



## SEXUAL VIOLENCE VICTIMISATION AND SUBSEQUENT PROBLEMATIC ALCOHOL USE: EXAMINING THE SELF-MEDICATION HYPOTHESIS

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Findings from in-depth interviews conducted as part of a larger study that examined the interrelationship between male-perpetrated intimate partner violence, mental health problems, and alcohol/other drug use are presented. A subset of 15 adult women who were part of a larger study ( $N = 227$ ) were asked about their experiences of sexual violence by an intimate partner, and their motivations to use alcohol in the context of chronic victimisation. Results suggested women use alcohol as a deliberate stress response to cope with anxiety and fear. Furthermore, participants reported to use alcohol as a form of gaining and/or maintaining control. Additional unsympathetic treatment by professionals was reported to exacerbate perceptions of helplessness and readiness to utilise alcohol as coping mechanism. The study concluded that women subjected to sexual violence by an intimate partner use alcohol for self-medication purposes. Positive and negative reinforcement effects increase the probability of ongoing self-medicating behaviours. Recommendations include addressing the needs and fears of women using an empowerment approach. An improvement of inter-professional collaboration efforts may result in removal of barriers victimised women experience accessing support services.

**Keywords:** Alcohol, Intimate partner violence, Rape, Self-medication, Sexual violence.

### Background

Sexual violence within an intimate relationship has become to be known as a significant public health problem with serious mental, physical and behavioural health consequences (Black et al., 2011; Guggisberg, 2010). Despite decades of awareness raising and development of support service programs for victims of sexual violence, professionals and researchers agree that interventions have not been as effective as expected (Temkin & Krahé, 2008; Wall, 2012). Consequently, it is imperative to further develop understanding the issue of sexual violence in the context of an intimate relationship to provide appropriate intervention services and prevent its occurrence.

Sexual violence remains a common problem worldwide. For example, in the United States, one in five adult women will have experienced attempted or completed forced penetration, commonly referred to as 'rape', in their lifetime. Of these, the majority of victims are assaulted by an intimate partner, while only about 15% report being raped by a stranger (Black et al., 2011). Globally, according to the World Health Organisation (2010), up to 59% of women experience rape and other forms of sexual violence perpetrated by an intimate partner.

Sexual violence has become recognised as a key feature of male-perpetrated intimate partner violence (MP-IPV), which is usually ongoing (Guggisberg, 2010; Mahoney, 1999) and may escalate over time (Temple, Weston, Rodriguez, & Marshall, 2007). Numerous studies reported a strong association between different types of MP-IPV (see for example, Duncan & Western, 2011; Guggisberg, 2010). Importantly, the negative impact of sexual violence has been reported to be most devastating affecting victimised women's physical and mental health, sense of safety and security, self-worth and eliciting a sense of powerlessness (Black et al., 2011; McOrmond-Plummer, 2008).

Sexual violence not only affects victims' physical and mental health directly, but increases the risk of poor health behaviours, particularly harmful alcohol use (Guggisberg, 2010; Kaysen et al., 2007; Seedat et al., 2005). Women with alcohol use problems commonly report a history of violence victimisation either as a child (Lown, Nayak, Korcha, & Greenfield, 2011), in adulthood (Messman-Moore, Ward, & Brown, 2009), or both (Ullman, Najdowski, & Filipas, 2009). One of the reasons for the strong association between alcohol use problems and a history of sexual violence among victims is the difficulty to negotiate an uncontrollable environment (Williamson, 2010) and the reinforcing effects of the drinking behaviour (Guggisberg, 2010). Any form of MP-IPV may be associated with a range of long-term consequences (Lown et al., 2011).

