PSYCHO-SOCIAL ASPECTS SUPPLEMENT

Cultural Analysis as a Perspective for Gender-Informed Alcohol Treatment Research in a Swedish Context

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Abstract — Aim: An exploratory study to investigate the role of culture in women’s drinking at a clinic for women with alcohol problems in a Swedish treatment context. Methods: A content analysis of the case journal material of 20 consecutive female patients at the EWA clinic (Early treatment of Women with Alcohol addiction) in Stockholm, Sweden, was conducted using an original instrument informed by the field of cultural psychiatry and emerging from recurrent themes in the case journals. Results: The patients perceived themselves as having a sub-group status. A trajectory of ritualized actions around drinking, especially private drinking rituals, was identified. Existential components of patients’ struggles with addiction in a highly secularized cultural context were identified. Multiple, contradictory explanatory frameworks for understanding drinking problems were creating cognitive dissonance. Conclusion: Using cultural analysis as a perspective for gaining gendered information may allow for identifying new patterns within specific cultural and subgroup contexts. It may contribute new information to the following treatment research areas: gender-appropriate measurement issues; service integration; gender-appropriate services for women; and, drinking rituals and patterns.

INTRODUCTION

In addiction research, the term ‘gender’ most often indicates a biological sex classification. Implicit assumptions are made about gender constructions in a cultural context, without explicit analysis. This results in broad gender categories covering women’s treatment needs (Kaskutas et al., 2005), without specificity concerning operationalization in cultural context.

A general consensus exists that women differ from men regarding certain patterns, consequences and reasons for use of alcohol and other psychoactive substances, and that these differences are due to numerous and complex factors (Lex, 1991). Data available on women’s substance abuse have increased (Weisner, 1993; Spak, 1996). However, gender-informed research on women concerning the complex nature of substance use relevant for both treatment and prevention remains scarce (Wilsnack and Wilsnack, 2002).

Multiple data collection methods and analytical tools are needed for measuring women’s drinking problems (Ames et al., 1996). A recent Swedish study supports the use of qualitative methods for identifying new assessment areas in sex and gender analysis in substance use research (Jakobsson et al., 2005).

Further, multiple service needs require an integrative model of addiction treatment for women (Smith and Weisner, 2000).

Women with substance abuse problems have lower levels of self-esteem and higher levels of anxiety and depression than men (Kohn et al., 2002). Co-morbidity of substance abuse with other psychiatric disorders is more prevalent in women than men (Yaffe et al., 1995), and women also have higher levels of guilt and shame related to drinking (Gomberg et al., 1991).

Women often enter treatment later and often seek treatment in other settings than specific alcohol and drug treatment programmes (Weisner and Schmidt, 1992). An integrative model of addiction treatment might help women address multiple problems in a coordinated manner (Smith and Weisner, 2000).

In research conducted by Kaskutas and colleagues (2005) in the United States, and Dahlgren and Willander (1989) in Sweden, two of the very few randomized studies on women’s programmes versus mixed-sex treatment programmes, different conclusions are reached in relation to the need for distinct, specialized treatment programmes for women. Only the Swedish study concludes that such treatment programmes are necessary.

The different methodologies involved in the studies make a comparison difficult. However, one area of reflection not included in either of these studies is cultural analysis. Such analysis takes into account societal patterns involving sub-culture identities, gender role expectations, social support structures, healthcare system equity, constructions of health and illness, as well as the symbolic and ritual expressions of health and illness (Kleinman, 1980).

Although cultural analysis has contributed to gender-informed healthcare research (Kirmayer, 2006), there is a limited use of such analysis in addiction research. Research in prevention (Unger et al., 2004), cross-cultural and cross-national studies comparing one or more variables around addiction patterns (Vogeltanz-Holm et al., 2004) and ethnic minority-dominant culture studies comparing treatment consumption and between population groups (Caetano, 1994) contain implicit cultural information but lack explicit analysis. Research on typologies of drinking cultures (Room and Måkelä, 2000; Järvinen, 2003) provides cultural analysis for gender-informed, male patterns. Schmidt and Room (1999) identify culture-specific analysis as important for cross-cultural applicability in international classifications and for research related to alcohol dependence and the diagnostic process, as does Adrian (2002) for interpreting theoretical and applied issues concerning multiculturalism and addiction.

