselling' also proved unsatisfactory for several women. Undoubtedly, the counselling approach used, the skill to empower rather than pathologise, and the empathic quality of the counselling relationship, have been most influential considerations affecting whether counselling has benefited women in my research. Within that frame of reference, counselling approaches which seek to respect diversity have offered the most support. The use feminist, empowering principles within counselling has obvious potential for some women who wish to explore some of complex dynamics which impact their drinking problems.

Discussion: Finding Relevant Support For Women With Drinking Problems

Women with drinking problems are such a diverse group that no single treatment approach will be effective for all. However, the experiences of the women in my research indicated that many supports available to them have failed their needs. GPs, as primary gatekeepers of resources in the primary health care setting, often lacked interest or knowledge; they generally offered psychotropic medication or suggested AA attendance as the only alternative available. For some women, therefore, it was the unsatisfactory outcome of their initial interaction with their doctors which effectively blocked their route to further suitable help. Perhaps significantly, only two women in my study were referred by a member of their Primary Health

Care Team for assessment in specialist statutory agencies, such as Alcohol Treatment Units; although even these settings appeared to give only limited help to participants, apart from offering medical support during detoxification.

Although most had attended AA at some time, this community support group proved to be generally ineffective. AA expects members to admit they have a disease, that they lack control, that they are powerless. Life stories asserted that these sets of principles, based on individual progress or failure, with strong moral overtones, endorsed a type of group confessional which colluded with social and sexual divisions, rather than challenging these inequalities as being the likely basis for many women's problem-drinking. Mixed–sex group therapy, which is widely used in hospital in-patient and community settings, and in AA, proved to be a hostile environment for many, who felt unable to discuss important personal issues. There were also complaints of both linguistic and non-verbal domination of groups by male group members.

The overall preferred treatment approach, of individual help within a confidential counselling environment, is perhaps not surprising, given both the stigma and shame which surrounds women who drink excessively, and the traumatic and intimate nature of many of these women's past and current experiences. None of the women in my study were referred for personal counselling by a professional working in a statutory agency, and the financing of counselling usually had to be met personally, sometimes with great difficulty. As contact with counsellors was through self referral, this required a degree of confidence and insight into personal needs. Ultimately, these needs were often only realised after a series of unfortunate and rejecting interactions from more traditional, male-orientated alcohol treatments. The potential of woman-centred counselling, alongside other flexible approaches such as women's self help and support groups, for those who require more than clinical detoxification and strict behavioural programmes, may only be sufficiently valued when models of alcohol treatment reflect the needs of women as central. Traditional alcohol treatment perspectives have been developed and endorsed from a male dimension; these need to challenged, and the kinds of supports developed which will offer a holistic and more sensitive approach to women's diverse needs and wishes.

Many myths have been developed around problem-drinking women and their treatment: beliefs such as they are difficult to treat, that they are not open or honest about their drinking, and that they have a poor prognosis (Plant 1997). Possible researcher bias, including the choice of methodology used, may have affected available data, and added fuel to the proliferation of such negative information. Certainly, unlike my research, few studies have actually asked women problem drinkers themselves for their views about the quality and effectiveness of the kinds of supports which have been offered to them (Baker 1992).

The experiences of my research participants challenge many assumptions. Indeed the determination shown by many, to try and find understanding and help for their drinking problems within atmospheres of rejection and lack of interest, is surely testimony to their assertiveness, commitment and honesty, not their negativity. Hearing and accepting the stories of women themselves will hopefully begin to redress unhelpful bias and focus instead on the potential of listening to, and learning from, women's experiences, before judging the appropriateness or 'success' of the treatment which they may have been offered.

Chapter Ten

Regaining Control: Choosing Self-Reliance

There has been very little published work on women who have recovered from alcohol problems outside formal treatment regimes, indeed the paucity of research in this area has been identified as being of particular concern within alcohol literature (Hartnoller 1992; Copeland 1997). It is therefore noteworthy that the final emerging theme in my research provides a rich and informative view of recovery without professional help.

By surveying the final stages in each woman's life history, it has been possible to identify, and then compare, how each made the usually solitary, always courageous, steps to stop drinking. These stories document and offer important insights into the personal resources and strength necessary to make, and carry out, such decisions. They also outline important information concerning what precipitated decisions to finally stop drinking, and what strategies were used, and are still being used, to regain control over alcohol.

As I have described in previous chapters, the women in my research had spoken of many ways they had tried to find help to overcome their drinking problems. There was a strong history of frustration and injustice that the right kind of understanding had been lacking; they were left feeling alone and untreatable. At this critical stage every life history narrative described feelings of almost unbearable hopelessness and isolation. This dark period lasted for a few months for some, for others, several years. Then each participant described a turning point, a growing awareness, which became a realisation, that if she was going to achieve sobriety, she would have to reach this on her own. Regaining control of drinking and future lives was to depend on the notion of **self-reliance**:

I'd looked for help with my drinking for years, but there wasn't much help out there. I'd tried doctors, alcoholics anonymous, family, friends, even the church. I was looking for advice and help from anyone and everyone ... I was so desperate ... because I knew I'd reached rock bottom – yet again! So in the end I decided that I couldn't rely on any one else to help. Other people don't know how hard it is, they blame you for not being strong enough, not pulling yourself together. But I knew I had to make it, or fail, on my own. When I faced up to that, it changed me ... the future seemed clearer, I felt less scared than I had. More lonely, but less scared, because I had no false hopes that any one else was going to help me. Getting back control over the alcohol and adjusting to your new life was going to be the hardest thing you can ever do. But I knew that only I could do it, on my own.
(Maggie)

Maggie's memories of the personal commitment she made to fight her alcohol problem on her own was underpinned by the loneliness she experienced during her solitary struggle for recovery. This was reflected in the stories of most women's fight to achieve sobriety. She also reflected how she had reached 'rock bottom – yet again!', and this provided an interesting statement to compare with other women's experiences.

In AA, and from the perspective of many medical models, the concept of reaching 'rock bottom' before alcoholics can manage recovery, is accepted (Sorbell et al. 1993). However, for Maggie, and most other participants, the decision to finally stop drinking did not always represent the reaching of a solitary 'rock bottom'. Many admitted they had often experienced prior crises because of their drinking, and had felt they had reached 'the end of the road' before. It is noteworthy that all participants confirmed that earlier opportunities to work through crises with support, to reconstruct their lives and seek solutions, would have been welcomed and used constructively. Such support systems were unavailable to these women, so, unfortunately, their alcohol-related physical, psychological and social harm continued. Therefore, rather than being motivated to stop drinking by the shock of reaching 'rock bottom' for the first time, it was instead their self-acceptance that they could only depend on their own resources if they were to

stop drinking, which ultimately provided their strongest catalyst for sobriety. They chose self-reliance.

Turning Points

All life histories documented clear factors which appeared to trigger a **turning point** towards the resolution to stop drinking, and also the **strategies** which were useful in maintaining this change. The notion of triggers, or turning points, emerged in life stories at the point when participants realised they had to be responsible for doing something about their drinking, and from that time would take charge of their own recovery.

The most frequently illustrated turning points fell into three categories:

escalating loss of control over drinking,
fear of irrevocable damage to self,
concerns over serious neglect or harm to loved ones.

The convergence of all three categories often provided the strongest impetus for change, as was endorsed in Maggie's story:

> **The final straw for me was waking up in a police cell, not knowing how I'd got there, or why. I was totally horrified. I'd been brought in in handcuffs they said. I went to court the same day and was fined £20 for being drunk and disorderly ... devastating. Life couldn't have got any lower, could it? I knew then if I didn't do something I'd lose my kids' love, my mind and probably my life. It took me two years to feel I'd really beaten it, and it was so bloody hard, but I got there ...**
> **(Maggie)**

The 'final straw' (turning point) for Maggie had culminated in the humiliation of being arrested for being drunk and disorderly. She could not remember the incident, as she had begun to experience

alcoholic black outs. She knew she had to stop drinking, or lose everything she valued in her life, which illustrated the terror of **escalating loss of control.** Her references to her fear of losing her children, and her own mental health, connected the other two categories for turning points, that of **irrevocable damage to self**, and **harm of loved ones**. Maggie withdrew from alcohol without support, alone in her flat.

In common with Maggie, both Mary and Alex (below) also cited personal experiences of law-breakir around turning points. This factor has been absent in previous literature concerning motivations for recovery without formal treatment for alcoholics (Tucker 1995).

