

Tracking Alcohol Use in Women Who Move Through Domestic Violence Shelters

**Report to the
British Columbia & Yukon Society of Transition Houses**

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**British Columbia
Centre of Excellence
for Women's Health**

**Submitted by the
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INTRODUCTION

This study investigated the links between the use of alcohol and other substances among women who have experienced violence and accessed help from transition houses in British Columbia in 2002-2003. The study was done in collaboration with the thirteen organizations delivering transition house services throughout BC, which are members of the BC and Yukon Society of Transition Houses. The study explores the stressors and issues faced by women who use alcohol and other substances and have experienced violence. It is our hope that the findings of this research will be helpful in further developing a collaborative response on the part of substance use treatment providers and domestic violence services.

The study was funded by the Alcoholic Beverage Medical Research Foundation. We express our sincere thanks to the British Columbia & Yukon Society of Transition Houses (BCYSTH) for their participation in this study and for the important work they do every day.

BACKGROUND ON THE RESEARCHERS

The British Columbia Centre of Excellence for Women's Health (BCCEWH) aims to improve the health of women through innovative, multi-disciplinary research endeavors and action-oriented approaches to women's health initiatives, women-centred programs, and health policy. A key focus of the BCCEWH is to facilitate policy-oriented research on the social determinants of health for disadvantaged and marginalized women. The BCCEWH also has a robust research and knowledge transfer program on addictions and substance use.

Dr. Lorraine Greaves, Executive Director of the BCCEWH, led the research team for this study. Dr. Greaves is an expert in the fields of violence against women, women's tobacco use and addiction, and gender influences on women's health. Nancy Poole, co-investigator, is a Research Associate with the BCCEWH and the Provincial Research Consultant on Women and Substance Use Issues for BC Women's Hospital. Other research team members were Natasha Jategaonkar, Lucy McCullough, Cathy Chabot, Ann Vanderbijl, and Renee Cormier, each of whom contributed to either design, data collection or analysis.

METHODS: HOW THE STUDY WAS CARRIED OUT

Recruitment

The research team approached the BCYSTH for assistance in identifying transition houses to participate in the study. Invitations to participate were distributed to all 64 member houses in British Columbia from January to July 2002. Participant screening and interviews took place from October 2002 to June 2003. Of the houses who expressed interest, the research team selected 13 on the basis of the following criteria:

- *Numbers:* the number of women with alcohol and substance use issues who enter the house per year and the estimated number of these with substance use problems, to ensure that the target sample size could be attained;
- *Location:* the urban/rural status of the house was considered in order to obtain representation from different areas across the province; and
- *Substance use policy:* Houses with a variety of significant, minimal, or no interventions for alcohol and substance use were included.

Staff at the participating houses were asked to tell each woman entering the house about the study within the first three days of her arrival. Women who were interested in participating in the study were

asked to sign a consent form, complete a confidential screening form, seal both items in an envelope, and return to a transition house staff member to be mailed or picked up by the local interviewer.

Women who completed screening forms and consent forms were considered eligible for the study if:

- they identified using alcohol or any substance more than five times a week, except if the only substance identified was nicotine, or
- they identified the use of multiple substances, from once a month to more than five times a week, or
- they identified that they have a current problem with alcohol or any of the other substances, except if they identified nicotine use only.

Thus, the women described in this study are those who were accessing help for violence-related concerns *and* using substances.

Interview Procedure

Women who participated in the study were interviewed twice, with the initial interview taking place when the woman was staying at the transition house (Time 1), and the second interview taking place approximately three months later (Time 2). Each interview was comprised of two parts. First, the interviewer administered a questionnaire regarding use of alcohol and other substances, stress levels and experience of intimate partner violence. Second, the interviewer asked a series of open-ended questions designed to gather information expressed in the women's own words. For each interview, each participant was given \$30 cash or a \$30 grocery voucher in thanks for her time. The questions asked in the second interview were similar to those in the first, designed to capture any changes that had occurred over the three-month period between interviews.