The aim of this exploratory study was to investigate the role of culture in women’s drinking at a clinic for women with alcohol problems in a Swedish context. For this purpose, an exploratory cultural analysis study was undertaken using the case journals of the first 20 patients from a larger cohort study (N = 199). It was hypothesized that this qualitative study would provide information that could be of importance for planning and evaluating treatment interventions, providing culture-specific knowledge about women’s drinking problems, patterns and resources for change.

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SUBJECTS AND METHODS

Ethical considerations
This exploratory study is part of a larger cohort study of a specialized substance-abuse treatment clinic for women in Stockholm. The women gave consent for their records and data to be used in the cohort study. The cohort study was approved by the Regional Ethics Board in Stockholm, Dnr 2006/876-31.

Setting
The EWA clinic (Early treatment of Women with Alcohol addiction) in Stockholm is one of very few specialized treatment facilities in Sweden, concentrating on women’s substance-abuse problems. The primary target patient population is women with children <18 years of age. In addition to medical treatment for addiction and related problems, the clinic offers individual, family and child support services as well as acupuncture and relapse prevention courses. The clinic provides outpatient treatment. All members of the treatment team are women and include family therapists, nurses, a psychologist and a physician.

Subjects
Inclusion criteria for this study were the first 20 consecutive patients who sought treatment at the EWA clinic in the first half of 2001. According to the DSM-IV (American Psychiatric Association, 2000), 60% satisfied criteria for alcohol dependence and 30% for alcohol abuse. For 60%, the childhood environment included a substance-abusing parent. All began drinking as teenagers. All had psychological problems during the past several years and had received treatment. Most (70%) were married or in a relationship. The majority (90%) had completed a high school education, with 60% having completed college studies. When beginning treatment, most (70%) were working, in school or in job re-training. The mean length of time in outpatient treatment was 5 months (range 3–8).

When comparing the present group with the rest of the study cohort group (n = 179), there were no significant differences found in the background variables mentioned. The study group, however, had a slightly older mean age, M = 43.2 (SD = 8.9), compared to rest of the study cohort group, M = 41.5 (SD = 6.9), P = 0.04. With reference to self-reported measures of alcohol problems in the Alcohol Use Inventory (Berglund et al., 1986), the patients in this study had less severe alcohol problems, P = 0.04, compared to the rest of the cohort group. It is noteworthy that there was no significant difference in alcohol consumption between the groups (M = 499 g of alcohol per drinking week, SD = 310 g and M = 410 g of alcohol per drinking week, SD = 227 g, respectively).

Culturally, the group was relatively homogenous, with 85% being of ethnic Swedish background, 10% from other Scandanavian countries and 5% from another part of Europe. The patients were representative of the clinic’s population, reflecting similar patterns concerning education, work, family structure, social networking and leisure activities. Their lives reflected expected participation in Swedish society in that they had both salaried work and family responsibilities.

Data
The data for the cultural analysis were based on the patients’ case journals that include material from all members of the treatment team. They contain demographic information, treatment notes, diagnostic notes, relapse information, process indicators and social network information. This system of notation is common in Sweden. Though there are required areas in the notation process, other relevant information can be included. Using case journal material means that our data are filtered through the clinicians’ perceptions and viewpoints.

Instrument
The original instrument used here was informed by three sources. The first, the Outline for Cultural Formulation (American Psychiatric Association, 2000, pp. 897–8), contributed to understanding the individual patient’s way of understanding and approaching her illness, as well as setting that understanding into a cultural life context (Committee on Cultural Psychiatry Group for the Advancement of Psychiatry, 2002, p. 19). The second, based on the cultural dimensions model of Kleinman (1980), highlighted the interactions of biological, psychological, social, ecological and symbolic as well as ritual (repeated behaviours that have special significance for the participant) dimensions of patients’ constructions of illness and health. The third came from case discussions with the EWA treatment team. Important patient concerns were identified that included problems with cultural labelling of women who drink; lack of female empowerment support groups for women with drinking problems; culturally mixed messages regarding women’s roles at home and at work, and the need for a better understanding of behaviours surrounding drinking patterns.