For many years Mary had tried to access the help she needed, but even after hospitalisation and community detoxification programmes, she soon returned to drinking. As with Maggie, it was the experience of being arrested which she would not risk happening again, as this, for her, depicted **loss of control, damage to self** and to **those she loved:**

> **I was arrested one day for shop-lifting. I was so drunk I didn't know what I was doing really. I just went into Asda and walked out with a bottle of Bacardi ... maybe wanted to get caught? I was left in the police cells most of the day ... the shame of that! If my people in Ireland had heard, well, I'd have been out of the family. So that was it for me. Ten years trying to stop drinking - but this time I knew I had to do it. I did it on my own, I didn't tell the doctor or anything. A couple of friends called by from time to time, and they told a community nurse, and she called once a month to congratulate me. But no one really knew what it meant to me.**
> **(Mary)**

A court appearance, leading to family threats of rejection, motivated Alex's decision to detoxify. She had tried this unsuccessfully before, and suggested that this attempt was effective because this time she felt fully committed to make the change, and would be doing it on her own. She felt her life was chaotic because of her **uncontrolled alcohol misuse**, and that she was **harming loved ones**:

I'd been through two community detox. programmes, and weeks in the treatment unit, but they hadn't worked. I'd lost any direction, any control, lost all hope that things could ever get any better. I really felt no one had any understanding of how things were for me. I felt totally alone, and thought I was the only person who'd ever felt like this. That's when I ended up in court for a string of offences related to drinking. Some of my family came to the court and said if I didn't stop I'd never see them again. It worked - because I had to make it work. I just knew that this would probably be my last chance, if I failed, that would be the end. It was very, very hard.
(Alex)

Sue decided to stop drinking because of her deteriorating health, caused by **lack of control** over her alcohol consumption, which she believed would harm her children. Similar fears that children would be negatively affected by continued drinking were expressed by other participants, affirming the importance of the category **causing harm to others** for women in my study. Yet it is interesting that previous research on supervised recovery has cited that concerns about children is often a strong internal barrier used by women to deny, rather than accept, the severity of their drinking problems (Bammer and Weekes 1994). This may indicate that women problem drinkers are more fearful of sanctions from professional agencies following accusations of poor mothering, rather than a supposition that they lack insight into their problems. Sue felt clear about her concerns:

I knew in the end I had no choice. I was becoming so physically ill because of all the drink ... I knew I just had to stop, or end up not being able to look after the girls properly, and they were growing up, and beginning to notice things. Ultimately, I couldn't let my drinking be their problem as well, I just would never do that to them, however badly I needed drink. Giving up was the hardest thing I've ever done in my life, it felt like I was giving up the only release from my depressions.
(Sue)

In her life story, Wendy recalled that her long standing and serious alcohol misuse had been largely ignored by her husband, whom she saw as being disinterested and distanced from her. Ironically, it was only when her husband's employer raised his concerns about Wendy, that her husband appeared to acknowledge the extent of her drinking. Her belief that he was ashamed of what others may feel about her was later reinforced by his reluctance to support Wendy's wish to disclose her drinking problem to others. His attitude added to Wendy's feelings of loneliness, and absence of understanding or validation about her struggle to stop drinking. But she realised that her **escalating loss of control** and **damage to self** had to be halted. Wendy took two years to completely withdraw from alcohol, which she did without help from any alcohol related service:

> **I think I thought I could drink myself to death to find some peace. I drank for over 15 years, and no one really talked to me about the underlying reasons for my drinking. The last 5 to 10 were the worst, two bottles of spirits most days, although I seemed to be capable most of the time. My husband either didn't see it, or ignored it. Then his boss told him I'd once sounded drunk on the phone. He was far madder that his boss had found out, than having any concern for me. It was then it dawned that I had to beat this thing on my own, no one else was going to help me do it! The counselling I'd got for sexual abuse had helped me understand that. I was out of control and it was suicidal - the abuse was still punishing me through the drink, and I think I got to realise I deserved better than that.**
> **(Wendy)**

Jane, another participant who, like Wendy, had feared and resented being financially dependent on her husband, stopped drinking because of his threats that he would leave her, and withdraw all financial support if she continued to drink. She also felt her decision to stop drinking was influenced by her wish to be abstinent for her daughter, documenting that her turning point was reached by rapid convergence of the three familiar trigger points common across my research group. Jane endured a long and difficult withdrawal from alcohol, finding very little support from health care professionals:

So it had reached a bottle of vodka and a bottle of vermouth a day. I was drunk all the time, having blackouts, collapsing. I felt so guilty for my daughter - she was going away to do her nursing training and I knew she'd worry so much about me if I stayed like this. Then Paul (husband) **said if I didn't stop drinking, he'd leave me and wouldn't give me any money. I'd have lost the house and been homeless and penniless. I had no where else to go. This time I had to stop. Then it was withdrawals, hallucinations, the lot. The more I sobered up the iller I felt. Pains in my chest, stomach, limbs – I felt like I was dying. The doctor just said keep taking the antidepressants, he wasn't interested in my drinking – he said that was all up to me now, that it was in my hands. Paul said the same. I didn't feel there was any one who really cared about helping me, so I knew I had to get on with it on my own. The doctor did send some practice nurse round once and she said she'd come to put me on a diet, so I'd feel better about my appearance. I couldn't believe it. I was detoxing on my own, alone at home all day, felt like the living dead, and the doctor thought I was worried about my appearance!**

(Jane)

Despite having had support from her mother for some time about her drinking problem, Frances felt her father's threats and ultimatums did little to motivate her to want to stop drinking. Her eventual decision to change was described when she accepted she was doing irrevocable **harm** to herself and her mother:

I'd been drinking so much for so long that I'd almost given up caring, and my father's constant anger was just making me want to drink more. But I did realise, just in time, that my physical ill health was deteriorating quickly, and I began to question whether I really wanted to die because of alcohol. It was taking away any happiness I might find in life … and it was destroying my mother, and she didn't deserve that. So one day I decided I had to stop, once and for all … it wasn't an easy decision.

(Frances)

A potentially dangerous house fire, which began when Violet was drunk, was the event which consolidated her realisation that her escalating drinking problem was now completely **out of control**:

> **I'd become a hermit. Frightened of answering the door, only going out to go to the Off Licence. Afraid of everyone and everything. And so it went on for months and months. Then I woke up one day and my bed sit was in smoke. I was drunk, and had left some food on the cooker. I just managed to get the fire out, but it could have been very serious, for me and my neighbours. I realised just how sick I had become of me, and my life. I knew I'd either keep sinking down and never crawl back up, or that this was the time to sort myself out, for good. So something as unconnected as the fire started it all. I stopped drinking that day. It was terribly, terribly hard, both to stop drinking and to keep sober ... but I did it!**
> **(Violet)**

Over many years, Jean's life had become dominated by alcohol. Inescapably, she found herself needing to stay constantly intoxicated, not even allowing herself brief periods of sobriety. She had **lost all control over her drinking**. When a request for support came from her daughter who was in hospital, her response was to 'drink herself senseless', her now usual reaction to any crisis. She described her guilt, that she could not have 'sunk any lower' by failing to give her children the priority attention she had always freely given. She believed she was **harming and neglecting her loved ones**. This was her final turning point; she made an immediate decision to stop drinking:

> **I was drinking heavily. I mean daily, with no break, not being sober for months and months. Didn't bother eating much ... it was all about moving from one drink to another, making sure I didn't sober up ... I don't know how I survived it. I knew it had got completely out of control when Sandra needed me at hospital and, as usual, all I could do was drink myself senseless. That was the turning point- there was no way back. I'd reached the bottom, I couldn't sink any lower. And so I made the decision, and I've**

not drunk since.
(Jean)

Jill was still comparatively young, in her early 20s, when she decided that her alcohol misuse was denying her any semblance of a rewarding and meaningful life. She was living alone, without social or family support. Her main aim from sobriety, like so many other women, was to establish **more control in her life**; to feel she could begin to make personal choices, rather than be controlled by the needs of her alcohol habit:

> **It was all the waste, just wasting my life ... it was so out of control. I'd lost my job, most friends and the family ... there was no point to anything any more. But I suddenly saw the light, and thought I was worth more than being constantly pissed all the time and forgetting big chunks of my life. Days and days of being so drunk- it was like a big, black hole, I was getting very scared. I knew it was down to me, and that with luck I'd do it. So I did.**
> **(Jill)**

Total physical collapse, leading to emergency hospitalisation, confirmed for Joan that she had lost **all of control** of her drinking, and that this was causing irrevocable **damage to herself and to loved ones**:

> **I ended up collapsing at home one morning, or so they told me ... I woke up in hospital a couple of days later. I'd nearly died of alcohol poisoning. He** (husband) **made me promise I'd never drink again, or our marriage was over. That's when I stopped, three years ago and I've never drunk since. We didn't go to the doctor or anything, I just did it at home. I knew I had no choices, this time I'd have to do it or I'd lose everything.**
> **(Joan)**

Strategies used to maintain change

The personal strategies selected by participants to withdraw from alcohol, and remain in control of this change, varied. However, just as the triggers which had stimulated a 'turning point' suggested commonalities across life stories, it was also possible to identify strongly reflected common categories which made up **strategies for maintaining change**.

These strategies relied heavily on:
using personal willpower and motivation,
choosing personal ways to stop, or control, alcohol consumption,
selecting positive changes in lifestyle,
becoming more accepting and confident of self.

Life histories illustrated that participants were insightful in making wide ranging assessments of their lives, before personally selecting the strategies which they hoped would help them end their drinking problems. This showed an awareness and acceptance that to stop drinking within a vacuum of other change would be difficult, if not impossible.