Level of Substance Use Intervention

Each transition house was classified as having either a "minimal" or "significant" substance use intervention. House representatives identified whether they proactively discuss the issue of substance use with residents and assist them in making change or getting connected to needed services (significant intervention); or if substance use is reactively and briefly discussed if women raise the issue, and some assistance provided in getting connected to needed services (minimal intervention).

RESULTS

Description of the Participants

A total of 191 women completed the confidential screening form, which represents approximately 10% of all women who accessed services from the participating transition houses during this time period. The majority (72%) of those who completed the screening form met the screening criteria and were eligible to participate in the study. Time 1 interviews were completed for 125 women, and 74 of these women were successfully contacted for a second interview approximately three months later (Time 2), representing a follow-up rate of 59.2%.

Among the 74 women who completed both interviews, the average age was 35 years. The majority of participants reported white/Caucasian ethnicity and heterosexual orientation, had completed some high school, and had an annual income of less than \$20,000. 88% of the women had children, and among these women, 45% reported having current child custody issues.

Substance Use

Women were asked to report their frequency and level of use of alcohol and other substances. Substances were grouped into four categories: Alcohol, Stimulants, Depressants (Medical Use), and Depressants (Non-medical Use). Examples of Stimulants used were cocaine and methamphetamines. Examples of Depressants were benzodiazepines, cannabis, heroin and codeine. However, depressants used in a prescribed fashion (regular frequency and consistent, appropriate quantities) were placed in the Depressants (Medical Use) category, and depressants taken in other than a prescribed way were placed in the Depressants (Non-medical Use) category.

Alcohol use is described by the number of days within the previous three months that the woman had consumed three or more alcoholic drinks on a single occasion (i.e., “binge drinking). On average, women reported binge drinking on 15.75 days over the three months preceding the first interview. Other categories of substances were assessed by considering the percentage of days that the substance(s) had been used over the same three-month period. At Time 1, stimulants were used most frequently, with almost half of the women reporting some use of these substances. On average, women reported use of stimulants 20.19% of the days during the three month period. A small proportion of women used stimulants every day. Use of depressants, both medical and non-medical, was less common. It can be seen that this sample of women used substantial amounts of alcohol, stimulants and depressants (both medical use and non-medical use) and that poly drug use was common. Please see Figures 1 and 2 for observed frequencies of substance use at Time 1 and Time 2.

We compared alcohol use among women in houses with significant and minimal substance use interventions. At houses with significant intervention, women reported binge drinking on an average of 17.71 days (19.68% of days) at Time 1 and an average of 1.97 days (2.19% of days) at Time 2. At houses, with minimal intervention, women reported binge drinking on an average of 13.78 days (15.31% of days) at Time 1 and an average of 4.86 days (5.4% of days) at Time 2. Thus, alcohol use decreased considerably for women in both houses with significant and minimal substance use interventions (see Figure 1).

While there was a significant reduction in the frequency of alcohol use for both groups of women, the decrease was greater for those women at the houses with significant interventions, who started out with the highest levels of use. The Time 1 level of alcohol use was higher among women who entered these houses, and the observed decrease in use of alcohol was also greater among this group. It seems plausible that women with higher levels of use of alcohol may make the decision to seek help and support from houses known to have significant alcohol interventions. However, another possible reason for the observed difference is that women residing in houses with significant alcohol interventions may feel more at ease in disclosing high levels of alcohol use.

Similar to alcohol, a significant reduction in the frequency of use of stimulants was also observed, for women in both houses with significant and minimal level interventions. In contrast, neither medical use nor non-medical use of depressants showed a significant decrease (see Figure 2). It is possible that the psychological and physical effects of depressants make it more difficult for women to reduce their use.

