Introduction: Gendering Socio Cultural Alcohol and Drug Research

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Abstract — Aim: The gender gap in alcohol consumption and alcohol-related harm still is considerable and largely unexplained. This paper introduces four studies performed in Sweden that explore factors influencing gender differences in levels of consumption, adverse consequences and treatment. Method: We summarize and discuss these four studies performed within the same cultural setting, which each analyze interaction with the gender. Results: Two studies focus on the individual level addressing criminal behaviour, alcohol problems and mortality, and gender identity and alcohol problems in women taking psychiatric co-morbidity into account. Two studies focus on the institutional and cultural levels addressing the handling of alcohol-related problems in primary healthcare and the effectiveness of using cultural analysis in identifying gender concerns for women. Conclusion: Future studies need to focus more on these complex associations to secure that treatment settings provide both genders with fair and adequate treatment of high quality and that prevention activities will start to test measures that take gender into consideration.

DIFFERENCES IN ALCOHOL CONSUMPTION—THE GENDER GAP

One of the most consistent findings in international research on alcohol is that men outnumber women as alcohol consumers, consume higher quantities and experience more alcohol-related health and social problems (Wilsnack et al., 2000; Babor et al., 2003; Grant et al., 2004; M¨akel¨a et al., 2006). Even if there is a trend of decreasing differences in many countries, the gender gap still is considerable and remains largely unexplained (Holmilta and Raitasalo, 2005). WHO identified alcohol as the third leading cause of disability adjusted life years (DALYs) attributing 9.2% of all DALYs in Europe, whereas 11.1% of all DALYs were attributed to alcohol in men, which was only 1.6% in women (WHO, 2002).

Women have a higher biologic vulnerability compared to men and this is mainly due to their smaller body size and different distribution of fat and water (NIAAA, 2000). Women further have increased sensitivity to alcohol damages, e.g. in the liver for uncertain reasons, possibly hormonal, and they also may have lower first pass metabolism of alcohol. This biologic vulnerability puts women at a higher individual risk, but given that more men consume more alcohol, and higher quantities when drinking, men as a group are at higher risk seen from a public health perspective. Social consequences are also more common in men with increased risk of absenteeism and sickness absence, high risk of separation and family problems, use of violence at home and in public, driving while drunk and other forms of criminality. These health and social consequences also constitute high costs to the community. However, the increased alcohol consumption in young and middle-aged women has led to a large concern regarding the future development of social and health consequences (NIAAA, 2000).

The gender gap in alcohol use is smaller in younger age groups and in countries with high gender equality. Sweden and other Nordic European countries are considered as being among the most egalitarian countries with legislation and policy promoting gender equality at work, in the family and in the public sector. The gender gap in alcohol consumption and its adverse consequences was less pronounced in countries with high gender equity and degree of modernization according to a recent analysis performed within the GENACIS project (Rahav et al., 2006). Gender differences in drinking were also reported from the EU concerted action ‘Gender, Culture and Alcohol Problems: A Multi-National Study’ (Bloomfield et al., 2006). The authors conclude that these differences varied substantially over European countries with a North–South gradient—smaller differences the more North the country was situated. The gradient to a large extent was explained by societal factors of which the level of gender equity was the most notable according to Bloomfield et al. (2006). The authors call for future studies that go more into details to further understand and explain differences over genders and cultures.

The average consumption of alcohol in Sweden in 2002 was 13.9 L (100% alcohol) in men and 5.8 L (100% alcohol) in women (Leifman and Gustafsson, 2003). This gives a gender ratio of 2.4 (M¨akel¨a et al., 2006). The difference in beverage type is clear and similar to the one found in most studies: men more often drink beer and spirits while women more often drink wine (Leifman and Gustafsson, 2003; Bloomfield et al., 2006; M¨akel¨a et al., 2006). The gender ratio of episodic heavy drinking in Sweden was 2.6 in the youngest age group (20–34 years) and 4.1 in the two other age groups (35–49 and 50–64 years). In Sweden, few population studies on the prevalence of alcohol diagnosis have been conducted. For men the last data emanates from 1972 that showed a lifetime prevalence of 10% for alcohol dependence and abuse (roughly equal to the DSM-IV criteria) (¨Ojesjö and Hagnell, 1980) and for women the corresponding figure was 3.3% in 1990 (Spak and Hallstr¨om, 1995). A similar figure was also found in 1995 (Thundal et al., 2000). A study from Malm¨o in Sweden showed among 42-year olds in 1983 that ‘problem drinking’ at screening was 15.5% in men and 4.6% in women, giving a gender ratio of 3.4:1 (persons previously identified with problem drinking were excluded) (Osterling et al., 1992). A study in 2000, in which risk drinking was measured as a score of 6+ for women and 8+ for men on the screening instrument AUDIT, showed that 8% of the women and 14% of the men scored above these limits (Helmersson Bergmark, 2001). In an international comparison, Sweden together with other Nordic European countries...
CONSTRUCTIONS OF GENDER AND THE ROLE OF ALCOHOL