Instrument: cultural analysis inquiry areas for identifying gender concerns in an alcohol treatment context for women
1. Is there a cultural identity status perceived by women in relation to their problem drinking?
2. What are the perceived cultural explanations related to drinking and to problem drinking for women?
3. What are the culturally important factors relating to bio-psychosocial function for women in alcohol treatment?
4. Are there cultural drinking patterns or ritual drinking behaviours that have a special meaning to women?
5. What is the perceived cultural means of relating between women and alcohol treatment caregivers and systems?
6. What cultural resources are identified that might be of importance for women’s recovery from/management of drinking problems?
7. Are there cultural implications that need to be incorporated into gender-informed diagnosis and treatment planning for women?

Data analysis
Using an established approach for qualitative research described by Malterud (2001), a qualitative text analysis of the case journals was undertaken. This was done by first identifying units in the case journals, then sorting into categories and finally making statistically determined connections. Through this procedure a thematic template was designed. A modified
grounded theory approach (Strauss and Corbin, 1998) was used to allow for the creation of new or refined themes. Two project researchers independently coded the data manually, following a content analytic dictionary approach method (Sobell et al., 2001).

RESULTS

The findings are presented through the instrument’s thematic areas as follows.

1. Cultural identity status perceived in relation to problem drinking

The cultural identity category was formed from individual expressions of personal identity related to the cultural context. Analysis of expressions of cultural identity status concerning substance-use problems revealed that all of the women located themselves in a negative sub-group. Expressions included feeling lost, not fitting in, being judged by society, and self-judgement as external judgement became internalized as a means of self-assessment. The vast majority (90%) expressed their situation of having a drinking problem as being labelled first from the outside and eventually from the inside.

The majority (75%) expressed frustration regarding the fact that Swedish society, known for its advancement of women’s rights and egalitarian social structure, still treats men and women differently around drinking patterns and problems. The case notes also reported the women referring to a cultural double standard for being intoxicated in public, but also related to drinking in general. These conflicting messages included that women need to be perfect and able to handle social drinking in order to be attractive but not engage in private drinking; that women can drink yet should be able to stop because women should not lose control; and emphasizing women’s liberation and the freedom to drink yet shaming women with alcohol problems.

A sense of perceived societal judgment contributed to feelings of shame, growing frustration and a quest for secrecy. These three experiences formed a common pattern. Over time the women’s need for secrecy increased and they tested different strategies. This process resulted in the creation of a private drinking world. The fear of being identified as a part of this subgroup drove the women to fight to maintain secrecy at almost all costs. The shame associated with this perceived labelling was deemed very destructive (90%). A common example involved the behavioural strategy of changing work hours to avoid underperformance and/or detection.

2. Perceived cultural explanations related to drinking and to problem drinking

The majority (80%) had multiple explanations for alcohol problems. A medical explanation placed the problem as needing to be fixed with medication or some type of specific intervention. The problem was out of their control and had biological—physical causation. A gender-specific social explanation identified drinking problems as resulting from social pressures on women to be everything to everyone. Shame resulted when perceived expectations were not met. A third explanation was individual guilt, where blame was placed on the self and one’s own shortcomings. Guilt was also related to negative consequences resulting from commission or omission: doing harmful or hurtful things to others and to the self, or not doing things that needed to be done. These explanations often co-existed and created internal conflict in the formation of an explanatory model.

3. Culturally important factors relating to bio-psychosocial function for women in alcohol treatment

Patterns of somatization developed or worsened in response to perceived social judgment. This in turn led to increased social avoidance and withdrawal. The body became the voice of the problem. Symptoms of depression, anxiety and stress were present in different combinations for 95% of the women. All reported a state of bodily exhaustion and lethargy associated with these symptoms. Different areas of recurring pain such as headache, back pain and stomach pain were reported. In many cases, no specific physical condition was indicated in the journal information to account for such pain. For many (80%), these symptoms lessened in frequency and severity with new strategies for understanding their problems, through feeling respected and heard in the clinical context, and by testing strategies for addressing their problems. It is also important to note that the role of medication received in the treatment process, though not included above, certainly needs to be taken into consideration here.

