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Irish descent, religion, and alcohol and tobacco use

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Abstract

The West of Scotland has traditionally been a focus for Irish migration. Using data from two studies carried out in this region, one quantitative, the other qualitative, this paper shows little difference in drinking and smoking between Scots of Irish descent and other Scots. It does, however, show significant differences in these behaviours according to religious affiliation in adulthood. Rather than confirming the stereotype of Irish Catholics as heavy drinkers and smokers the present paper puts forward the hypothesis that drinkers and smokers are differentially retained in membership by different religious affiliations, and argues that this accounts for differences in reputation and in health-related behaviours.

Introduction

The link between the Irish and heavy drinking has been a common stereotype encountered in both Britain and America, and historically the Irish have often been portrayed as a hard-drinking, hard-living group (Stivers, 1976, 1978; Daiches, 1982; Gallagher, 1985; Pearson, 1992). There are strong echoes of this stereotype in the research literature and the relationship between fact and stereotype is difficult to untangle. Bales (1962), in one of the major works on the drinking practices of both the native Irish and the Irish migrant to America, compared the 'convivial' or 'utilitarian' drinking of the Irish with the 'ritual' drinking of the Jews. It is not only heavy drinking that has been associated with being Irish; in Britain, certain cause-specific mortality rates of immigrant Irish have been linked to excessive smoking (Marmot, Adelstein & Bulusu, 1984; Balarajan & Yuen, 1986; Britton, 1990).

However, more recently the problems of relying on the earlier ethnographic research detailed by Bales (1962) rather than on more reliable social epidemiological and social survey research have been raised. O'Connor (1978) has cast doubt on the reliability of the documentary sources about Ireland on which, most of Bales' theories were built, while Walsh (1987a,b) believes much ethnographic work tended to focus on the more colourful aspects of social life and custom in Ireland, giving drink a higher prominence than it deserved.

Ethnographic work since Bales as detailed by Stivers (1976, 1978) and Heath (1987) has instead focused more closely on the Irish migrant. Pittman (Pittman & Snyder, 1962) has pointed out the importance of distinguishing the situation of the Irish in Ireland and the situation of the migrant, and the work of Stivers has been the most consistent in its attempt to develop the picture of migrant responses. Stivers maintains that originally heavy drinking was symbolic of Irish-American identity in the nineteenth century; it was then integrated into the consumer ethic of American society; and most recently heavy drinking became a means of re-discovering and asserting one's ethnic identity and heritage (Stivers, 1978). This persistence of Irish-American drinking patterns has been confirmed in quantitative studies (Greeley & McCready, 1978; Greeley, McCready & Thiesen, 1980).

However, the cultural context of the Irish in Britain, and therefore the meaning of acculturation (Gordon, 1964; Alba, 1976) or of reasserting cultural identity, is different from the American context. O'Connor (1978) argued that the historical ideas of the Irish and the English about the use of alcohol were similar, both being affected by the religiously orientated temperance 'movement'. In her study of young drinkers in Dublin and London, she found higher proportions of abstainers among Irish youth in Dublin than among the English in London, and the heaviest drinking occurred among the Irish second generation, as both Stivers and Greeley et al. (1978: 47-48, 1980) also found among Irish-Americans. She suggested that the second generation drank heavily because they were placed in a dual and ambiguous situation. In a more recent study O'Connor & Daly (1985) concluded by characterizing Irish drinking behaviour as tending more to both extremes, but being otherwise similar overall to that found in England and Wales. Similarly Greeley et al. (1978, 1980) found Irish and English drinking in American cities to be fairly similar; differences were mainly in comparison with Italians and Jews, and with English from a rural or southern Protestant background with strong Baptist and Methodist affiliations.

As for smoking, figures in O'Connor & Daly (1985) in the Irish Republic showed similar consumption figures to those for Britain. Pearson, Madden & Greenslade (1991), analysing 1984 General Household Survey data, found a complex pattern with regard to smoking among Irish immigrants compared with the indigenous population, and concluded that no clear pattern emerged from their analysis.