The gender gap in alcohol consumption has been discussed by several researchers (Room, 1996; Wilsnack and Wilsnack, 1997; Bloomfield et al., 2006). Wilsnack and Wilsnack (1997) suggested that a gender perspective needs to be developed in alcohol research since drinking patterns and behaviour can be seen as a reflection of the cultural construction of femininity and masculinity, but at the same time also as a part of ‘doing gender’ in a specific culture (Butler, 1999; Connell 2003). The gendering of alcohol and drinking behaviour takes place and acts at several structural levels through the social practice of women and men in their lives (Fig. 1).

The cultural level includes conceptions and norms that are incorporated as natural and unreflecting parts of our lived experiences (Connell, 2003). Such conceptions can be visible or non-visible within a specific culture, but even if they are visible, and even questioned, they still can be influential and are often intertwined with other structural levels. At the institutional level the things that women and men can do at work, in the family and during leisure time, are limited within formal and/or informal restrictions. At the individual level, the cultural conceptions and institutional restrictions interact with individual identity, rationality and behaviour to reproduce or change gender norms. The cultural, institutional and individual levels provide certain gendered boundaries in which men and women live their lives. However, the everyday social practice at each of the three levels can also contribute to changes, and neither men nor women are powerless victims (Butler, 1999; McNay, 1999; Bourdieu, 2001; Connell, 2003).

Eriksen (1999) made a social historical analysis of texts and documents from the period when the Temperance Movement was most active in Denmark at the end of the 19th century. She found that the description of drinking and sobriety was gendered to a very high extent and identified alcohol as a gender symbol. She suggested that sobriety was linked to women being pure, honourable and feminine, while the association to sobriety in men was that sober men were powerless and impotent. Sobriety thus was associated with increased femininity in women and with decreased masculinity in men. Drinking (but not drunkenness) on the other hand was associated with increased masculinity since drinking men were considered robust and manly while drinking women were seen as licentious and lecherous.

What Eriksen identified through her reading of newspaper articles, debates and other documents was gendered conceptions of alcohol and norms guiding women and men in their private and public drinking behaviour. Not all men and women complied with the existing conceptions and norms. They behaved in different ways, which can be described as subversive social practices (Butler, 1999; Eriksen, 1999; Bourdieu, 2001). Subversive social practice is deliberately performed to influence or change gender norms. Some women at the end of the 19th century deliberately transgressed the gender norms for drinking behaviour and at the same time they questioned the established boundaries for social practice.

EQUITY BETWEEN MEN AND WOMEN IN TREATMENT?

There is a gender gap in alcohol consumption and drinking behaviour and these differences can partly be understood within a framework of alcohol as a gender symbol involved in the construction of masculinity and femininity at cultural, institutional and individual levels of society. Furthermore, men as a group have more power and influence than women in economy, politics and most social arenas in Sweden and in other societies. Several researchers have pointed out that an aspect of this gendered societal order is that men often are considered to be the norm. This probably has important implications in alcohol prevention, treatment and research.

The notion of men as the norm is associated with assumptions that disease, symptoms, consequences and treatment are based upon male experiences and male presentations of symptoms. Heart diseases have been the focus of much interest and research and researchers have shown that the typical symptoms of how a myocardial infarction presents differ between genders (Swahn, 2006). The common conception of how a myocardial infarction presents with symptoms typical for men can influence both physicians and patients to misinterpret the symptoms when these do not fit into the expected model. It is possible, but much less researched, that men are the norm for alcohol problems and that women with problems are ignored since the problems experienced by women are less familiar to the physicians. Sätherlund Larsson (1989) found in a study of primary healthcare that men more often were asked questions regarding alcohol consumption compared to women. If alcohol and alcohol problems are seen as male problems, women with alcohol problems might be less often identified than men.

SWEDISH CASE STUDIES

As part of the need to develop theory and explanatory models on the mechanisms involved in the gender gap, we started a
network of interested researchers. Collected in this special issue are a number of studies performed in Sweden that more closely analyse and explore factors that can influence gender differences in levels of consumption, adverse consequences and treatment. The aim was to perform different studies within the same cultural setting, with gender as a variable and a point of departure for further theoretical discussions.