Many stories describe, even years after stopping drinking, how some women continue to feel acute temptation to drink, and how they use personal strategies to maintain their determination to stay sober. No one found withdrawing from alcohol, staying abstinent, or within a strict controlled drinking regime, easy, although several women, characteristically, sought to undervalue their achievements. For some, however, the celebration of the personal achievement of gaining control over alcohol provided a strong impetus towards sustaining recovery, and additionally boosted self-esteem:

> **Every night I'd go to bed, put my head on the pillow and say: ' well done Mary, another day without the drink'. A funny little habit, but it has really helped me, and I need encouragement from somewhere! I still wonder how I did it all on my own ... in that way, I feel very pleased with myself.**
> **(Mary)**

A man at the pub who does AA saw me with a drink once, and said I wasn't an alcoholic at all if I could still have the odd drink. He sneered at me ... but I've nothing to prove, I know how bad I was, I was as hooked as any alcoholic he knows. No advice or help from anyone, no AA telling me how it should be done, I kicked it all on my own. I'll never drink alcoholically again. If I decided to kill myself, I'd choose a quicker way next time! But that won't happen now, I'm past the worst, things can only get better. It's a very satisfying
feeling, actually.
(Maggie)

I often think of that psychiatrist who saw me years ago and said I'd never be able to control my drinking on my own - I've proved quite a few people wrong, and that's rather satisfying! Sometimes a little smugness spurs you on, you know!
(Frances)

But for Jean, there was no place for self congratulation, even after eight years of abstinence. In view of her long-standing, very high alcohol consumption, and her decision to **suddenly stop drinking,** her achievement required remarkable **willpower and motivation**. Yet Jean denied herself any pride for her sobriety, she transferred all authority for the achievement on the intervention and help of her God. It has been her devout religious belief, rather than belief and support from others, which has sustained her through detoxification and her subsequent alcohol- free life:

I stopped that day and haven't drunk since. I know that's unusual, but that's how it was for me. In some ways it wasn't such a hard thing to do, I'd come to the end of the road, and there was no where else to go ... I just had to stop and I had to do it suddenly and for ever. Maybe that's the kind of person I am. But it's worked for me for over 8 years now. I won't take all the credit ...

I kept dry because it was something I had to do, rather than being some clever achievement. I was just taken over, and here I thank God for his strength, so there is no other credit .
(Jean)

The importance of the spiritual/ religious context of recovery for some women with alcohol problems has been cited in a previous study (Baldwin 2001). Mary also turned to her strong Christian faith when she gave up alcohol. To sustain sobriety required a rethinking about her past and present life, and Mary used her Catholic belief positively and privately, to help her to accept her past life with less guilt and self recrimination. She also described how she had **adjusted her lifestyle** and chose to spend more time on her own. Living a quieter, more solitary life brought her less stress, which she believes gives her less reason to drink alcohol. Like many others, she achieved **sudden sobriety** without medical or psychiatric support, but by discovering, and drawing on, personal **strength**:

I started to see that the problems I drank for were still there when the bottle was empty. You have to try and sort things out yourself. Nowadays I spend much more time on my own, and I feel calmer inside, I enjoy my own company these days – before I couldn't stand myself! I do quieter things like reading and knitting when I'm not at work cleaning. And I try not to get worked up over things I know I can't change. A lot has happened in my life, things I can't change, but God has helped me to accept this, not be always blaming myself. I don't go to church, I can't be doing with priests ... my prayer is private . Being without the booze can be really hard, it means I have to face up to things a bit more, but my faith has helped me to stop looking for answers which aren't there. I'm a more contented person now, I like my life more like this.
(Mary)

Sue made **changes in her personal and professional life** which would compensate for loss of alcohol. Centrally, she believed that she no longer drank alcohol to self medicate her depression.

She learned to use counselling, and the improved self-awareness which that has offered her, to manage her depressive episodes. **Self-acceptance** has been the key to her sustained recovery:

> **I spent a year not drinking at all and then I went for more counselling to help the depression. Gradually I knew I'd got control of my drinking, and I can now even have the very occasional social drink without the fear of that dreaded compulsion to keep drinking. I've been problem free for about five years now and I'm confident I'll stay that way. I have a good job now, which fills in a lot of my time and I feel so much better about myself. My children are doing well and my life is altogether more satisfactory than when I was drinking. I still suffer from the depressions, but I'm learning how to manage them. I'd say that self acceptance has been the most important thing I've learned since I stopped drinking. That has helped me to cope with almost anything.**
> **(Sue)**

Feeling a new sense of self-pride in her 'incredible **willpower**', which was a major strategy used in maintaining her sobriety, Maggie built herself a satisfying new life as a single woman 'with a future to look forward to'. She found a new sense of purpose by studying at an evening class, reclaiming some of the education which had been denied to her when she was younger. She is now a more **self confident** woman, hoping to follow a new career. She feels she can still drink **occasionally** without feeling compulsion to re-abuse alcohol and has found **new interests** to follow and friends for support when she feels vulnerable:

> **I look back, and am still surprised at the incredible willpower I must have to have been able to stop drinking, suddenly and without one slip! You think, well if you can do that on your own, you can take on anything! So I got a lot of new belief in myself and I went off and signed up for the Youth and Community course at the college. I'd never had anything just for me before ... and I met people there who respected me for having a brain, or a nice personality, rather than just seeing me as the old slag who drank everyone**

under the table. I feel like I'm a very different person now, I care about looking after myself ... and when things get bad, and they still do of course, I listen to music, or get a good book to get absorbed in, sometimes I find a friend to talk to. I have a future to look forward to at last, I have no man in my life, and that's best for me, as that always ends up badly, and now I've got my new qualifications I can seriously start looking for a decent job. I'm not afraid of alcohol any more, because I know I've won the battle. I stopped completely for a few years, but when I feel like it, I still can have a drink, but only very occasionally, Christmas or Birthday parties - I really can take it or leave it now, after the first couple of years I found saying 'no' quite easily, because at last I had the confidence to live life without drink.
(Maggie)

Although most participants chose to immediately abstain from all alcohol as soon as they had made their personal decisions to overcome their drinking problems, others felt a more realistic strategy was to withdraw slowly. Wendy **reduced her intake in stages**, and after two years of reduction was able to be completely abstinent. Interests in church and choir singing were **new activities** which allowed her to feel personally satisfied and occupied outside of her loveless marriage, in which she feels trapped because of financial dependence. Wendy remains committed to total abstinence, she believes her fear of alcohol remains her strongest deterrent to drink and this supplements her **willpower** to maintain change. Her personal insights have led her to avoid situations where alcohol will be available. She endeavours to be more accepting about her drink problem, and of herself, especially the primary reasons why she believes she drank, the sexual abuse in childhood which she now sees was outside of her control. Although unsupported by her husband, she adopts an honest approach about her alcohol problems with others, believing that if they know she has had a drink problem, this will make them more understanding of her discomfort around alcohol. Her sustaining interests, and new friends outside her domestic sphere, are now fundamental to her growing **self-worth**. Wendy's home situation continues to cause her much unhappiness, but she has decided to accept its limitations rather than endure the constant frustration of trying to improve and change things. However, for Wendy, maintaining sobriety remains a constant challenge:

I came off gradually, took about two years in all. They say that's not the right way to do it, but I'm sure there can't be a right way for everyone. I didn't tell anyone, I just did it. Anyway, gradually coming off was best for me. I went a few days without a drink, and then stretched that for a week, until I was managing months without one. Four years ago I felt strong enough to say ' that's it then' and I've not drunk since. When I feel really bad, I know I have my friends and my church group and my singing, they take up a big part of my life now. My marriage is only there because financially it's my only option. I have no expectations of things improving there, so I need to try and make a life for myself outside the home. The worst of the craving for drink has gone, but the longing is still as strong ... some days it's like climbing Mount Everest. Bill (husband) **decided it's been easy for me to stop and stay stopped ... he has no idea, gives me no support, his attitude is really hurtful. I know I can never risk drinking ever again. My habit is so established now, that I'm certain it would just start it all up again. I couldn't be a controlled drinker, my only control is never to drink again. I tell people I'm an alcoholic if they press me to have a drink. It makes Bill furious, he tries to interrupt and say it's because I'm on tablets. Most people accept honesty, but Bill is obviously ashamed of me admitting it. I still find it a torture to watch people drinking as much as they like, so I don't spend much time where there's alcohol. I know a lot more about why I drank, and I try to blame myself less. I have to try and be philosophical ... these things happen. I won't drink again because I'm terrified of it. My fear made me drink, but now I fear the drink itself more. It's all gone full circle, hasn't it. (Wendy)**

Alex also spoke of strategies she learned, and still uses, to minimise her need to drink. The concept of 'keeping her mind distracted' - a frequently mentioned strategy for many women – was important, as was the attempt to find **self-respect** and regain control over her life. Making significant **lifestyle changes**, benefiting from further education, gaining a degree and a new,

successful career were also compensations for Alex. Being totally **abstinent** from any substance, rather than adopting controlled or social drinking, has also been a crucial decision for Alex, as this helps her feel in control and self-determined. In common with several others in my study, Alex continues to have recurring depressions, which she recognises could make her vulnerable to drinking again. Her selected strategies for maintaining change have been adopted with that acknowledgement:

> **I still get depressed and they are the hardest times. I know I've got to be so careful around those times, so I've learned routines which help, like watching the telly, bringing work home, anything to keep my mind distracted. I've also learned to cry, something I could never do before, and I'm learning to use friends, people to talk to. I'm still working on liking and respecting myself, accepting what I've been and done. It's been so hard to get here that I have to look back and try to see all that's happened as a learning experience. There are no special answers, but I do know I have to accept who I am. I've been abstinent for eight years now. During that time I got a good degree and a good job. These were things worth fighting for. At my worst times, I remind myself that I can never go back to that place again, all that lingering pain ... controlled drinking works for some people, but I'm not going to try it. I don't think anyone should gamble what they can't afford to lose. I'm abstinent from choice, and that is a decision no one can take from me. So now I stay in control...**
> **(Alex)**