Figure 1. Alcohol use at Time 1 and Time 2, by level of intervention

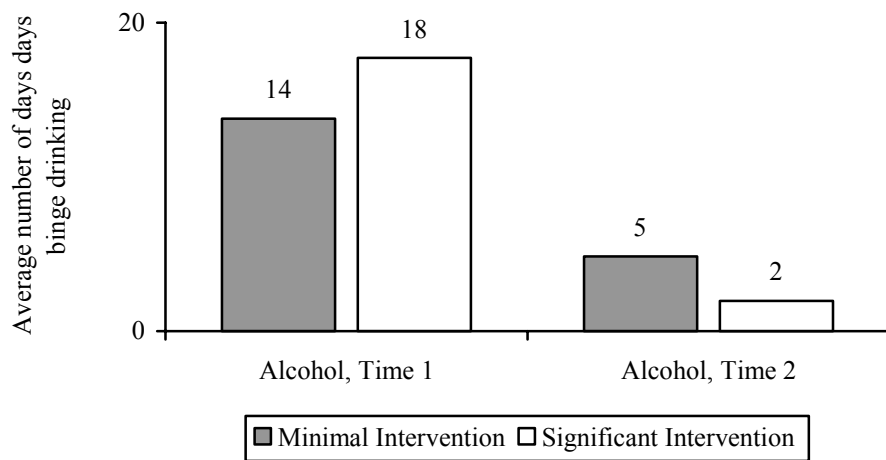
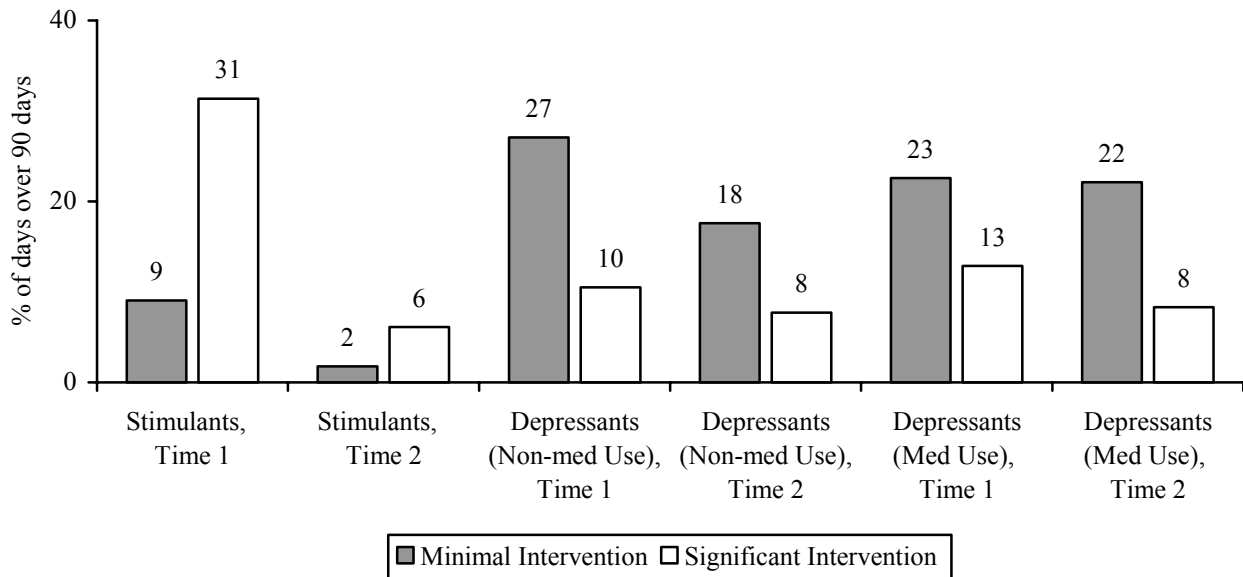


Figure 2. Use of other substances at Time 1 and Time 2, by level of intervention



Motivations for alcohol use

The Drinking Motives Questionnaire was used to examine motivations for alcohol use among this sample of women. The questionnaire assesses how often respondents drink for three types of motivations: to manage or cope with negative emotions, to maintain or enhance positive affective states, or to achieve certain social goals. Each woman received a score from 0-2 for each of the three types of motivations, with a higher score indicating that the woman drinks more frequently for that reason. At Time 1, drinking for coping reasons received the highest scores among the study participants. However, significant decreases were observed between Time 1 and Time 2 for all three types of motivations, with the largest decrease occurring in the coping motives (see Table 2).