The studies focus on different structural levels of the gender model (Fig. 1). Eklund and af Klinteberg (2009) studied criminal behaviour, alcohol problems and mortality, and possible underlying factors in a sample of Swedish boys and girls. Their study focuses the individual level and contributes to a deeper understanding of the interaction between biological and psychological development in boys and girls. The results revealed relatively similar behaviour patterns in males and females, although a much smaller group of females participated in norm-breaking and violent behaviour. Adolescents with patterns characterized by more serious norm-breaking or violent behaviour reported the highest occurrence of alcohol use and frequency of drunkenness.

Hensing and Spak (2009) studied women in a general population sample. Both alcohol consumption and alcohol diagnoses were used as outcome variables. The study has a direct focus on gender issues and it can be placed at the individual level focusing on gender identity (Fig. 1). The theoretical framework includes an understanding of gender identity as a phenomenon that is influenced by external changes in society when it comes to gender norms and ‘doing gender’, and thus it is subjected to changes over time and age. Unlike earlier studies of gender identity, psychiatric co-morbidity and personality are adjusted for in multivariate analyses. The paper identifies an association between the lack of leadership confidence and alcohol use disorders also after these adjustments. Increasing leadership confidence could be an important target for the prevention of alcohol problems in young women.

The two papers from Geirson et al. (2009) and de Marinis et al. (2009), respectively, focus on the healthcare sector. Geirson et al. (2009) studied the handling of alcohol-related problems in primary healthcare through a questionnaire delivered to general practitioners in a Swedish healthcare district. The authors found that both the gender of the patient and that of the general practitioner, and also the amount of alcohol the GPs consume themselves, were associated with the handling of alcohol problems; both excessive and dependent male drinkers were more often recommended to cut back on drinking compared to their female counterparts, who more often received the advice to abstain completely. This was interpreted as men’s alcohol problems seemed to be less adequately dealt with. It might be that men’s alcohol problems more readily were identified because these problems were regarded as a normal and expected behaviour, compared to women’s, and hence also less attended to? De Marinis et al. (2009) based their study on specialized alcohol treatment and tested the effectiveness of using cultural analysis in identifying gender concerns for women in a study of case journals of female patients. Their most critical findings were the identification of a subgroup status as part of a cultural identification in the group of a primarily Swedish ethnic population and further that using cultural analysis in gender analysis can be supported. These two studies belong to the institutional level (Fig. 1) since they not only focus on the healthcare sector but they also inform us on processes of ‘doing gender’ in institutional settings reinforcing notions on masculinity and femininity through social practice.

**DISCUSSION**

Gender differences in alcohol consumption, drinking behaviour and consequences are well documented but studies trying to further explore and explain the differences and pathways to the differences are less common (Room, 1996; Wilsnack and Wilsnack, 1997; Holmila and Raitasalo 2005; Bloomfield et al., 2006). The studies performed and discussed in this multidisciplinary network of researchers show the complexity behind the gender differences and that the social practice contributing to these differences is performed at several different arenas and at different structural levels. An intricate interplay between psychological and social factors contributes to individual gendered identities and rationalities in adulthood. However, the role of alcohol as a cultural symbol involved in the development of gender identity in childhood has not been explored, but the findings from Eklund and af Klinteberg (2009) raise the question. They found that the psychobiological structure in boys and girls was similar but still more boys participated in norm-breaking and violent behaviour. It is of course important to identify children with specific vulnerabilities to alcohol, but with such an approach it is difficult to achieve cost-effectiveness since high-risk strategies need to be tailored to the multitude of risk courses and already the present strategies such as MST are rather expensive. A population strategy aimed at the development of supporting environments at school and in leisure activities would probably benefit more individuals, at a similar cost. It is also important to be aware of the gender perspective in the development of supporting environment, which has generally been lacking so far.

The association between men, traditional masculinity and alcohol consumption is obvious. According to Courtenay (2000), the traditional masculinity is associated with less interest in positive health behaviours. Such efforts are perceived as feminine and thus abandoned by ‘real men’. Addressing such gendered perceptions seems to be important if the close association between men, masculinity and alcohol shall be opened up and changed. There are some signs in this direction by the decreased use of liquor and increased use of wine in traditional ‘dry’ countries (Mäkelä et al., 2006). Thus the reason for the decreasing gender gap in alcohol consumption and drinking behaviour is two sided: women drink more as men but men also drink more like women. It is possible that this diminishing gender gap is the result of changes in gender equity but it might also contribute to the changes through the intricate ways that ‘doing gender’ takes. Men drinking wine in the 21st century are similar to the women in the end of the 19th century that transgressed the gender boundaries by their subversive acts of drinking alcohol in public (Eriksen, 1999). Very often these steps are taken by men and women in the middle class, which seems to be the situation also right now.