In the context of Britain, then, heavy drinking by the Irish may be merely a migrant phenomenon; and the socio-economic position of the migrants may be relevant. Pearson et al. (1991) hypothesized that social class and deprivation account for elevated rates of alcohol-related disease among Irish migrants in Britain. They show that since the Irish are over-represented in the lower social classes, it can be expected that Irish mortality rates across a wide range of causes of death will be higher (Pearson et al., 1991). The work of Raftery, Jones & Rosato (1990) suggests that such health disadvantage may extend to the second generation. Other studies carried out both in Britain and the United States have shown high rates for psychiatric admissions related to alcohol problems among Irish migrants (Cochrane & Stopes-Roe, 1979, Muhlin, 1985; Cochrane & Bal, 1990), although there are methodological problems with institutional admission studies in potentially overestimating the problem in the Irish migrant community. Issues of the high visibility of problem drinkers in migrant groups and ethnic stereotyping are also very pertinent.

So far we have considered Irish ethnicity; but in Britain, the association of the Irish with Catholicism is strong if not overwhelming in many areas. Indeed, the religious identity has become more easily adopted than the republican one, partly because of the conflict in the north of Ireland. O'Carroll (1979) has hypothesized a close link between Catholic culture and the drinking behaviour of the Irish. In his study of Irish-American drinking, Irish Catholic drinking practices and problems were seen to relate to a relatively tolerant normative religious structure which initiates a routinized cycle of rebellion (abusive drinking) and reinstatement (confession, forgiveness and re-incorporation into group life) that is easily transferable from religious to secular domains. The findings on religious differences are contradictory although high levels of alcohol consumption are often assumed in the research literature, with Catholic subcultures being viewed as encouraging permissive drinking norms and Protestant cultures ambivalent ones (Pittman & Snyder, 1962; Pittman, 1967).

Again, the important effect of religion on tobacco as well as alcohol use (Mullen, 1990b, 1993; Francis & Mullen, 1993) needs to be taken into account. Data from Northern Ireland (Continuous Household Survey, 1983) showed that among those aged 16 years and over, 28% of Protestants compared to 38% Catholics were cigarette smokers.

Thus, the research literature with regard to both alcohol and tobacco use is contradictory, but there is little evidence of high average levels of drinking and smoking among the Irish in the Irish Republic, although these are often assumed. The drinking and smoking practices of the Irish migrant and of Catholics in Northern Ireland may well be atypical. The paper considers how the

drinking and smoking practices of people of Irish descent and of Catholic affiliation in Clydeside compare with those of the rest of the population.

The -major research focus for alcohol and smoking has often been on what are considered to be problem populations—either younger, adolescent drinking and smoking, or older, clinic populations, with little linkage between studies of the two groups. However, both general prevalence and the consumption levels of those who do smoke and drink are on a high plateau among those in their 30s (HMSO, 1990), reflecting teenage initiation and carrying implications for the problems of older drinkers and smokers. Patterns in mid-life are therefore a useful indication of patterns over the life course in the United Kingdom.

Method

The analysis described in this paper uses data taken from two studies, one quantitative, the other qualitative, carried out in the West of Scotland. The quantitative study was the 'West of Scotland Twenty-07 Study' (Macintyre et al., 1989), which is designed to test competing hypotheses relating to inequalities in health. It is longitudinal in design and involves follow-up of three age cohorts who were, respectively, 15, 35 and 55 years at the baseline survey in 1987/88. The present analysis is based on the information from the 35-year-old cohort.