Considerable research has documented the seriousness of MP-IPV, which remains a global social problem, despite increased community awareness and legislative changes to underline the criminal nature of the violence (Russo, 2010). MP-IPV takes many different forms including physical and sexual violence, threats of violence, intimidation, controlling behaviour and economic deprivation (Garcia-Moreno & Watts, 2011; Hanson Frieze, & Chen, 2010), and tends to have a particular capacity to attack the identity of victimised individuals (Campbell, 2002; Russo, 2008) because of the multiple forms of violence experienced at the same time. According to Boonzaier and Schalkwyk (2011), MP-IPV cannot be isolated into one single form of violence (e.g., a one-off event of physical violence), but rather must be understood as ongoing, involving multiple forms of physical and non-physical violence that are perpetrated in the context of an intimate relationship. These destructive experiences of degradation and humiliation alongside physical and/or sexual violence affect victimised women's self-concept and bodily integrity, which may lead to severe psychological and health risk behaviours (Boonzaier & Schalkwyk, 2011; Messman-Moore et al., 2009).

### **The connection between alcohol and violence**

Emerging evidence suggests that women victims of MP-IPV report alcohol problems, particularly if sexual violence is experienced (Lown et al., 2011; Messman-Moore et al., 2009). However, little is known about the association between female victimisation of MP-IPV and women's motives for alcohol use (Andrews, Cao, Marsh, & Shin, 2011). Explanations of this phenomenon point to coping motives in an attempt to self-medicate mental health symptoms (e.g., Logan, Walker, Cole, & Leukefeld, 2002; Messman-Moore et al., 2009). For example, a large body of knowledge suggests that alcohol is often used as a means to cope with the mental health effects following violence exposure to reduce distress (Brière & Jordan, 2004; Temple et al., 2007; Williamson, 2010).

## Self-Medication

The self-medication hypothesis, developed by Duncan (1974) as a 'wild idea' (p. 724) has since been well established as a valid explanation for the strong association between experiences of mental health problems and distressful environments and substance use disorders (Leeies, Pagura, Sareen, & Bolton, 2010). This model suggests that traumatic experiences stemming from interpersonal violence victimisation such as child abuse and/or MP-IPV accounts for the co-occurrence of mental health and substance use comorbidity (e.g. Stewart & Israeli, 2001). It suggests that experiences of MP-IPV, particularly physical and sexual violence victimisation increase the susceptibility to developing mental health problems, particularly PTSD, which in turn increases the susceptibility to developing alcohol use problems. These substances, it is hypothesised by Stewart (1996), are used to reduce or control the symptoms of the mental health condition. Stewart also suggested that trauma victims use substances to reduce tension and to dampen intrusive memories. The maladaptive behaviour is reinforced due to the fulfilment of expectancies such as feeling brave, being able to sleep or alleviate anxiety (Ryder et al., 2006). However, women's substance use in the context of MP-IPV victimisation may increase their vulnerability to further and more severe violence as a result of the pharmacological properties, which may impair their judgement and ability to sense danger cues (Andrews et al., 2011).

## The Present Study

The core of the study centred on open-ended creative interviewing (Schutt, 2006) of women who self-identified as currently experiencing MP-IPV and alcohol use problems. This form of qualitative enquiry enables the researcher to engage participants in a dialogue by which understanding of partnership in the research process is strengthened even though hierarchy is not completely removed, which was termed 'conversation with a purpose' (Schutt, 2006, p. 311).

## Participants and Procedure

Participants were a sub-cohort of a larger quantitative study from Perth, Western Australia who received services from government and non-government agencies (see Guggisberg, 2010). The mean age of the participants was 38 years (range from 23 to 50 years). The majority of women were married (up to 23 years) and were of Caucasian appearance. There was a small minority of women who identified as Aboriginal. Of the 15 participants, 13 women had children (it was reported that some of the children were in state care), and two participants did not have children at the time of the study. One in three participants did not have a formal qualification and some were unemployed. The majority of women participated in the workforce either part-time or full-time. There was substantial common ground with self-identified current sexual violence victimisation experiences of MP-IPV associated with physical and/or controlling behaviours, and problematic alcohol use. Consequently, meaningful exploration of this association through in-depth interviews could be conducted.