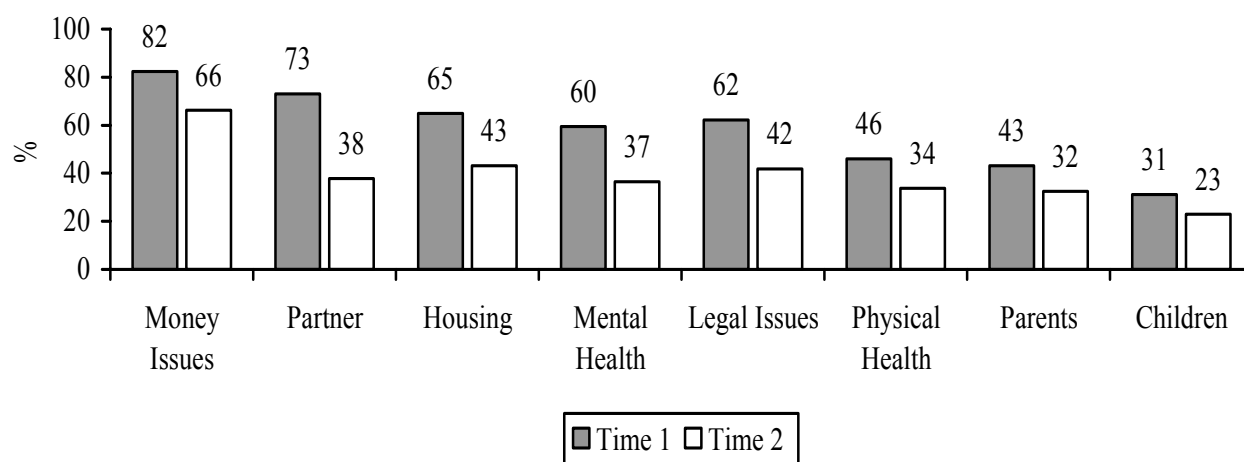
Table 2. Motivations for alcohol use at Time 1 and Time 2.

	Mean score, Time 1	Mean score, Time 2
Coping motives	1.12	.63
Enhancement motives	.97	.51
Social motives	.98	.59

Stressors

Women were asked to report on the areas in their lives causing them stress. At Time 1, the most common factors causing “great stress” were money issues (82%), relationship with partner (73%) and housing (65%). At Time 2, the most common factors were money issues (66%), housing (43%) and legal issues (42%). When individual stressors were compared from Time 1 to Time 2, a significant decrease in level of stress was observed for many of the major stressors. Relationship with partner had the most significant decrease, followed by mental health, legal issues, housing, and physical health. No significant decrease was observed in stress caused by relationship with parents, relationship with children, or money issues (see Figure 3). Although large and significant decreases were observed in the proportion of women reporting that their relationship with their partner and other factors were causing them “great stress”, it is important to note that these factors are still major causes of stress in the women’s lives at Time 2. This is illustrated in the qualitative portion of the study, as many women who had found housing still describe a living situation that is difficult due to their roommates or parents.

Figure 3. Women experiencing "great stress" due to factors in their lives, at Time 1 and Time 2



Perceived Stress

In addition to asking women about the factors in their lives that cause them stress, also considered was women's perceived ability to handle the stress in their lives. The Perceived Stress Scale-10 (PSS-10), was utilized which includes questions such as "In the past three months, how often have you felt that you were unable to control the important things in your life?" and "In the past three months, how often have you found that you could not cope with all the things you had to do?" Each participant was given a score ranging from 0-20, with a higher score representing a higher level of perceived stress. At Time 1, the average perceived stress score was 14, whereas at Time 2, the average perceived stress score was 11. Thus, there was significant decrease in perceived stress over the three-month period, indicating that the women felt better able to deal with the difficulties in their lives. It is also possible that this greater self-efficacy in handling stress was reflected in the lower scores for individual factors on the stressors questionnaire described above.

By having temporarily resided at the transition house, the women had had an opportunity for respite with greater support and time away from their violent partner. Thus, it is not surprising that they reported less perceived stress at Time 2. The support and counseling women received at the transition house may have helped them to learn coping skills in order to handle the stress in their lives and bolster their feelings of self-efficacy to cope with stress and negative emotions. Further, the house may have provided women with assistance for their housing, legal and medical concerns, which in turn may have had a positive effect on their physical and mental health.