However, as often when it comes to gender issues, things are rather complex. Masculinity obviously is part of the explanation of why men drink more, but for women characteristics usually associated with, or labelled, masculinity seemed to be protective according to Hensing and Spak (2009), and at least in an egalitarian culture as the Swedish. It is important to note
that a gender identity shaped by leadership confidence, often regarded as masculine, does not imply that the woman is manly but that she has acquired an identity that makes her more capable to make her own choices and decide her own limits for example when it comes to drinking behaviour or sexual contacts.

The absence of research on men, male gender roles, masculinity and alcohol is even less developed than research on women, female gender roles, femininity and alcohol. According to gender researchers, the notion of men as the norm discussed earlier in this paper not only makes women and women’s health problems invisible but it also contributes to a neglect of specific living conditions and health problems found among men. Alcohol and alcohol problems is an example. There are some studies that have identified these issues. In a Swedish interview study among men with substance abuse, fatherhood was found to be a very important motivational factor in the treatment (Leissner and Hedin, 2002). According to the study, it has been uncommon to work with men’s role as a father in treatment and motivational encounters, mainly due to the fact that this role has been less prioritized by both the professionals and the clients themselves. There might be other such areas where the cultural constructions of masculinity hinder identification of individual characteristics or life situations.

Finally, treatment settings can be seen as highly gendered even if they are directed at one of the genders only. The studies included in this issue by De Marinis et al. (2009) and Geirson et al. (2009) showed that gender and gendered perceptions are involved in different healthcare settings such as primary healthcare and specialized treatment settings, and that different part of the treatment process are involved, such as identification, diagnostics and treatment. Geirson et al.’s study may also shed some additional light on the matter of men being the norm for health problems and treatment in the healthcare. As they point out, perhaps as a result of drinking being considered as ‘manly’, in this case by both female and male physicians, men’s hazardous drinking habits were inadequately responded to. It might be expected by professionals that men should drink, and even if problem drinking is identified the need for help is neglected in male patients. On the other hand it might be that women’s problem drinking is not identified, but when it is noticed, proper treatment is given since drinking in women might be seen as a more serious problem.

It is important that professionals in healthcare, social service and correctional treatment have an insight into gender differences, gender constructions and gender equity issues. Mattsson (2005) found in a study of addiction treatment settings in Sweden that ‘doing gender’ influenced professional’s behaviour and the goal setting for the treatment. A normalizing practice was identified where doing gender was observed for both men and women. De Marinis et al. (2009) found that shame was a large part of women’s resistance in treatment and treatment seeking. To identify themselves as women with alcohol problem were to identify themselves as less successful not only as individuals but also as women. Shame was a pattern not present to the same extent in the interviews of men. This notion also receives support from a study where shame-proneness was related to problematic alcohol use, whereas guilt-proneness did not (Dearing et al., 2005). Higher co-morbidity with depression and anxiety disorders found in women with alcohol problems compared to men may be related to shame.

It is not easy or relevant to point out a single factor or develop a single theory that can explain the complexity of ‘doing gender’. Several other power relations are important in the understanding of alcohol and alcohol problems apart from gender such as social class, education, ethnicity, religion and sexual identity. Biologic vulnerability is of course also very important (Prendergast, 2009) but cannot be seen as part of the socially constructed relations that contribute to the living conditions of men and women. Social constructions can be changed if they harm the health of a certain individual or population group. From an equity point of view, it seems as if women are exposed to an accumulation of disadvantages reflected in a more negative view of women with alcohol problems, are paid less attention from professionals and face a stronger cultural demand of conformed behaviour adapted to the traditional role of women as mothers and housekeepers. However, these demands have also contributed to a lower consumption in women and thereby also less prevalence of alcohol problems and alcohol-related harm. On the other hand, men as a group are from a public health perspective much more exposed to the negative effects of alcohol than women, but the specific needs based in men’s roles as fathers and partners have been less focused than their roles as offenders and deviants.

CONCLUSION

Differences in alcohol consumption and drinking behaviour are well documented. In these studies, we aimed at increasing the understanding of the mechanisms behind the gender gap. We found complex associations between gendered cultural conceptions in society and treatment settings, intertwined with personality, identity and biological and disease processes at the individual level. Future studies need to focus more on these complex associations both to secure that treatment settings provide both genders with fair and adequate treatment of high quality and that prevention activities will start to test measures that take gender into consideration.

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