During initial phone calls, a series of screening questions were asked to ensure participants fulfilled the criteria (current exposure to MP-IPV associated with problematic alcohol use), after which a mutually convenient time and place for the interview were selected. All participants were provided with the interview guide in advance, which contained the questions to be asked, respective topics to be discussed. These arose from the literature and evolved through the conversational nature of the conversation.

Women attended the interviews in the absence of their intimate partners, which lasted usually between one and two hours. Interview schedules were constructed to allow participants to elaborate on their lived experiences, telling their stories of victimisation and reflecting on the circumstances and reasons for alcohol use. At the end of the interview, participants were given the opportunity to 'unwind' (Schutt, 2006, p. 313). Some women asked specific questions about referrals or child protection issues.

No incentives were provided for the participation in the study. However, in case where children accompanied their mothers, a research assistant was on duty during these interviews minding the children allowing the mothers to talk freely.

Participants were keen to share their stories, despite having to cancel scheduled appointments up to five times. Empirical evidence suggests that victims of sexual assault are willing to participate in research for altruistic reasons in an attempt to encourage other women and to provide assistance in the hope their contribution will improve community services for victims (Campbell & Adams, 2009). However, a challenging factor was the likelihood of creating distress in participating women. Often, the women's affective state required to stop the interview and provide comfort and reassurance. Women were reminded that participation was entirely voluntary and asked whether they preferred discontinuation of the interview. One occasion required rescheduling the interview due to the participant's distress; all others were continued and completed on the same day.

Interviews were tape recorded and fully transcribed verbatim with help of two research assistants who previously had signed a confidentiality agreement. To protect the rights and safety of participants, specific strategies were implemented. All identifying information was removed and women were identified with a pseudonym on the transcripts.

Data were analysed using NVIVO8, a computer-assisted qualitative analysis tool. The analytic process used a multi-step model, in accordance with the principles of interpretative phenomenological analysis, following Giorgi's phenomenological existential approach that proposed that human experience can only be understood by acknowledging individual meaning of experience (Giorgi, 1997). The data were interrogated and coded into major categories of meaning. Text searches and query combinations allowed examination of underlying processes. Interpretation and further understanding was achieved through exploration of the data over a period of time, allowing for reflection.

Using this technique assisted in identifying specific themes and relationships between topics within and between the categories. Additionally, trends and patterns throughout the coding process were recorded. While these categories may appear to be mutually exclusive, it is important to note that they do not stand alone, but that they are highly interconnected.

After identifying key topics, the initial coding was refined and explored re-occurring meanings in the content analysis. Accounts of circumstances explore the deeper meaning of the conversations, while looking for overarching segments of shared experiences. This step allowed for a content analysis, which aimed at developing deep understanding of women's experiences of MP-IPV, as well as their narratives of alcohol use as behavioural coping mechanisms. This analytic process enabled constructing meaning and gaining insight into re-occurring themes.

## **Results and Discussion**

Direct verbatim quotes from participants' transcripts are included in this paper allowing women to have a voice and to illustrate interpretations obtained. The names in the extracts are all

pseudonyms. This section first discusses women's experiences of sexual violence, which is followed by extracts presenting women's explanations for their alcohol use.

### **Sexual Violence by a Current or Former Partner**

Female participants reported victimisation being usually accompanied with physical and psychological aggression towards them over a period of time. Respondents experienced many occasions and numerous forms of sexual violence. This is what some of the women experienced:

#### **Sky**

First he bashed me and then he wanted me to have sex. When I refused, he took his gun and held it to the back of my head ... [He] does not leave me alone until he got what he wanted. Then he leaves.

#### **Emma**

The more often the abuse happened, the more vicious and intense it became. As I fought back, mind you, I was just defending myself and my children, the more severe it became. The violence was fighting to keep me down when he raped me and I was fighting to just get back up and it simply never stopped... he made me fear for my life while keeping the control of abuse constant in so that I never felt safe...I was forced to have babies and could not gain control over my body...

A substantial number of women reported to have been sexually assaulted while they were asleep. This experience was, according to them particularly disturbing as they were not able to give or refuse consent.