The topic of relationships provided a central category in the case material. The majority (95%) reported difficult experiences as children, including inadequate parenting, verbal abuse, physical abuse or sexual abuse, and (60%) had at least one parent with alcohol problems. Current family constellations were varied in the group but for those with partners, boundary setting and marital problems were common. A partner’s negative reaction to her drinking was reported by 20% of the women as a primary cause for entering treatment. The interpretations of spousal reactions as supportive or destructive varied.

Relationships to her children were equally complicated in terms of boundary setting. Both guilt and shame were reported in relation to her children’s negative reactions to parental drinking (76%, 10 of the 13 women with children under 18), as well as for problems that the children were having (62%, 10 of the 13 women with children under 18), in terms of different acting-out or self-destructive behaviours.

4. Cultural drinking patterns and ritual drinking behaviours

For 85% of the women, drinking patterns over time seemed to follow a similar trajectory. Experimental drinking began during the early teenage years. This served as a way to mark belonging to a specific group of friends. Such groups were generally mixed gender. Group pressure led to compliance. Different social drinking patterns emerged later on, and for many these were linked to identifying with different groups at work, female friends and to a lesser degree with sport/hobby groups. As drinking became more problematic and as life problems increased, social drinking rituals continued while private drinking rituals began (100%).

The private rituals had another character from the very beginning. These were planned activities meant to provide a special ‘energy’ for problem solving. For most, these rituals served a positive, stimulating function in the beginning. The function of these rituals, as drinking volumes increased over time, changed to a means for self-medication, managing the desire to drink, escape, calming down, managing an uncomfortable relationship, and/or forgetting painful memories. Two common features of
such private drinking rituals included finding a designated time, most often in the evening when the children were asleep and the partner was otherwise occupied, and having a special routine for drinking, incorporating the use of a favourite glass or mug.

5. Perceived cultural means of relating to alcohol treatment caregivers and systems

The women’s interactions with healthcare contexts in the 5-year period prior to contacting the clinic showed that the majority (75%) had long standing patterns of healthcare utilization for both psychological and somatic conditions. Over 50% had been on sick leave in the past, and in general approached sick leave as being an important part of the healthcare recovery process. Several women (20%) specifically noted the need for sick leave to address their drinking or combined substance use problems (most often sedatives or other prescription drugs). They also noted the need for such leave to be planned carefully, as having too much time would be a risk factor for relapse. This concern needs to be contextualized in relation to Sweden’s welfare system and its rather generous system of sick-leave compensation and rehabilitation.

Self-referral was the main means (85%) for beginning treatment. Many had read the clinic’s brochure that had been distributed widely over the larger Stockholm area. Women decided on the EWA clinic for one or more of the following reasons: that this was a women’s clinic; that they felt invited to be part of a process; that they would be respected and not shamed or judged; and that their children and partner could also receive help.

6. Cultural resources for recovery from/management of drinking problems

Regarding the women’s existential or meaning-making systems, several common themes arose. The role of long walks in nature and returning to a symbolically safe place in nature were common themes (70%). Finding a quiet time for reflection, being at peace and having time for oneself were important themes for all. Physical activity and exercise were important activities for 95% of the women. Finally, 85% identified a need to grieve over the anticipated loss of alcohol and its different functions in their lives. Half of the women noted the need to do something specific in place of drinking, something that could be a healthy and meaningful alternative activity that was special for them. This need for a kind of re-ritualization was linked to the rituals of drinking (outlined under area 4), especially for replacing private ritual drinking.

The women’s information about things that helped them make sense out of their situation and the recovery process did not include any references to traditional religious or spiritual beliefs. As Sweden is one of the most secularized countries in Europe, this finding is not surprising. Private religiosity and different forms of spirituality are not uncommon (Pettersson, 2002). Only 15% of the women indicated that they had attended Alcoholics Anonymous support groups, and only the non-ethnic Swedish women found this kind of support meaningful. Many identified a need for another, more empowering type of support group for women with drinking problems.