Now completely **abstinent** from alcohol for the last three years, Jane's next goal is to withdraw from the antidepressant medication which she was prescribed shortly before she began drinking. In many ways it may appear that Jane's life has not changed a great deal since she gave up drinking; she still seems to be socially isolated, and describes a marriage where she plays a subordinate role. However, Jane has achieved important **lifestyle** changes, to embrace her life-long love of literature and reading, and to use this pleasure and satisfaction to find much contentment. Spending quiet time in her library helps keep her in a safe 'fantasy world', perhaps

distanced from the reality of her lonely life. Reading, Jane suggests, sustains the opportunity for the much needed escapism which she once found in alcohol:

> **The worst of the craving lasted about nine months, now it's less of a bother ... and when I still want a drink, I know I can't. So that's it really! The next step will be trying to stop the antidepressants, then I'll know I'm better at last. Things with Paul** (husband) **don't improve. I still feel very lonely with him and wish he'd talk about feelings and emotions, but he won't. My life is now just getting on with managing as best as I can. My lifeline is my reading, I spend days in the library when I get bad. I've even joined a little library discussion group, which has been hard because I don't mix with people very well, but I do enjoy the discussion about the writers! Books are my escape, they keep me sober. When I read it's a wonderful fantasy world, numbed, private ... like when I was drinking, I suppose. Paul says I'm mindless, spending so much time reading fiction, he really seems to hate me doing it, but he'll never stop me reading. While I've got my books, I think I'll be all right.**
>
> **(Jane)**

Frances' detoxification without medical support was difficult, especially as her depression returned. But medical opinion denied her access to supports to help her to explore the reasons for her depression, which was seen as being secondary, and reactive, to her alcoholism. After finding a trusted friend to live with for two years, Frances was at last able to explore some of the traumatic life events which she now believes caused her depression and her subsequent alcohol misuse. Challenging more medical opinion that she would never successfully manage controlled drinking, Frances refused to be denied a future without alcohol, and she eventually engaged in a strictly **controlled drinking** regime which has worked well for her. Having made significant **life style changes**, including taking early retirement from medicine, she lives alone, and has been free of alcohol problems for many years. Her time is spent nurturing and tending her country garden, the pursuit she identifies as being her 'therapy'. Frances reflects on a life which has not always been happy, but she is now able to acknowledge that she has often been subject to much

external direction and control, rather than always being personally responsible for the more distressing events in her past life. She has learned that she should not always **blame herself**, and benefits from the positive qualities such a realisation can bring:

> **I was already taking a lot of antidepressant medication when I stopped drinking, and I think that reduced some physical side effects. But the psychological withdrawal was appalling. I spent weeks in my bedroom, craving alcohol, convinced that my only chance of sanity had now gone with the alcohol. I complained to a psychiatrist about my depression, but he kept repeating that it was the effects of the disease he called alcoholism. Telling him I drank because of my depression was ignored ... he said I could never drink again. I wanted to explore controlled drinking, but he said that was totally out of the question. When I was well enough, I moved in with a friend and began to work out some of the reasons why I had drank ... confronting childhood memories, my failed career and marriage, rejection and humiliation ... the rape by my brother. I stayed completely abstinent until I felt it was safe to begin drinking occasionally, and I found that worked. I couldn't have faced a future without the possibility of alcohol, because it was all I had found to help with the pain and depression, the guilt I felt about wasting opportunities and throwing away my chance to have a successful life. The fact I could have drink sometimes has been a great comfort ... and for the past seven years I've lived alone, here in my cottage, which I love. I have many acquaintances, but no friends. I don't feel too lonely, because my life is filled with gardening. I'm a fanatic, and love to get out there and work every day, winter or summer. It's my therapy, it keeps me well, and depression is not too much of a problem now. Maybe I've mellowed with age, or maybe the years have taken me from the memories which caused the depression. I have one scotch a day, before bed, to help me sleep ... but never more than one. My future now is in my cottage and in my garden. I don't have any great plans for the rest of my life, it's too late now to go back and repair what has happened. It's been a strange life ... not really a happy one...**

but I believe we only have limited control over our destiny. I wonder what that illusive dream of happiness really is ... I didn't find it, but I no longer keep slating myself for that, and that will give me a little more contentment in my old age!
(Frances)

When Violet stopped drinking, alone in her bed sit where she lived at that time, sheer **willpower** kept her from drinking, while she focussed her energies on finding self understanding rather than destructive self-reproach. Her emerging **self-acceptance** was aided by a new ability to express her feelings, rather than deny them, to be able to challenge the frustrations in her life, rather than turn these inwards upon herself. Her more positive view of herself has, she feels, also enabled others to see her more favourably, and this has raised her **self-esteem**. Her now long-term partner has given her invaluable support, which Violet recognises is not available to all women who are trying to give up alcohol. Violet also commented on how she views her past alcohol misuse has helped her to move on and gain the 'spiritual peace' which she feels she has now achieved. She looks forward to a future without alcohol related problems, and sees that life has much to offer her:

Stopping all drinking was my first step. That was hell, and I suffered, I can tell you! The physical withdrawal alone nearly finished me off, but somehow I managed. As I sobered up, over the months I saw how I used alcohol to try and escape from myself, not from life, but from me. I had to accept me, not just keep punishing myself, before I could really leave alcohol behind. It's taken me 50 years to see that I am no better, and no worse, than any one else. It's pointless to be full of regrets and frustrations, I know life isn't all about self gratification, and at last I've found an inner peace. I've learned that it is possible to express feelings, vent anger, without the world coming to an end! It's been a hard process, but with my partner, I've had the support to do that. Many women, of course, will never have this, and I know I'm lucky. I'm also able to like myself now and that affects how others see me - I think I'm a much more likeable person than I ever was. Since I've stopped

drinking, I've really centred on being positive rather than negative, but like my sobriety, it's something I need to keep working on, even after nine years. I used to hope I'd be able to drink socially one day, but now I've given up that idea. It's just not worth the risk. I don't even regret all my alcohol abuse quite so much now, because without it I wouldn't have needed to work so hard at being spiritually at peace with myself ... I try to see it as a gift rather than punishment. Each day needs to be lived, not just got through, and life has a lot to offer me now...
(Violet)

Jean described a similar process, which became a strategy for maintaining her sobriety. She reflected on how she needed to remember painful memories from her past, the events which had made her feel miserable, guilty and fearful, to enable her to have a **less punitive** view of herself. She has discovered, through relaxation training, the benefits of feeling less anxious. Her new **lifestyle** is less stressful and demanding, centring around spending much time quietly on her own, or at her local church where she is organist and choir leader. Her enduring recollections of intimate relationships surround danger and rejection, and these have undeniably left her feeling uncomfortable about seeking close relationships with others. Her warmth and her loyalty are now invested in her God, whom she believes will offer unconditional love. It appears that Jean's future will remain self contained and invariably alone. She cannot risk allowing herself to become too close to others again, she feels that her alcohol problems have stemmed from a series of destructive relationships, and she will do whatever is necessary to remain safe:

Breaking the habit of alcohol has had to be down to me ... like being able to express feelings, remember the past ... I don't always like it, but it's not about liking it, it's about facing up to things. It's, um, therapeutic for me, I might say. Something tells me it's important, like answering your ad. is for a reason? Something tells me it's been right to do this. I have had too much to carry ... the shame, guilt ... always lots of consuming anger, and frustration ... not very pretty. I've had to face up to the fact - and it's been very hard to do - that all my drinking and obsessions have hurt many people ... yes, they

have. I've been unstable, not been able to settle in any one place, or with anything for long ... I could call it a spirit of adventure, but I think it's more that I was never satisfied. So what do I do about it ... one thing is I try not to be so anxious these days. I took a series of relaxation classes and they helped. Being able to relax is so important, something I've always found hard to do. Now I don't have any close relationships really ... it's safer that way. I have one or two nice women friends, but no one really close and I spend a lot of my time doing the church organ and with my music, that gives me so much pleasure. I know I'm a much better, nicer person without alcohol ... I can look in the mirror without wondering why I have turned into someone so destructive ... I really have found some peace in my life at last.
(Jean)

Like other participants, Jill was able to draw strength from focussing on the compensations she felt sobriety has brought to her; better health, improved finances, job satisfaction and security. She has maintained many positive changes in her **lifestyle**, and cited the importance of changing friendship groups in her struggle to stay alcohol free. Previous research has highlighted changing social or friendship networks as being important for continued recovery from alcoholism (Klingemann 1992), yet Jill was the only participant in my research to include this in her strategy for change. I suspect this may be because, being single, and youngest participant in my study, Jill's life story indicated her earlier friendship groups had been transient, and often linked to places or activities which centralised alcohol. To break away from these influences appeared to cause Jill no personal or family conflict, or loss of important time-honoured friendships, repercussions which older women may have wished to avoid. Another important change for Jill was her decision to have two pets, her 'new family', which gives her welcomed caring responsibilities. Jill has found a new sense of **self-awareness**, which has helped her to select coping strategies to use when she feels vulnerable:

Once I decided to stop I knew I had to be more in charge of my life, stop being in a daze. I had to change nearly all my mates, as they all would have pushed me to keep drinking. It was hard to begin with, but I stuck with it,

and the people I hang out with now are quieter and more reliable. The main thing which helped me was getting the dog and cat. I love animals, but I was never responsible enough to get pets before, but here they are, my new family who I have to keep fit for, or they'd suffer. They're brilliant, they give me so much. So really I don't miss drink too much now, and there's lots of compensations. Like having my taste buds back, being able to taste food again. And feeling fitter, not being so ill all the time. I've got a job I like now, I've got a bit of money saved, and I feel better about myself. I know alcohol has been really bad for me, caused so many problems. I drank because I felt I had no place in the world, no where to fit in. Now I feel more contented, and after three years of being in control of my drinking, I think I'm over it now, and things can only get better. Things aren't perfect yet, but I try to stay optimistic. When I get stressed out I try to keep my self to myself ... take the dog for more walks, stay quiet and read, watch telly or play music. I've learned a lot about myself, about the times when I might be in danger of drinking again. Staying off is a lot about knowing myself better, finding other things to do rather than drink when I feel bad.
(Jill)

Joan's strategy for staying abstinent was unlike any other in my study. She was alone in situating family support as her main strategy for maintaining sobriety. However, it seemed that guilt, fear and embarrassment were equally driving forces in her recovery, rather than the positive influence of the support of unconditional love from her family. This was illustrated in her deep fear of rejection by her relatives, especially her husband, if she drank again. Her description of her continued fight to remain sober reflected an unhappy, isolated battle, where she felt condemned to live without alcohol, rather than feel motivated and empowered to want to remain abstinent, as so many others in my research had presented. Her use of tranquilisers, and the endorsement of these by others, further confirmed that Joan is not free of the pressures which compelled her to drink, rather that she has replaced one forbidden substance with a more legitimised one. Unlike many of the women who have gained increased confidence and pride from their freedom from alcohol misuse, Joan is still racked with self-doubt and remorse. She is living without alcohol,

and although she can cite benefits connected with sobriety, she has not yet constructed a future based on meeting her own needs. Joan's position supports evidence from others in this study, that validation of self, self-forgiveness and self-respect are needed before an alcohol free future can offer real fulfilment:

> **The morning I got home from the hospital** (following admission for acute alcohol poisoning) **my husband made me admit to everyone in the family, one at a time, that I was an alcoholic. He even made me tell all of our friends and the neighbours. It was very humiliating ... but it probably helped me to accept just what I'd become. So many times I've locked myself in my bedroom and cried and cried, desperate for a drink, but I don't tell my family about those times, it would be like I'm not beating it, or something. That makes me feel very alone, but I can't expect the others to keep hearing about my moans! I don't really know what's kept me off drink most. Feeling fitter has been a sort of help, being able to take the dogs for walks again, or being able to go out to the theatre with friends. So, life is more normal. When I want a drink I try to keep busy, keep my mind occupied - I know that drink nearly killed me, almost ruined my marriage, and I can never do that again. My family are a wonderful support, of course. They never talk about my drinking, because they say it's best to forget it and move on. When things get bad I take some extra tranquillisers for a while. In some ways they're calming, like the drink was, but, like my husband and doctor always say, tablets are better than drink. I'll never drink again because of the love of my family ... I owe them that, I could never let them down like that again, be such an embarrassment ...**
>
> **(Joan)**

Discussion: Engaging Women's Personal Resources To Support Them Towards Sobriety

Conventional theory suggests that problem drinkers need formal treatment to help them recover, or they will continue with their 'addiction'. My research has authenticated that recovery without medical or social interventions is not only possible, but perhaps the only alternative for some women. None said they had consulted her GP, or other helping professional, to initially discuss their decision to withdraw from alcohol, for they had lost faith in such support. Nor did many participants initially share their decision to stop drinking, or seek support, from friends or family, and this is consistent with evidence that suggests that alcoholic women receive poor support from familial and social networks (Gomberg 1993). Most decided to stop drinking, and succeeded in doing so, on their own. This required great personal resolution, strength and commitment, the kind of valuable personal qualities which so much literature on women with drinking problems fails to document. However, to expect all women with drinking problems to have to take full responsibility for discovering and instigating changes in their lives to achieve sobriety is unrealistic. Alcohol services, clinicians and therapists, and those who live with and care for women with drinking problems, need to respond positively for requests for help, and also be able to identify the many presentations which such requests for support may take. Equally, it is abstract and patronising for professionals to expect women to stop drinking simply because they are told it is 'bad for them', as was the experience of some of my participants. If women problem drinkers receive understanding, and are offered a platform from which they may be able to make sense of their lives, they may have renewed hope for the future. Without this hope, largely found through increased personal insight, the participants in my study have endorsed that there would be little to change for.

Previous literature on the resolution of women's alcohol problems without formal treatment has been very limited. Research has primarily focussed on men, and this knowledge has then been applied to women. It has usually referred to changes in drinking behaviour without treatment, as 'spontaneous' or 'natural recovery' and has also proposed that 'spontaneous recoverers' are lighter drinkers with fewer alcohol dependency symptoms,

than other alcoholics (Vaillant 1995). Such concepts of 'spontaneous recovery' have obvious medical overtones, and tend to disregard the significance of factors such as personal commitment, developmental and sociocultural variables, as well as the influence of gender. Those who achieved so called 'natural recovery' in my research were influenced by such factors. Their drinking histories also firmly challenge the contention that recovery without treatment is unlikely for those who have endured severe alcohol problems.

The women who expressed least difficulties around staying in control of alcohol were those who suggested they had changed their life styles, and their self concepts. Increased feelings of self awareness, self confidence and self belief were important, as were the strategies used when temptation to drink became an issue. Crucially, those who increasingly saw themselves outside the parameters of constant self-blame, personal disappointment and social stigma were those who seemed to be living most comfortably without alcohol misuse. Finding more independence in life, both in personal relationships and hobbies which offered rewards and personal pleasure, was also helpful. The ability to look at the past and not negate the importance of this; the gaining of self-esteem from recognising the strength it had taken to now live without drink were key factors for some. Transferring trust to religious faith was fundamental for others. Significantly, for many, sobriety had been maintained by pursuing a more solitary lifestyle, the perceived need for relationships with others often being replaced by self directed pastimes.

Those who had overcome their drinking problems and who had hope for their futures had a sense of serenity and calmness which was often strongly conveyed during my research visits with them, although this may not always be reinforced so decisively in the written narrative. These women had felt as low as they could get in life, after recovery they were still themselves, but appeared also to have changed. Many claimed that they felt more powerful, more self-sustaining. There was a shared confidence that alcohol misuse was behind them now, that it would never control their lives again and that nothing was ever going to make them go back to the way things were.

My research has illustrated that it is possible to challenge damaging myths concerning the perceived reluctance of women to engage with the kinds of demanding changes which will support their sobriety. I further suggest that more research with participants from outside of clinical populations is needed, to question current approaches and replace them by a recognition of the many positive qualities which women can bring to the process of their own recoveries. Such approaches would do well to engage the resources and strength of the problem drinkers themselves, such as those in my research, who have powerfully conveyed that they are capable of considerable personal insight and resolution.

Chapter Eleven

Final Discussion And Conclusions

The aim of my research has been to explore the lives of a group of women problem drinkers, to uncover any significant life events and experiences which may have led to, or contributed to, their alcohol misuse. These life stories have also been surveyed to identify influences which may have been important during individual journeys towards sobriety. Those who are most knowledgeable about how it feels to have lived as women with drinking problems have privileged my study by sharing powerful, descriptive insights into their worlds, and these have guided and framed my direction. Their individual and collective experiences have both extended established knowledge about women who misuse alcohol, and in several areas, have directly challenged it. Significantly, their detailed and personal accounts have brought new and important interpretations to the way women with drinking problems should be viewed.

My conclusions will begin by discussing the relevance and potential of my chosen research methodology. I will then reflect on the implications of my findings from preceding chapters concerning the specific themes which emerged from my research. As each of these chapters ended with a separate discussion on each theme, my conclusions will now present more over- arching and connecting issues.

Observations on Research Methodology

No previous studies using life history data collection within a feminist research approach, emerged from my reviews of available literature on women with drinking problems. Some published research had demonstrated the development of a much needed move towards more woman-centred or woman-sensitive work (Ettorre 1992) but these studies had adopted techniques such as interview schedules or semi-structured questioning for data collection, rather than life story work. Such research had also tended to focus on participants from fixed, often clinical populations (Wincup 2000) and had concentrated on exploring specific pre-selected topics, rather than relying on participants' words to guide the process. In-depth feminist, qualitative work had not contributed to the exploration of the development of life events and experiences over the whole lifespans of women who have experienced drinking problems. This endorses that the methodology I have used in my research is innovative and original, and stands alone in advancing a feminist framework to illuminate the significance of critical and progressive life experiences for women with drinking problems.

Throughout my thesis I have frequently referred to what I believe to be the considerable contribution of, and advantages of, using my selected research methods to study my chosen topic . Individually, both life history and feminist research methods have been recommended for working with disempowered, silenced or vulnerable groups (Reissman 1993; Smith and Watson 1998) . To unite both methods into an unusual and creative methodology was undoubtedly appropriate for my research topic. The life history work that I carried out within a feminist research approach encouraged reciprocity, and was rewarded with strikingly detailed and powerfully intimate personal accounts, which I do not believe would have been collected using other research methods or approaches. The self-narrated dimension of life history work also facilitated a new and abundant longitudinal perspective across the whole of participants' lives, encouraging developmental, rather than fragmented or isolated, antecedent events.

My feminist standpoint helped me to reflexively analyse the important emerging evidence of how the sequential development of my participants' life experiences had influenced their drinking problems. Reflexivity was a constant part of my research process, a component of research which is crucially important for both life history and feminist methods (Plummer 2001).