#### **Corina**

B [Name of respondent's husband] did not do this often, but I recall the first time vividly because I was just so shocked... I woke up – him on top of me, having sex with me while I was asleep...then...I somehow carried myself into the shower, where I stayed for a long time crying.

#### **Simone**

I met K [name of respondent's former partner] when I was 17 through one of the many parties at my parents' house....Just after being together for approximately four months (it was a hot night), I felt comfortable enough in the relationship to sleep naked. I woke up the next morning to find K [name of respondent's ex-partner] having sex with me. Horrified at this happening, I lay there pretending to be asleep...I went to the toilet and cried because I had never thought that could have happened to me. I asked him why he did it... and K [name of respondent's ex-partner] told me that I was awake the whole time and knew what was happening and enjoyed it...

In addition, some participants reported of sexual acts performed such as anal intercourse. This was perceived as specifically degrading and humiliating. For instance, Adele reported:

### **Adele**

It usually happened when I was asleep. I would find him on top of me performing sex with me. Sometimes he would also do 'oral sex stuff' ... this happened throughout the six years. He always wanted to have anal sex with me – I often thought that secretly he must be homosexual...

The women reported of mental health problems as a direct result of victimisation experiences. Some were diagnosed with anxiety and/or depression and prescribed tranquillisers making them even more vulnerable to sexual violence as the account of Kelly illustrates:

### **Kelly**

You know, I am on antidepressants for a number of years now. I remember I was taking a sleeping pill because I was very anxious and I had a hard time.... I woke up, him being on top of me, he would take me every time he wanted to have sex with me. I said: 'what are you doing?' 'get off me!', but he just continued despite me not wanting. That is rape, is it not?... This was not a single event despite being in separate bedrooms for five years ...he made me do things sexually which I was not comfortable with and I did not want. But because I loved him, I would let him... He did not care whether I was in pain and did not want to have sex with him. That kind of thing happened all the time...

Not all women reported to have been raped. Some respondents discussed coercion into intercourse against their will. For example, this is what Fiona experienced:

### **Fiona**

...he has always put pressure on me... once we were in Germany on a business trip. He locked me in the bathroom. He would not let me out of the bathroom until I exposed myself through the keyhole. So I had to do that. It was totally humiliating... on other occasions... [h]e would wake me up in the middle of the night... It was always against my will, but I could not do anything about it...

### **Mental Health Problems**

Extensive evidence suggests that women exposed to sexual violence by an intimate partner over a prolonged time, experience a range of physical and psychological health problems, poor general health, and functional impairment (Black et al., 2011; Russo, 2010; Stark, 2007; Weiss, 2010). Many participants experienced these problems. They suffered sleep disruptions, social isolation, symptoms of posttraumatic stress disorder, other forms of anxiety and depression:

### **Corina**

I get a lot of nightmares, and I withdrew from everybody. I was not allowed to have contact with my mum, I was not allowed to phone her, but part of me didn't want to anyway.

### **Simone**



It was horrifying to think somebody would know...I was told so often that I am bringing shame onto the family. If I would tell somebody that I am being abused, this would bring shame onto the family... the abuse just kept going, it felt, and still does, like a black hole and there is no way out.

Recent evidence suggests that women subjected to MP-IPV, which involves sexual violence may experience a deep sense of shame. In fact, shameful and humiliating sexual acts may exacerbate feelings of extreme powerlessness and isolation (Weiss, 2010). Women humiliated by sexual violence, then may be particularly prone to using alcohol (and other drugs) as a coping strategy.

The interconnectedness between mental health problems and alcohol use has been well established in the literature (Davis, Stoner, Norris, George, & Maters, 2011; Guggisberg, 2010; Schumm, O'Farrell, Murphy, & Fals-Stewart, 2009; Tolman & Rosen, 2001). For example, Tolman and Rosen (2001) found female clients of a family support service were not only disproportionately affected by anxiety and depression, when MP-IPV was experienced, but many of the women who reported past-year victimisation and current mental health problems had also reported alcohol dependence.