7. Overview of cultural implications that can inform diagnosing and treatment planning for women

The information provided in 1–6 contributed to a fuller understanding of how individual, societal and symbolic levels interact in Swedish culture. This information resulted in several changes at the EWA clinic. In relation to treatment, family therapy was introduced emphasizing gender role expectations in the referred couples. Individual and group therapies focused more specifically on framing issues of women’s guilt and shame as cultural constructions. A semi-structured interview was added to the information-gathering process at the start of treatment. The interview format was based on the thematic areas of the cultural approach instrument.

DISCUSSION

The study’s findings support the idea of culturally influenced drinking typologies by Room and Mäkelä (2000), providing specific information on women’s private drinking patterns. In agreement with Lex (1991), the women’s patterns of alcohol use and drinking consequences were complex, involving issues of self-esteem, anxiety and depression (Kohn et al., 2002). Strong patterns of guilt and shame were also present (Gomberg et al., 1991).

The differences in the cultural context between Sweden and the United States and differences in treatment programme components may shed light on the different conclusions reached on the need for specific treatment programmes for women reached in the Swedish study by Dahlgren and Willander (1989) and the US study by Kaskutas and colleagues (2005). Only the Swedish study concluded the need for sex-specific treatment programmes. Some researchers have questioned the validity of the idea that female alcoholism is often hidden (Spak, 1996). In Sweden, Österling et al. (1993) found no significant difference in the rates of hidden female and male alcoholism. In a study from California, female alcoholics were over-represented in most treatment facilities as compared to males, when the prevalence in the population was taken into account (Weisner, 1993). For the Swedish women in the current study, however, choosing a women’s only treatment programme was important for the decision to get help for their drinking problems.

The study’s findings support the idea that cultural analysis might be a useful research resource in the diagnostic and treatment planning processes (Schmidt and Room, 1999; Kirmayer, 2006). Finally, the findings support the idea that qualitative methods are useful for gaining new and more nuanced information about a group that perceives itself as stigmatized by society (Ames et al., 1996).

Limitations and contributions of the study

This cultural analysis study has some limitations. The findings are limited to a specific outpatient group at a women’s treatment clinic in a specific cultural healthcare context. The population studied here is from a women’s only treatment service, which may attract clientele who may be more likely to describe their alcohol problems in relation to gender issues. The findings may not pertain to people who do not directly seek help for problem drinking. In this respect the themes identified cannot be generalized to other groups of female alcoholics.

There was only a single group studied and no female or male comparison groups were used. Therefore, it was not possible to directly test whether the findings are specific to women or might also reflect men with alcohol use disorders. Only case journals, reflecting the perception of the clinicians, were analysed; no
direct culturally focused material was collected from the group. Consequently, the data reflected the perception of EWA staff, and while the themes emerged from the women’s case journals, the women themselves could not validate the findings as they had already completed treatment.

Though the 20 consecutive cases included here were representative of the women in the larger cohort study in terms of demographics and diagnostics, the profile does not cover other groups of female alcoholics in the Swedish context. The fact that the women perceived this treatment setting as different from others and as providing a source of empowerment may indeed have allowed them to discuss topics in a very open manner.

Considering these limitations, findings from this exploratory study are, however, of interest for future research, particularly within Sweden and Scandinavia. These include first, the identification of a trajectory of ritualized actions around drinking for women and the need for a re-ritualization dimension, especially around private rituals of drinking; second, the understanding, especially in secularized cultural contexts such as Sweden, of the existential or meaning-making dimension of patients’ struggles with addiction and identification of resources for change; and third, multiple explanatory frameworks for understanding drinking problems.

CONCLUSION

Using cultural analysis as a perspective for gaining gendered information may allow for identifying new patterns within specific cultural and subgroup contexts. It may contribute new information to the following treatment research areas: gender-specific cultural and subgroup contexts. It may contribute new information in a Swedish population survey.