Spousal Abuse

Women were asked about both physical and non-physical forms of violence they had experienced from their partner in the three months preceding the interview. Figure 4 and Figure 5 indicate the percentage of women reporting "frequent" abusive actions by their partners at Time 1. The number shown in brackets indicates the weight (severity) of the action. Both physical abuse and non-physical forms of abuse are common.

Although the same questions about abusive actions were asked at Time 2, only half of the participants gave complete answers at the second interview. Thus only results from Time 1 are shown here. We speculate that a possible reason for the high rate of missing responses at Time 2 is that women who are no longer in an intimate partner relationship may not feel that this index applies to them. However, many of these women may still be in contact with the previous partner (e.g., due to custody issues) and may still be at risk for further violence. Another possibility is that women who have returned to their partner are experiencing a temporary absence of violence in their relationship since the return and thus choose not to report any previous actions on the index.

Figure 4. Percentage of women reporting "frequent" physical abuse.

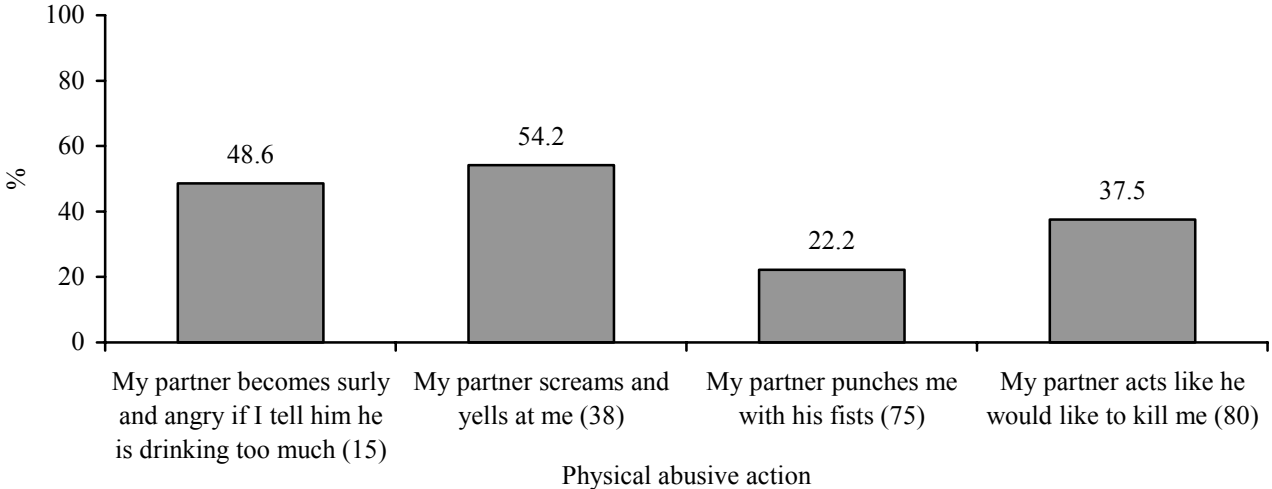
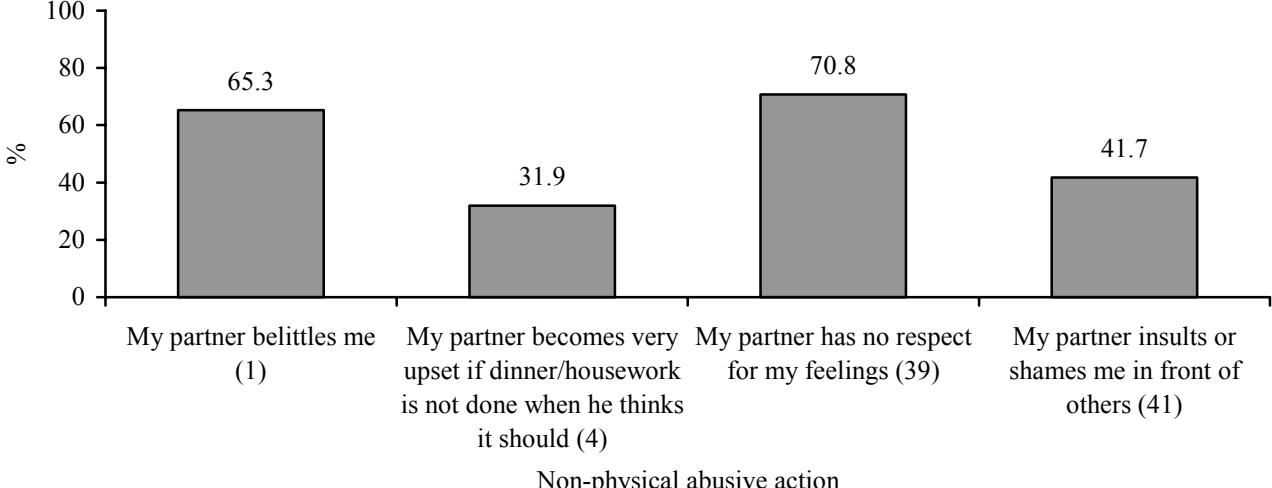