My chosen methodology also offered a sound anti-oppressive and ethically sensitive framework for working with participants who had potentially experienced stressful and distressing life events (Hagemaster 1992; Martin 1995). Other techniques may have fractured both the contexts and self understanding gained by the experience of life history narration, which was said by many participants to have offered them the opportunity to at last be heard, be believed and be validated. In turn, this process often facilitated increased self-knowledge, a stronger self-image and much relief or pleasure at sharing or releasing certain memories. Most participants found it a demanding experience, some found the experience cathartic, others told me they had just really enjoyed being able to talk to someone who seemed interested in their lives. No one appeared to regret their decision to join the research group, perhaps demonstrating a positive affirmation that my initial commitment to leave participants no worse after, than before, their research experience, was largely achieved. Participants often found that the insights they discovered in their stories affirmed, clarified and validated their dilemmas and experiences in relation to their lives, in a new and welcomed way. The therapeutic value of life history giving was undoubtedly profound for some, and this was also a gratifying outcome of the methods, which I had not fully anticipated prior to fieldwork.

From my own perspective, as researcher, spending time with a group of interesting, articulate women who agreed to share their intimate life stories with me was initially a rather daunting experience, but getting to know, and respect them, was a most satisfying one. That personal context, of the successful fostering of such potentially intimate relationships within a telescoped time-frame, must make life history work unique within research methods.

However, using the life history method may also increase the possibility of latent hazards for the researcher. Within such concentrated research encounters, where relationships are quite unlike other personal or professional ones, additional ethical responsibility is placed on the researcher to provide the most mutually comfortable, safe and respectful environment for life narrative giving and receiving. This additional emotional component, of establishing and maintaining appropriate supportive responses with vulnerable participants, should not be understated. I have spoken earlier of this, especially in my chapters concerning methodology and child sexual abuse. It is impossible to hear personal, often traumatic episodes from someone's life without being personally affected – often quite deeply, especially because of the additional dimension of the established rapport within life history relationships. Researchers need to manage any discomfort they may unexpectedly feel with sensitivity, in order to maintain elements of objectivity, and also as respect for their participants. I recommend that others who may consider using life history data collection should very carefully assess whether their current experience, supervisory research support and personal support resources will be sufficient to ensure that this important dimension within the research partnership damages neither party.

Drawing on my own experiences, I suggest there are other issues which may be viewed to be formidable by those who may adopt the life history research method . Although all research is time-consuming, especially for a lone researcher who may be involved in a project such as PhD work, there are processes within life history work which make it especially labour intensive. Life history gathering is a highly personal encounter, a creative relationship is built up, which will ultimately determine the quality of the collected data and its interpretation. A great deal of time will need to be spent with each participant, establishing mutual respect, and then collecting hours of life narrative. This must be duly anticipated when planning a locality and group number of research participants, as interviewing and travelling time could become unsustainable. Subsequently, all the hours of life narrative have to be transcribed from tape and analysed; this a particularly arduous task in life history work, and should not be underestimated. Depending on individual agreements with participants, and the researcher's own ethical stance, life history tapes will

often not lend themselves to writing or typing up of transcripts by helpers; indeed I would propose that by doing so, the researcher would lose an essential element of life history analysis. There is therefore a vast amount of transcription work to complete.

I was most fortunate, because my participants were reflective, interested narrators, who were often also able to intuitively make sense of their stories as they developed them. As women have a time honoured tradition of telling stories, especially of parts of their own lives, my participants' detailed, well articulated and interesting life narratives may be representative of the story telling skills of most women. My confidence in what I consider to be the positive aspects of life history work with women is very much influenced by this supposition. I consider there are limitless applications for its approach in research.

As a final note of personal reflection, I can look back on my research experience and recollect, with some irony, that many of the most disruptive or insurmountable difficulties which I encountered personally during my work were greatly contributed to by my gender. These included the responsibilities of being a lone parent with additional family caring commitments elsewhere in the country; trying to manage an increasing overload of work responsibilities in a part time academic post; managing the stress of hearing often distressing experiences within life stories – some of which I had also personally experienced; and occasional health related problems, largely associated with the above. For me, the wider implications of 'gender issues in research' will certainly now have more subjectively grounded interpretations.

New understandings of women with drinking problems

Uppermost, among the initial goals and expectations of the process I had when I began my research, was that my work should strive to authentically document the experiences of my participants. I was hopeful that my decision to gather life history data would give an unusual opportunity to let the otherwise hidden voices of a group of women with alcohol problems, from a non-clinical population, be heard within the public sphere. Similarly, I believed that the feminist perspectives which I would commit to my work would offer the potential to reflect the ignored or invisible realities of these women's lives. As my life history collection proceeded, it emerged that the compelling richness in the stories my participants were sharing with me, was offering me a valuable opportunity to move beyond boundaries of much previous alcohol research which has included women. The life stories I had heard were guiding me to new insights into how it actually was to be a *woman* with a drinking problem, and how their vividly articulated life experiences may have affected their drinking behaviour. Through analysis and comparison of their stories it has been possible to highlight life experiences, stressors and crises; pathways to drinking which have often been shared. My research has uncovered a descriptive picture of clearly grounded, common themes, which have been important to recognise and evaluate.

My developed analysis of the selected common themes in my thesis has endeavoured to challenge the essentialist, biological and pathological critique of women with drinking problems. I am aware there is a vociferous voice within feminist political debate which speaks of the drawing of any comparisons between and among women as being paramount to essentialist thinking. However, I contend that a dominant interest in upholding dimensions of difference – important though this undoubtedly is – should not shift attention from the equally important axis of the divisions which so powerfully sculpt the lives of girls and women in their 'gendered worlds'. Despite some radical social and economic change, evidence suggests that women usually remain socially unequal to men, and the experiences of my research participants have endorsed this.

To propose that all women who develop drinking problems have been uniformly oppressed and subordinated because of their gender (or any other oppression) would obviously be incorrect. Alongside patriarchal structures and ideologies are other important social divisions which will have influenced women's lives. So, although the boundaries of my research had to restrict the full analysis of the impact of all social divisions, I remain reflective of the consideration that the life experiences and actions of women in my study have also been responsive to other variables of power and control. However, my participants have shared many experiences which were directed by inequalities of opportunity because of their gender. My concluding focus will therefore be concentrated on the substantial evidence from life stories concerning the ways in which the gendered nature of being a woman has affected personal identity, experiences and action. These have both affected the drinking problems of participants and have mediated between individual experience and normative social expectations.

I am aware that drawing commonalities across women's lives may carry dangers of confining and defining women to roles of perpetual victimhood and passivity. I strongly argue that to acknowledge that many women in my study have been victims of gender-specific patriarchal constraints does not simply define them as victims. Personal agency for oppressed women requires an ability to know not only the scope, but also the limits of individual responsibility. Recognising the constraints to which one has been subjected is a vital step towards acknowledging one's own moral agency under oppression. Failure to name victimisation is a failure to name and accuse oppression. To understand the complexity of one's own experiences as being part of oppressive divisions was a vital step towards empowerment and release for several in my study whose previous situations had enforced their powerlessness. Within this context, many were able to conceptualise their heavy drinking as being a possible expression of their oppression, their adoption of a coping mechanism which had arisen from, and reflected, the very unequal distributions of power and control across their lives. In other words, their stories have given strong grounds to critique the traditional view of women problem drinkers which is evident in much current research and literature. This often defines women and their actions as simply being controlled by alcohol, rather than emphasising the contexts within which they have chosen

to control and use alcohol to temporarily release them from relentless distress and lack of opportunity.

Similarly, my research has concentrated on the predominantly negative experiences of participants' lives, for these were the events most talked of by my participants, and singularly or cumulatively appeared to lead to, or exacerbate, drinking problems. This should not disregard the positive and joyous experiences which all my participants have also celebrated in their lives. Inevitably perhaps, the identification and analysis of so many damaging events in my participants' life narratives could additionally raise questions about whether my self referred group had especially traumatic lives: whether it was the acuteness of their experiences which led them to misuse alcohol, or whether, in fact, their life experiences resemble those of other women of their generations, cultures and opportunities. This could lead to a questioning of the validity of problematic life events as being aetiologically significant for women with drinking problems - why certain women develop drinking problems when those from similar backgrounds and experiences do not. Although my research has not targeted the uncovering of such anomalies, my participants' stories have suggested personally valid reasons, and circumstances, when they were guided to use alcohol to cope with the pain and disappointment in their lives. Other women, who have experienced similar life events, may be guided to use alternative coping mechanisms. This observation should not undermine the significance of the view that alcohol may be used as an accessible substance for personal relief by many.

However, my analysis of all the complex and interactional data which I have collected about this group of women who experienced drinking problems, does not lead me to propose a definitive aetiological theory. The establishment of 'irrefutable truths', which would inevitably extend beyond a group of life history research participants, is not part of life history research tradition. My conclusions can, however, represent significant, common experiences in the lives of those in my study. Within this I also intend to avoid rigid declarations which could be (mis)interpreted to extend devaluing stereotypes about women with drinking problems, as has sometimes followed other research on women alcoholics.

