EDITORIAL

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Alcoholism – treating 'the second sex'

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Much of our theory surrounding the development and treatment of problem drinking women has derived from our knowledge of drinking in men. This had led to deficits in the mainstream treatment for problem drinking women.

Most treatments have been developed by male providers for the treatment of male patients.[1] The 'male-as-norm' bias defines male alcoholism as the standard by which female alcoholism is judged.[2] This has affected research, assessment and treatment standards for women. Weaknesses in our existing theoretical models spring not only from the fact that women have not been adequately studied, but also from the fact that we have stereotyped ideas about female alcoholics.[3] There has been an increase in the number of research and review reports addressing gender over the last number of years. Despite this, Gomberg[4] describes women as "the second sex" in theory development and diagnostic definition.

Throughout history women have been drinking for as long as men. In many cultures women drink as often as men and in some cultures women drink more than men, despite the fact that a given amount of alcohol has a greater physical impact on women. Heath[5] in a review of world-wide literature on women and alcohol suggests that norms, values, attitudes and expectations may be as important as physiological differences between the sexes with respect to treatment outcomes. Too narrow a focus on physical, psychological and social problems may have hampered our understanding of women's diverse roles with respect to alcoholism.

A review of published material by Tonaetto *et al*[6] shows no sex differences in the outcome of treatment, but 72% of studies do not address gender. Treatment units and prevention strategies would benefit a greater number of female substance abusers if they were tailored to suit women's specific needs.[7] Women usually display solitary drinking, neurotic and family problems, early health impairment and abuse of other drugs. Therapy may be enhanced by addressing these specific factors. Prevention programmes may also benefit by addressing them.

Changes have occurred in women's drinking patterns over time but epidemiological studies have not shown the expected convergence of male and female drinking rates. Antecedents to female drinking include difficulties in impulse control, depression and other psychiatric diagnoses such as eating disorders.[4] Societal attitudes may act as protective or destructive factors in women's alcoholism.[9] Smith[10] considers factors which may affect a woman's ability to enter, maintain and sustain treatment. The onset of heavy drinking tends to be at an older age in women, and they tend to have a shorter history at the time of presentation for treatment.[11]

Specific issues encountered by women include incest,[12] homelessness,[13] employment [14] and aggression, both as aggressor and as the object of aggression.[15] Pregnant or parenting female alcoholics have problems which may be best addressed by co-ordinated, comprehensive 'family centred' care.[16] We need to acknowledge the effects of alcohol on women's relationships as daughters, partners and parents. Consideration must also be given to its role in violence against women. Primary care physicians have a unique role in the treatment of female alcoholics. They need accurate information about female alcoholism in order to overcome prejudice, and to enable them to offer the most appropriate treatment.[17]

Schmidt *et al*[18] have developed an extensive taxonomy on indicators of women's alcohol problems. Important factors appear to relate to individual characteristics including psychological and behavioural issues. Social factors are important, in particular family or partner relationships. Physical appearance also seems to bear importance.[19] This review was drawn from the literature over a spell from 1970 to 1986 and the authors suggest that the resulting taxonomy may serve as a base line against which to assess material from other sources such as ethnographic studies or studies of the general population.

Corrigan's study, on *page 48* of this issue, is timely and addresses some of these issues as they pertain to female drinkers in Ireland. This is a replication of Corrigan's study of American alcoholic women in treatment.[20] The American study found that 84% of 150 women recruited into the study drank most often in their own homes. Professionals and those employed were more likely to drink in restaurants and bars. Two thirds of the women hid their drinking and most offered escapist rather than social reasons for their drinking. More