Figure 5. Percentage of women reporting "frequent" non-physical abuse.



Qualitative Findings

During the open-ended questions that were asked of each participant at Time 1 and Time 2, the connections among all of these issues were expounded. We identified three primary and interrelated themes (psycho-social issues; relational issues; and structural & environmental issues).

Psycho-Social Issues

The relationship between violence and the use of alcohol and other substances is enmeshed in complex ways. The findings illustrate that we cannot assume that one experience causes the other. This woman, for example, described how their use of alcohol and other substances to cope with stressors and violence created further problems:

“I used it to cope with the violence and would then put up with more violence. Using only served to numb me – that was the only benefit – I got used and abused.... Using ended up making everything so much worse for me. It made me forget. My using helped me accept his drug addiction better.”

Another participant described how her substance use and experience with violence was like a perpetual circle:

“I use to forget life, everything, to escape from everyday.... It just created more problems, a never ending circle.... I look at the use of substances, stress levels and experience of violence as all facets of the same problem, they are all connected.”

Women’s alcohol and substance use was often linked not only with recent abusive experiences, it was also sometimes affected by abuse they experienced in childhood or earlier intimate relationships. In this study, we did not ask women if they had experienced abuse in their childhood, although a number of women disclosed such experiences.

Women described their use of alcohol and other substances as interconnected with their mental health and experience of violence. One woman said her alcohol use was related to:

“Hopelessness, escape, putting off what I have to deal with. It’s the way I tolerate a situation. It’s a reprieve. Violence and substance use – It has to do with alcohol. It helps me stuff and not deal with anger but it also helps me to blow off my anger. I stuff my anger so much that when I blow up I’m insane and not able to deal with it. I’m afraid of what I might do. I have drank many times in my life to cope with feelings of abuse.”

Relational Issues

Women’s relationships with past or present intimate partners, family, friends, and their children are also quite complex. Participants recounted a number of issues they faced with regard to their current or ex-intimate partners. Women who left their intimate partners were often still in contact with them and frequently, this contact was related to child custody issues or divorce proceedings. This contact with ex-partners was typically described in negative terms:

“My daughter stresses when he comes to pick her up. He plays games and she’s caught in the middle. Having to deal with my ex on occasion – he still tries to control me and also he thinks we should have sex occasionally.”

The degree of social support available was also a key consideration in many participants' decisions about whether or not to leave an abusive relationship. For example, this woman spoke about the financial and social support issues she faced:

“My mother and sisters were against me coming into the shelter. My mother has abused me throughout my life.... So many cutbacks means I am doing my divorce myself. He has money and I don't which means that he will fight to keep my share.... Money is a huge stress. I don't have enough to eat and I don't have bus fare even to get to doctors appointments. I am still experiencing abuse from ex-partner who I am trying to get a settlement from.”

Women's relationships with their children were also a critical concern. A few women said that they delayed leaving their abusive partners because they did not think they would acquire custody of their children and they worried about the safety of their children if they left them in the care of their partners. A few women said they gave up custody of their children in order to get away from their abusive partners. This was a very difficult choice, but some women felt they had little alternative:

“I use because it takes me out of the present, it takes me out of the here and now. It takes away the loneliness. The present is too sad, my parents aren't supportive. I gave my ex custody of the kids – it is the only way I could get away from him. I wanted to get away from him because of the constant belittling, everything was my fault. Just to forget all the crap, right from childhood on.”