In fact my research findings have directly challenged many negative stereotypes about women with drinking problems, such as the well established myths that they are passive and unmotivated. Some of my participants described how, in very proactive ways, they had used alcohol to temporarily liberate them from their predicaments. They may have been subject to many circumstances outside their control during their lives, and their reliance on alcohol could be seen only as a perpetuation of their victim status. However, these 'victims' decided to step outside of their subordinate roles by turning to the anaesthetising effects of alcohol, a substance which could offer them temporary relief, and one which was easily accessible to them. But then, within the extended contexts of their life stories, they have explained how they have eventually emerged as survivors. They identified that alcohol was further damaging their lives, and each made the decision to stop misusing it, showing considerable courage and self reliance in usually achieving this without help from others. This introduces another important focus for analysis – the concept of alcohol as a substance of empowerment and pleasure for women.

Participants sometimes spoke of the pleasure which drinking had given them. This is an interesting consideration, as women who drink heavily have characteristically been regarded in literature as self-destructive and dependent, rather than as assertive and self-seeking, not only with the vision to use alcohol for transient escape from intolerable personal circumstances, but also with the assertiveness to want to enjoy the effects of alcohol. Alcohol as a pleasure-giver, when there may be little else to enjoy, could be seen as being a positive, liberating substance. Of course most women who use alcohol, and discover pleasure from a temporary release of frustration or inhibitions, will be expected to use this pleasure-giver only in moderation. However, from the series of life circumstances outlined by of most women in my research, it is understandable that many may have tried to seek more pleasure and more release through alcohol. Inevitably, their substance for pleasure would become a substance of harm. Because of this, I am reluctant to over- emphasise that any long term excessive use of alcohol should be endorsed as a potentially empowering mode of resistance for women. I do acknowledge that women can find heavy drinking pleasurable or temporarily empowering, but to advocate this as a form

of unconscious protest or long term benefit, would come close to romanticising or sanctioning the risks of heavy drinking.

The influence of oppression across life spans has been overlooked as potentially being a primary factor in the development of drinking problems among women, with lack of longitudinal work severely limiting new theory in this area (Wilsnack et al 1998). 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 towards women often represents. Yet analysis of the constraints of gender based oppression evidenced in my study has provided crucial 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 every day lives of these women, with structures and relationships of power and control, have provided both the possible reasons for their pathways into individual experiences of drinking problems, as well as the processes to perpetuate them. I have therefore been able to position what I term: ' the gendered nature of the aetiological roots and perpetuation of some women's drinking problems'.

The gendered nature of the aetiological roots and perpetuation of some women's drinking problems

Previous research has uncovered some areas of women's experiences where gender may have had much impact on their drinking but, unfortunately, the focus of enquiry has frequently under-appreciated the potential importance of this . Additionally, previous studies have sometimes usefully identified one or two specific, but unconnected, areas in women's lives where gender has been recognised as being an important component in their drinking problems. However, my research has been able to go much further. My work has extended the boundaries of current understandings, by documenting the pervasiveness and regularity of oppression, and associated limited life opportunities, throughout the lifespans of many women in my research group. The supposition that women with drinking problems may have experienced influential gender-related oppressions at certain life stages can now be illuminated by the evidence from my participants, who often endured unrelenting continuums of oppressions throughout their lives. From childhood through to their current situations, many spoke of how they were subjected to a continuation of forms of persistent psychological, sexual, emotional and physical abuse, contributed to by male ideology and patriarchy. The ubiquitous, yet sometimes hidden, key variable of gender-based oppression has emerged as central.

Oppressive gendered life experiences have, through a chain of personal and social circumstances, suppressed and eroded the self-belief and self-worth of my participants. Their frustration, unhappiness, loneliness, depression, and anger has promoted a tangible and deep sense of powerlessness and injustice. A way of numbing, forgetting or surviving their oppression was to use alcohol to self medicate to try to temporarily bury their anger and distress.

The social and psychological construction of gendered power relationships have been clearly illustrated in the economic, social, political, domestic and sexual domains of my participants. Gender-based violence and threat, such as physical and sexual assault, rape, child sexual abuse, harassment, domestic violence was commonplace for many in my study

in both childhood and adult lives. Other oppressions resulting from gender inequality may not always have been so explicit, but have included unequal treatment at home, school and even within religious teaching and practices. Marital status and successful heterosexual partnerships are also frequently viewed as a measure of accomplishment for women, and failing relationships have made many in my study feel vulnerable and ineffective. Husbands and heterosexual partners were often identified by participants as having strongly encouraged and influenced their problem drinking. These men had often been violent, were heavy drinkers themselves, and had usually misused their power over these women in a variety of ways. Traditional family roles also served to block access to power for many women, with limited economic decision making and lack of freedom to choose often causing imbalance and conflict within their adult relationships. Failure to achieve the idealised gender image lowered their self esteem further. The experiences of participants who were lesbians were additionally compounded, for these women had also been judged to reject heterosexuality and the associations of certain male privileges, which they often believed would make them vulnerable to suspicion by both men and heterosexual women.

The effects of such emotional, psychological and physical oppressions for all participants were constructed within levels of subordination which were embodied in the form of fear, humiliation, guilt, powerlessness, anger, shame, pain, and the regularly shared experience of depression. Heavy drinking served briefly to mediate such dilemmas of their 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 emotional 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. Some also drank to forget, such as the child abuse victims. Some drank to try and cope with the concurrent trauma of events such as domestic violence. Some began drinking in their teens, feeling bored and hopeless about their life opportunities. Others drank to self medicate, to try and relieve their depression which was, in turn, usually misunderstood by the sexist theory and practice endemic in psychiatry. 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. Any treatment or support which

they accessed did not attempt to acknowledge either the primary reasons for their drinking, or the additional shame and hopelessness which their alcohol misuse produced. In fact, the stories of several women 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. Being female appeared considerably to limit the amount of support and help the women received from professionals, family and friends. My participants continued to drink, and to repeat their abuse, as a reflection of the valuelessness which others showed towards them. My observations of the severe shame, guilt and self loathing of my participants suggested this was both the result of, and the cause of, their initial misuse of alcohol. The stories recounted of girls and women who had been physically, sexually and emotionally mistreated suggested that they felt both their bodies and their boundaries had been violated; they felt desperate with little sense of control. 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.

For women in my research, this concept of dependency raised particular issues and contradictions. Like all women, they grew up through childhood and into adulthood being socialised to accept dependency. As daughters, wives and mothers, their roles not only permitted, but expected dependency on others, especially men; in fact it was within these roles that many had found most respect and status. Also, central to their dependent social roles, others were expected to be dependent on them, both emotionally and practically. However, when they chose a different kind of dependency – alcohol - this was unacceptable. For, according to the beliefs of others around them, and in fact their own beliefs borne out of their socialisation, heavy drinking jeopardised femininity and threatened their prescribed social roles of nurturer, caregiver, lover. Dependency could only be tolerated when it fitted dominant ideologies, so women in my study were deemed to be guilty on two levels, for showing dependency on alcohol, and for potentially rejecting their prescribed social roles as women. Within this complex scenario of trying to balance personal dependency with expectations of self and others, their feelings of shame and self- hate escalated, and led to more drinking.

My research has demonstrated how debates about women and alcohol misuse must be linked to wider social and political dimensions. When considering the dissatisfaction and depression expressed in my participants' life narratives, I suggest they did not show stereotypically pathological disturbance, or mental imbalance, by their behaviour. Their choices to begin drinking may more accurately be judged to have been sane responses to the unrelenting forces of oppression; a logical response to the suppression of identity and self concept. My participants used alcohol to help manage often intolerable social structures and experiences. 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.

Supporting Women to Overcome their Drinking Problems

The ways in which women experience drinking problems, and their individual needs for any medical treatment, social or personal supports, are heterogeneous. It is not possible to prescribe standardised or simple solutions for their complex problems, nor to advocate one ideal treatment response. However, my research participants have offered sufficiently insightful commentaries to enable me to articulate the kinds of directions which I am confident would make future systems of care more positive and appropriate to women's needs. I will now outline these, but also consider that several other important areas for change have been identified in previous chapters of my thesis, where more specific topic areas were developed.

The way forward for care and support for women with drinking problems requires a rethinking of many commonly held beliefs and practices. This includes a fundamental shift from responding to women who misuse alcohol as if they were a homogeneous group with identities and lives which are judged from within stereotypical notions. The ongoing adherence to androcentric theory and practices, and the rigid, traditional ways of defining women who misuse alcohol, neglect the changing demands and social and political realities of women's lives. Successful support needs to offer a complex and creative range of interventions based on the capacity to appreciate collective considerations about the gendered nature of women's lives, as well as the commitment to respond to the individual needs and circumstances of all women. From primary health care settings and social care agencies, to specialist addiction facilities, it must be possible to move towards a situation in which attitudes and services are gender-specific, gender-sensitive and respectful of diversity among women.