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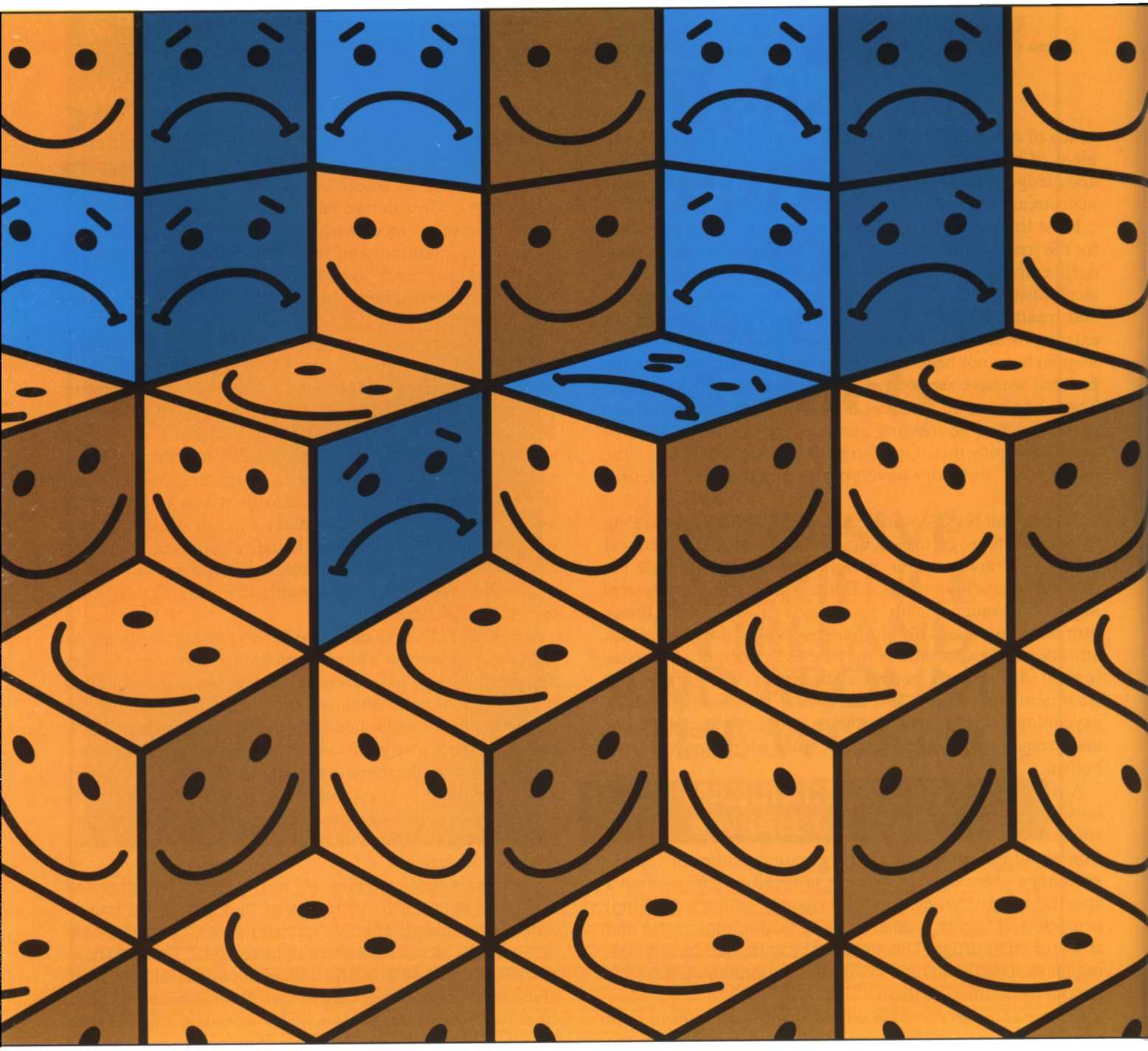

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than half reported a specific stressor in the period preceding their drinking, particularly emotional losses. Many were unhappy, lonely, anxious and depressed. Almost half of the subjects used other drugs while drinking. The outcome of treatment for these American women was much better than the outcome in comparable studies for men. Of 116 completed interviews 13 months after treatment, 41% had not had a drink since leaving treatment. A further 12% drank on only four occasions or less and 71% had had no alcohol in the previous month. Professional women and those in higher socio-economic groups were more likely to remain abstinent. The entire group showed improvement in symptoms of emotional ill health, but regression analysis suggested that this improvement was due to abstention from alcohol.

Despite the fact that abstinence was the aim in treatment for the Irish women described in Corrigan's study in this issue, only 26% remained abstinent in the 13 months after treatment. A further 24% drank up to four times and 43% had had no drink in the previous six months. Self-esteem was found to be improved in those who were abstinent. Seasoned therapists will derive some reassurance from the 74% accuracy of staff predictions about clients outcome. The number of years working with alcoholics and the number of alcoholics treated were factors which influenced successful predictions.

The face of alcoholism treatment is changing as efforts are made to provide forms of treatment delivery which are cost-effective. It is imperative that such changes are based on relevant theory supported by adequate clinical research. In the course of conducting this research and in the course of designing appropriate prevention and treatment strategies, we must ensure that there is not further marginalisation of the second sex.

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