Similarly, Ullman and colleagues (2006) found that women who had been subjected to sexual assault by 'a romantic partner/husband' (p. 732), reported high prevalence rates of symptoms of anxiety and/or depression along with problematic alcohol use. A distinct finding was that the women with severe mental health and alcohol use problems had reported highest rates of repeat victimisation. Participants reported to self-medicate the after-effects of sexual violence and often had a history of suicide attempts.

The current study found corroborating evidence. Women experienced high levels of vulnerability being exposed to sexual and other forms of violence. They desperately attempted to have control over their lives.

### **Self-Medication: Alcohol Use as Deliberate Stress Response**

Previously experienced positive and negative reinforcement effects were key factors that motivated the women to using alcohol on a regular basis to being better able to cope with their circumstances. Participants reported experiencing the effects of alcohol not only to help them sleep as a positive reinforcer, but also to reduce anxiety. Alcohol is often utilised to reduce physical tension and/or emotional distress (Thombs, 2006). Thus, the substance serves as a negative reinforcer as it reduces stress and anxiety in the individual consuming this substance. A number of studies found that self-medicating behaviours are closely related to the experiences of extreme distress, feelings of helplessness, and the desperate attempt to control physical and mental health symptoms (Schneider, Burnette, Ilgen, & Timko, 2009; Tolman & Rosen, 2001; Ullman et al., 2006). This is what some of the women reported:

#### **Adele**

Alcohol I use as coping mechanism. I don't like to get drunk, but having some glasses of wine every night help me to go to sleep. Why I drink at night time – I have these horrific nightmares because of what he did to me and drinking wine is my way of getting to sleep and using it as calming effect. I can feel that I am not in control of it; it is in control of me.

## Reinforcement

Because stress relief is experienced as a result of alcohol consumption, the behaviour is reinforced, even though people may be aware that they will develop an addiction (Flora, 2004). McKim (2007) asserted that the principles of Skinner's operant conditioning apply to human substance use behaviours, arguing that an attempt to understand the expected and experienced effects will assist in the treatment of alcohol use. Along the same lines, Lejuez and colleagues (1998) stated that individuals' substance use problems are not to be misinterpreted as "weak morals or lack of will" (p. 117), but should be viewed as a result of strong reinforcement. It is noteworthy to emphasise that the women in this study were often aware that their alcohol use is potentially harmful in the long-term. However, some of them asserted that against the background of adverse life events and feelings of powerlessness, they believed alcohol use to be the only feasible coping strategy.

## Danielle

I need peace and this is my way of getting that. I know that drinking is addictive and I know I need to make changes. I feel I am having an unhealthy relationship with alcohol. The nightmares are sometimes coming so bad that I am often fearful of going to bed.

## Ashleigh

I drink because it's just an unwind, I am just unwinding because it has been hard for a couple or months or I just feel like a drink... I feel a lot tired, a bit drained, that's because of everything. I feel stressed, but I bounce back quickly. I got to get on and I got to stay strong. You know, for the kid's sake and for my sake...

The women discussed their alcohol use patterns. Fiona is one participant who approached her consumption strategically to achieve the desired effect. She had unsuccessfully attempted to leave her husband multiple times and used alcohol as self-medication strategy for the past 10 years. This is what she said about her daily red wine consumption:

## Fiona

Well, I'll have one and a half bottles at night. And this is the way for me to shut myself out - to shut myself out and to make me sleepy... But I never drink alcohol during the day. I would always wait and start drinking... 6 o'clock is my starting point..., and I never drink during the day or get up and have a drink in the morning. I can't do that. It's always from 6 pm... the evenings are usually the hardest with kids and that's when M [name of husband] is coming home, of course...

As illustrated in the above extracts, alcohol is used as a positive reinforcer. The women reported that the regular use of alcohol assists them to cope with life stresses. Respondents described the necessity to drink in order to be able to sleep and cope with psychological disturbances. Alcohol has a sedative effect on the individual and can induce sleep (Winger, Woods, & Hofmann, 2004). Alcohol as a central nervous depressant is said to reduce anxiety (Winger et al., 2004). Winger and colleagues argued that the effects of alcohol are similar to tranquilisers and sleeping pills as the substance produces an acute decrease in anxiety and increases sleep results.