Other women chose to leave abusive partners to protect their children. For example, this woman said that the loss of social support from her ex-partner's family and friends was a stressor, but this was mitigated by the fact that she and her children were no longer living in an abusive environment.

“My ex's family and his friends have all turned against me. Now I'm dealing with everything on my own and it's stressful but I feel I cope better.... It's so bad but I'm keeping on with things.... Having to deal with my ex, him thinking we'll be coming home but I have no intentions of doing that. He's doing really bad with his substance abuse – he's doing crimes and getting caught. He gets supervised visits as do his parents. The Ministry [responsible for child protection] implemented this – ministry won't let any of them see the kids alone.”

Structural & Environmental Issues

Financial stressors were a significant concern for the majority of women who participated in this study. These financial worries were often linked with other stressors, such as mothering issues, access to transportation and services, legal concerns, and health problems. A number of women said that money stressors prevented them from being unable to leave their abusive relationships earlier. One woman stated:

“I left my husband many times. But when I was on my own I had to get my own place, childcare, pay all my own bills, etc. So it was easier to just go back to the abusive partner who has the job, the house, the drugs, etc.”

Fragmented social services were also a common barrier to women who are trying to improve their lives. Many participants said they had difficulties navigating the social services system because programs are not coordinated to deal with multiple issues. As one participant stated:

“I look at the use of substances, stress levels and experience of violence as all facets of the same problem, they are all connected. The different funding sources put women into different slots. However, all of the women seem to be coming from the same background. It’s all life problems, it’s societal, they shouldn’t be so easily defined and separated.”

The time women spent on seeking appropriate assistance often hindered their efforts to make change in their alcohol and other substance use. One participant mentioned that she was unable to make it to an appointment with her alcohol and drug counselor because she was participating in a job search program, which is a requirement for people receiving social assistance. This woman wanted to get into a detox program, but a shortage of such programs in British Columbia meant that she had to wait.

The stress women experience trying to access appropriate services when they need them can also exacerbate their drinking and/or substance use. One participant described the pain she experienced when she lost custody of her children, because she worked in the sex trade to support her substance use and that of her abusive partner:

“My reasons [for drinking] are because it helps me when I’m dealing with...I feel like my rights have been taken away with legal issues – a drink before makes me feel more empowered.... I feel that I’ve been stripped of my feelings, opinions...like no one really cares about me in this world, a hopeless feeling. I feel like I’ve been raped by the system.”

When this participant left her abusive partner, entered a transition house, and reduced her alcohol and substance use, she encountered barriers to being with her children. She went on to say that social service providers should be trained to better understand the multiple factors that can affect women’s use of alcohol and other substances, as well as their experiences with partner violence:

“It would be very helpful to [the child protection authorities] to understand the cycle of abuse regarding women coming out of abusive relationships – they should be trained because they are putting women down because [of] the lack of parenting skills or the use of alcohol – the reason is because they were abused. They judged me without the understanding of my experience of violence.”

Women’s experiences with abusive partners and their use of alcohol and other substances and other relational and systemic stressors have a significant impact on their self-identity and self-esteem. The majority of participants wanted to create positive change in their lives and most of them did not place responsibility for such change solely on others. Rather, they spoke of mutual responsibility for engagement and support. As one woman said:

“Women need to have some support services available to them, even the most simple of tasks seem to be overwhelming for these women. They need to be called on their ‘shit’. I wish someone would have done that for me. I was able to fool everyone into thinking I was okay.”

When participants received constructive, empowering support from service providers, family, and friends, they were often able to improve their situations and exercise more agency:

“I feel much more empowered. More able to stop things getting off track and stop miscommunication. I can recognize when I am saying A and he is saying L. I just stop

it. I just don't do it anymore. Not drinking it and not missing it. I have my own room now. It is totally my room. I'm a real person. I needed my own physical space.”