Outdated concepts in addiction studies, such as biological determinism, need to be challenged. The belief that women who drink heavily are sick, diseased and inherently different from other women centralises negativity and powerlessness. Women who experience drinking problems need to be given permission to express their full range of feelings; their sadness, their needs and their hopes. This philosophy of empowerment,

which should be a fundamental approach for all who work with women experiencing drinking problems, would establish an explicit invitation to support each woman to be able to function as the woman she wants to be. Such empowerment would also help women to see the broader picture of their lives, to enable them to live more consistently according to their own needs and choices, rather than those of others. To encourage women to care more about themselves, they must be assisted to survey the choices and new possibilities in life which may be available. This has to be tempered by realistically acknowledging the kinds of social and political constraints which impinge on women's free agency. To appropriately encourage change requires an open consideration of these intransigent oppressive ideologies which have regularly challenged women's personal power, and previously frustrated their ability to choose. This frustration was frequently part of my participants' lives, and often transferred into consuming anger which was usually directed towards self, especially prior to their sobriety. To free themselves from disabling self blame and personal hate, participants spoke of how they had begun to accept that elements of their histories and current lives could be rooted in collective structures which exacerbated their personal subjugation. By doing this, their damaging self-reproach could be directed more positively towards naming and challenging their unfair and unequal life opportunities. Self-blame was reduced and vital self-esteem and self-awareness improved, as they moved on to accept that they did indeed have the basic human right to deserve more from their lives. Gaining these pivotal insights, which proved essential for successful recovery, did not necessarily need their entry into official (voluntary or statutory) treatment ' systems'. Future service planning should acknowledge that appropriate support of women with alcohol problems could often be effectively facilitated by less formal and less stigmatising systems of support, perhaps offered from within confidential local primary health, social care or voluntary settings .

For women to feel they do not have to continue to rely on alcohol, they must be supported and guided to develop other alternative coping styles. It should be accepted that successful and continuing recovery will often be limited by the kinds of structural and practical considerations which are additionally affected by gender. Women may be likely to present for help in desperate need of practical support with consuming troubles related to violence

and abuse, poverty, housing, health, childcare, and training or employment. There are unlikely to be long term positive outcomes from interventions which do not assess such fundamental constraints in women's lives.

Another decisive affirmation from my research participants has been 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 respected; those women asking for support from 'experts' should be encouraged to be actively involved in the creation of their own treatment or care plans.

The participants in my research have also strongly recommended that support which appreciates the possible importance of depression in women's lives should always be offered. Gender-specific services, such as individual or women-only groups, staffed by female staff, which would offer therapeutic work with traumatic childhood or adult experiences, should routinely be developed. It is not enough to remove women from situations of danger – whether that may be domestic violence, or alcohol misuse- without helping them to build more rewarding lifestyles and strong personal identities. Supporting women's capacity to develop their personal strengths has also been highlighted by my participants, and suitable provisions may include improved access to leisure and pleasure activities, as well as educative and new training programmes. Services planned by, and for, lesbian women are also needed; as would be appropriately planned supports for women from other sub-groups of women problem drinkers.

My study has shown that the use a non-judgemental, respectful method of collecting information, such as life story work, could offer much for programmes which work with women problem drinkers. Not only can such assessment approaches facilitate a detailed overview of each woman's life, they also encourage her to draw confidence from being more in control of her own recovery process. I have highlighted elsewhere the additional

potential advantages of the therapeutic, cathartic benefits of life story telling; and I believe this should be considered as valuable by those who care for women with drinking problems.

Ultimately, I have learned from the women in my study 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 struggle towards sobriety could have been achieved more safely, from outside the destructive vacuum of rejection by others, which has left indelible damage on their lives. I am confident that if we begin to listen with more integrity and care to the voices of women with drinking problems, they will help guide us towards both the individual and collective solutions which are so badly needed.

Future directions for research with women who have experienced drinking problems

My research has explored important new perceptions concerning women with drinking problems, and it endorses the importance of research work in this area which will uncover previously hidden experiences, especially from non-clinical populations. A constantly motivating element of my work has been the realisation that there is so much still to learn about women who have experienced drinking problems. I have been aware that by developing and documenting recurrent themes, there has been a necessity to abridge the problem areas in women's lives - that to accommodate the breadth of the task I chose, required the reduction or non-inclusion of material which may have had significant personal meaning to some participants. There is still much left to do. The focus of each of my themed chapters deserves further intensive research work, and I am sure that much would be gained from this. The influences of childhood experiences, depression in adulthood and lesbian sexuality have been particularly under researched, especially among women problem drinkers in the UK. My hope is that my research endeavour will be developed and extended by future feminist researchers, who like me, will accept the privilege of being guided to new understandings by those who have lived as, and known what it means to be, women with drinking problems.

APPENDIX 1

This letter/sheet below was used as an additional source for information and simple guidelines about life story narration, which was offered to each research volunteer, following her agreement to join my study. Although I had already discussed the process of life history giving with each participant, several women additionally chose to take the sheet to read on their own, when I offered them it. Several said it helped them to feel more confident about being able to successfully narrate their life stories (as outlined in Methodology chapter).

Information below was typed onto my personally addressed notepaper, including business and home telephone number.

..... (space for handwritten name of participant)

Thank you so much for agreeing to take part in my research study on Women With Drinking Problems. Your life story is unique, and will help me to learn new understandings about the lives and experiences of women who feel they have had problems with alcohol . Your life story will be an invaluable contribution to my work , and I very much look forward to hearing it.

Telling me your life history is very much like telling a story – your story.
The way you chose to tell it is up to you, but it often helps to begin at the start of your life, and then continue through to the present day. Whilst doing this, you will probably find that you will need to refer back and forwards to events throughout your life, so don't worry if your story sometimes appears to 'jump around'. You also should not be concerned about forgetting experiences or events, or not having clear recall of everything you want to mention – there really is no right or wrong way to tell your story, whatever you can remember, and decide to tell me, will be right. Additionally, between our sessions you might remember something you meant to include in our previous meeting – once again, don't worry about this, we will begin every new session with time for you to clarify, add to or change anything you want to from previous sessions.

When you have finished your life history, you will also have the time to share any further insights, experiences or discussion with me about your life in general. Sometimes the process of telling your life stories raises some new understandings or issues for you which would be valuable for me to hear, should you wish to do so.

When I write up my research if I mention certain of your personal details, these will be changed to protect your complete anonymity. Short quotations from parts of your life story may be included in my final report (for instance, to support a point I may be wishing to make) but details of the personal overall development of your life, as you will tell me, will remain confidential between us. As I have already mentioned, you can decide to stop giving your life story at any time; and should this happen I would not use any of the information you had given me. At the end of my research I will destroy your taped story, unless you request otherwise.

I hope that during your life story narration , that you will feel confident to say, or to withhold, whatever you wish. I am sure our sessions will be informal and relaxed, and I will be pleased to answer any questions which may arise for you as we go along.

Please remember that the following notes are just to give you some starting points and some ideas about how you may wish to progress. They are certainly NOT meant to be a rigid framework which you should follow – and I know you will have many other important issues of your own to raise, apart from the few I have listed.

So, from the beginning of your life, until now, as you remember:

When and where you were born? What early memories are there for you? How do you recall your childhood, and your family life? What or who were main influences? You may wish to mention school, your friendships/social life, cultural background etc.

On to teenage years. How were these for you? What stands out in your memories? Relationships, leisure, your work or education etc. How did these influence the adult woman you were growing into?

Then continue by telling me about your adult years. Relationships, jobs, work, leisure, health.... Whatever has happened to you over the years, how it happened, and how this affected you. It's often quite hard to talk about the kind of women

we are, our personal feelings, hopes and fears, but this adds a unique personal dimension to your story, if feel able to do so.

Obviously, the influence which alcohol has had on you, and those you know, has been an important part of your life. As you tell of your life experiences you will be building up a developing picture of where and how alcohol has affected you, so you don't need to talk about your drinking problem as a wholly separate life experience, unless you wish to.

.....

(My signature, then, also handwritten: 'don't forget, if you have any queries, however small, give me a ring or drop me a note and I'll be pleased to sort these out with you. See you again soon').

APPENDIX 2

The following are two examples of the kind of short news stories which appeared in local newspapers, to promote my search for volunteers for my study. I had no control over the content of these news stories, although they were based on some of the information I sent each local paper in a formal news release, sometimes followed up by a telephone call from the reporter who was writing the story.

Women With Drinking Problems

A locally based research project is hoping to discover why some women abuse alcohol. Researcher Judy Davison, a lecturer who lives at Sherborne, is carrying out the study to try to find explanations about women and drinking. She has many years experience of working with people with alcohol problems, and believes that current knowledge about women with drinking problems needs to be updated: ' I believe that some women may misuse alcohol for different reasons from men, yet most of our information has been based on male studies. If we can better understand some of the life events which can lead women to start heavy drinking, this will hopefully bring about some improvement in the care of this often misunderstood and invisible minority group in society.'
Judy Davison's research involves in-depth discussions with women who have had alcohol problems. If you think you can help, contact her in confidence at Bournemouth University, Dept. Health & Community Studies, Christchurch Road, Bournemouth.

Blackmore Vale Magazine. September 1996. Page 7.
(Free paper delivered to homes in mid and west Dorset.)

Studying Women Who Drink

A local university lecturer is carrying out new research to try and find out why women turn to drink.
Researcher Judy Davison, who lives in Sherborne, and lectures at Bournemouth University, claims there may be different reasons why women turn to the demon drink:
'Having worked with both women and men who have alcohol problems, I have been very concerned that most of our understandings about alcohol misuse are made to fit both sexes – yet there may be very real differences why some women drink too much,' she said.
'If we can understand some of the life events which may lead some women to heavy drinking, this will hopefully improve care of this misunderstood group.'
Ms Davison's research will include in-depth discussions with women who feel they have had alcohol problems. If any woman would like to assist with her research, they can contact her in complete confidence at Bournemouth University, 17 Christchurch Road, Bournemouth.

Western Gazette. 2 March 1996. Page 5.

(Paid for weekly Somerset County newspaper).

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