Given the women's experiences of sexual and other violence, it is not surprising that they talked about many mental health problems, associated with extreme emotional distress. For example, Corina, a young mother who recently separated from her partner recalled her victimisation as follows:

### **Corina**

He was physically, sexually, and mentally abusive... He used to punch the walls, punching and shoving me up the stairs... Occasionally, there was this real bashing... I never had broken bones or things like that. Of course I had lots of bruises, from my neck down, occasionally on my face. But because bruises could be covered up, he purposefully avoided bashing me so that people couldn't see...I think I also received internal damage because I often was in agony for days after.

MP-IPV tends to consist of multiple forms of violence that co-occur within the abusive relationship (Black et al., 2011). All of the respondents reported feeling distressed and confused. The women talked about how they constantly felt uneasy, suffered physical symptoms such as difficulty with breathing, racing hearts, back and/or stomach problems. They reported efforts to actively regulate their emotions by using alcohol to manage mental health problems that interfered with their daily lives.

Research found that alcohol is frequently consumed in order to increase a person's ability to cope with certain situations after traumatic events, particularly if symptoms of PTSD are severe (Vujanovic & Zvolensky, 2011). In this study, women reported the necessity of using alcohol just to be able to function and 'get through the day'. As most participants were mothers, they also reported of their active struggle to mitigate the harms caused by the violence, which involved protective strategies towards their children.

### **Experiences with Statutory Agencies – Unsympathetic Treatment**

A statement often made by interview respondents was their concern of feeling helpless, losing control over themselves and their children, and being blamed for their victimisation. While they felt protective of their children, the women reported unsympathetic treatment and disbelief by professionals they sought assistance from. Emma, a mother of four children, whose husband was incarcerated at the time of the interview, reported to having had to call the police on numerous occasions. She expressed her lack of control as follows:

### **Emma**

With the police, I always got the blame, but I have to say they would always come to my calls and take him away. But they didn't understand why I let him come back and why I went to live with him again. It's not so difficult to understand that I don't want my door kicked down all the time. I have seen it kicked down many times and then I have to pay the repair costs.... despite the restraining order I had to let him in. When he wanted to come in he came in. Either I opened the door or he kicked the door down. There was no choice and I did not want the door kicked down. Of course, the police blamed me... I let him in, they say. He is breaching the restraining order but the woman gets into trouble for letting him in.

The majority of women in this study reported that government support service providers posed additional threats and were regarded as enemies. Many interviewees reported that caseworkers

failed to acknowledge the unfavourable conditions the women found themselves in. Furthermore, participants reported a great deal of distress in dealing with government support services, and extraordinary fear of having their children removed. For instance, Corina, who was married for 12 years with four children reported to have her children in state care:

### **Corina**

Well, first they took my son, and then they took my baby, and, I just don't feel that they tried very hard to keep us together. They know that my ex-partner has got a problem with beating up women. And they know his circumstances and they just... I feel like they were too busy to take my kids off me, and I just wish that they had maybe come and seen me and tried to work with me rather than work against me.

Some respondents were involved in family court processes. Jane opted to seek separation from her partner, and mentioned that she had spoken about her victimisation experiences and that she had expressed her concern about the children's safety to the Child Representative. This is what happened during criminal justice proceedings:

### **Jane**

I feel like I've been put on trial by the Child Representative. I've spoken out about domestic violence and the abuse. There is all these campaigns, you know. 'Australia says No', 'any violence is violence', and 'speak out' and all this stuff. But, if you do, nothing happens. I've not found the level of support I was hoping for ... I feel victimised. I do feel victimised, like I am the one on trial.

The above extracts demonstrate how the legal system may pose a threat to women who want to protect their children and as a result become an additional source of distress and feelings of fear. Unsurprisingly, women reported of high levels of fear and a sense of helplessness. Research evidence suggests that abusers continue to successfully use support services to victimise their female partners, even after separation (DeKeseredy, 2006; Guggisberg et al., 2010).