Many participants, such as this woman, not only did not return to their abusive partners, their self-esteem also improved when they received effective support during this critical period in their lives.

Limitations of the Study

One of the greatest challenges in conducting longitudinal research is the successful follow-up with the participants. Many researchers have noted that it is particularly difficult to track community samples of people who use alcohol and other substances and people who have been victims of partner violence. A large proportion (41%) of women did not complete Interview 2. The reasons underlying this loss to follow-up are not clear. The main differences observed between women who completed both interviews and those who did not, were related to education- and income-related variables. Further, there was a slightly larger proportion of Aboriginal women among those lost to follow-up. We speculate that many of the women may have moved during the time between interviews, and hence been difficult to contact. Finally, it is possible that women may have preferred to not participate in the second interview if they had returned to live with their partner.

A second limitation of this study was that we were not able to determine the proportion of women who returned to their previous violent partner. Although many women discussed having a partner at the time of the second interview, it was not determined whether this was the same partner as at Time 1. Women who described themselves as no longer having a partner were often still in contact with the previous partner (e.g. due to custody issues), and may still be at risk for further violence.

CONCLUSIONS

Often, attempts are made to describe violence and substance use as causal, with one due to the other. This study offers a more multifaceted view of the relationship, by illustrating how women's experience of violence and use of alcohol/other substances are embedded in a range of social and structural influences. Further, it illustrates how using individual stress as the key determinant for use of alcohol and other substances gives only a limited understanding of women's experience and fails to identify opportunities for positive change.

Women residing in transition houses who volunteered for the study cited significant levels of alcohol and other drug use. Given the stigma associated with women's substance use, especially for substance-using mothers, as well as the context of violence, it is remarkable that transition house residents were open to participating in the study and sharing their substance use histories. Further, the extent to which women were able to decrease their use of alcohol and stimulants in the period following their shelter stay is also noteworthy. This is a compelling testament of their motivation and capacity to change given the multiple stressors they face.

This study also points to the importance of the support offered by shelters on health, income, housing and related issues, and how this can have a pivotal impact in helping women restructure their lives and reduce their use of substances. It is of note that women's substance use decreased irrespective of the level of intervention offered by the shelter; thus, both brief and more substantive interventions can assist women in reflecting upon and making changes in their substance use. Given the complex inter-relationships of life stressors, substance use and violence demonstrated by this study, the alcohol- and

drug-specific, as well as broader, work done by transition house staff appears to function as a form of harm reduction to effect positive change. It is important for transition houses to acknowledge this impact of their current work, and also consider how to build upon it further. Their continued effort helps to ensure that all women accessing their services are freely able to discuss their substance use, make connections with other stressors in their lives, and find support to heal and grow.

This study also reveals the potential for collaborative approaches between substance use treatment service providers, domestic violence services and a host of other women-serving agencies. While women are making gains in spite of the obstacles presented by fragmentation of services, policy application and other barriers; their healing and growth could be made much easier by concerted support. Opportunities for services providers to inform each other on new approaches to treating substance use problems, working with women on violence/trauma issues, and supporting mothers to retain custody of their children, are currently being taken up in a number of locations¹. Comprehensive, integrated strategies for working with women who are facing multiple issues are being developed in a number of jurisdictions, with benefits for the women facing these burdens, the service providers working with them and the overall systems designed to serve them.

In summary, there are a range of social, structural, and personal factors that affect the use of alcohol and other substances by women who have experienced violence. At the time of seeking shelter services and in the period immediately following a shelter stay, women are reconstructing their lives and identities. They are influenced by the supports available to them and the discourses that surround them about alcohol/other substance use and violence. Women can greatly benefit from integrated, empowering support during this time. Transition houses are a critical component of the various supports women need to improve their lives at this time. At the same time, other social and structural supports are needed to ease, rather than exacerbate, the stress women are facing at this time, and support movement away from alcohol and other drug use as a means of coping with this stress.

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¹ For example, see Moses, D.J., Huntington, N., D'Ambrosio, B. (2004). *Developing Integrated Services for Women with Co-Occurring Disorders and Trauma Histories*. Substance Abuse and Mental Health Services Administration. USA.