### **Fear of further victimisation**

Fear of further victimisation as a consequence of past exposure to MP-IPV has been mentioned by a number of women. This feature of victimisation suggests an inverse relationship between experienced victimisation in the past and an increased sensitivity expressed in concern of future victimisation. The fear of future victimisation as a consequence of past exposure to violence has been termed 'fear-victimisation paradox', a concept more frequently experienced by women than by men (Pain, 1997). This phenomenon, similarly to actual experienced victimisation, direct victimisation, may affect a woman's psychological health and well-being to a great extent. Fear of victimisation can lead to anxiety, fear and depression as future victimisation is anticipated (Bachar & Koss, 2001). The fear of future victimisation may reinforce women's feelings of entrapment and perceived inability to escape. As a result, the only feasible response may seem to cope with using alcohol to control feelings of distress and fear.

Furthermore, participants reported to deliberately engage in behavioural emotion regulation to avoid the negative feelings, while also trying to 'walk on eggshells' in an attempt not to trigger any anger response from their partners. The example of Hannah is typical:

### **Hannah**

I am anxious when I see him. I find myself shaking when he comes in – I wish that he would just please go away. I just feel constantly anxious around him... I constantly try not to make him angry. I have to constantly walk around on egg shells... I have learned not to wind him up.

This combination of managing environmental stresses by anticipating their partner's wishes and using alcohol to manage emotions seems to be a successful approach for victims of sexual and other violence. The lack of perceived power may have been a motivator to apparent passivity, which in fact is rather a calculated response and effective coping strategy to the women's victimisation experiences.

### **Conclusion**

This study examined women's use of alcohol in the context of sexual and other violence by a current or former intimate partner. It gave participating women a voice and allowed to break the silence that often surrounds their victimisation and alcohol use problems. Findings of this study suggest several conclusions. Firstly, there is a connection between victimisation and alcohol use. Participants reported to use alcohol for self-medication purposes, not only to cope with the violence, but associated problems such as sleeplessness and anxiety issues arising from threats of violence. Secondly, most of the women interviewed experienced multiple forms of victimisation and an involvement of children, which they were most concerned about. Their reports indicated a desire to protect the children from direct and indirect violence, while at the same time being aware of the real possibility of having the children removed by child protective services. Women did not hold government support services in high regard. Experiences of victim-blaming further contributed to their alcohol use, which in turn was associated with acts of resistance. Finally, the women's desire to control the situation, in combination with a perceived lack of support, was reported to influence their decision to engage in ongoing alcohol use despite insight as to its harmful long-term effects. Insufficient professional assistance tends to be a factor in women's use of alcohol. Consequently, it is fair to argue that increased and appropriate services may result in reduced self-medication behaviour and eventually make problematic alcohol use against the background of MP-IPV victimisation unnecessary.

### **Limitations**

Despite the findings of this study providing a unique insight into the lives of women suffering from MP-IPV and using alcohol as a coping strategy, it is important to note that they are not generalisable to all women victims of sexual and other violence by a current or former intimate partner who utilise alcohol.

Further limitations include the reliance on women's self-reported experiences of the phenomena discussed within the research context. While rapport was developed with participants and most valuable information was obtained, the women's accounts are not illustrative of the complexity of their relationships and situations they experienced. The information obtained

allowed access to participants' accounts only to the extent the women were prepared to share their stories. Finally, the analysis process relied on participants' accounts as well as the researcher's inside knowledge about the impact of MP-IPV. Analytical process was shaped through the lens of having worked with victimised women for many years.

This study, despite the limitations, made a significant contribution to the body of knowledge in a much under-researched area. Findings make an original contribution to the building and expanding of knowledge, while increasing awareness of the interrelationship between the two phenomena of sexual victimisation by a male intimate partner and women's problematic alcohol use. Given the importance of reducing alcohol-related violence in intimate relationships, it is imperative that the association between violence victimisation and alcohol use be further investigated.

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