A stratified random sample of 985 respondents from 52 postcode sectors was taken in the Central Clydeside conurbation, and structured questionnaires administered in home interviews of around 2.5 h in total yielded data on many aspects of social life and health. This paper presents an analysis of four alcohol and tobacco use variables: two self-assessments of smoking and drinking, and two estimates of alcohol and tobacco consumption. Self assessments comprised (for alcohol) never drank/ex-drinker/hardly drink at all vs. drink a little/a moderate amount/quite a lot/heavily, and (for smoking) never smoked/only smoked once or twice in the past/ex-smoker vs. smoke occasionally/regularly, both here treated as dichotomies.

To estimate consumption, respondents detailed how many units and what types of alcohol they had drunk during the last week, and their weekly levels of tobacco use. These measures are grouped for alcohol consumption using the definition of the British Royal College of Psychiatrists (1986): none, light (men 1-10 units per week, women 1-5), moderate (men 11-50, women 6-35) and heavy (men > 50, women > 35). One unit is half a British pint of beer or a 'measure' of spirits, in practice c.10.8-14.2 ml of absolute alcohol (Hammersley, Finnigan & Millar, 1993). Measures for tobacco use are grouped into none, 1-20, 21 + cigarettes per day following definitions used in a British government survey (HMSO, 1980). The numbers in this sample are sufficient to make us 75% confident of detecting differences at the 5% level in the population born Catholic of either sex when 10-12% more of them drink regularly or smoke 21 + cigarettes per day, or where 15% more of them smoke, or drink moderately or heavily (Boag et al., 1971).

Measures of Irish descent in Britain require an innovative approach (Williams, 1993). Immigration began before the 1840s, and was at its peak in 1861. Consequently, to ask contemporary respondents for the birthplace of parents or grandparents is to miss the bulk of the Irish-descended population, while the element of Irish descent nevertheless remains strong because Catholic endogamy (in areas such as Glasgow largely involving Irish Catholics) was high until the 1970s. On the other hand, asking for self-defined ethnicity also fails to identify most of this population; since the alliance of Catholics with the Labour Party at the beginning of this century, and the intractable problems arising from conflict between unionists and republicans in the Irish north, many Catholics of Irish descent prefer to identify themselves as Scots or English.

For these reasons Irish descent is here represented by two indices. The first is religion: Williams (1993) has shown that in Clydeside being born Catholic is a usable epidemiological indicator of Irish Catholic descent (estimated sensitivity 79%, specificity 91%). The second is names: this method was developed by Williams (1993) and showed that migrants to Greater Glasgow Health Board from the Republic of Ireland could be recognized by name alone (sensitivity 89%,

specificity 73%). Because maiden names of women were not available, only men are considered in the name analysis.

Current religious affiliation is used as a contrast to these measures, and is classified by answers to the question 'Which religious group or church do you belong to, if any?'

The qualitative study, the 'Health and Ways of Life Study', was an ethnographic research project aimed at assessing the respective importance of class and religion on the health attitudes of a group of men in mid-life, aged 30-49 years, living in Glasgow (Mullen, 1990a, 1992). It was designed as a linked study which could use the survey as a comparative reference group of similar age for quantitative estimates. The study focused on men as being at greatest risk, with an age range slightly wider than that of the mid-life cohort, and the method aimed at more in-depth coverage of ideas about religion or class and alcohol and tobacco use than was possible using survey methods.

The means by which the qualitative sample was collected has been described by Glaser & Strauss (1967, p. 105) as theoretical sampling, which aims to include adequate numbers in all relevant theoretical subcategories in the final selection of respondents (Denzin, 1970). Unlike our quantitative sample, this sample is not intended to estimate prevalences, e.g. of smoking and drinking behaviour, but to cover the range of possible relations between logically connected beliefs, e.g. between beliefs about smoking and drinking and religious beliefs. An equal number of respondents was sought for all six combinations of two social class subcultures (manual and non-manual workers) and three religious belief types (protestant, Catholic and non-religious), although these six combinations are not of course equally represented in the Glasgow population. A computerized list developed by the Medical Research Council's Hearing Research Unit in Glasgow provided a random sample Stratified by age (30-39 years, and 40-49 years) and social class (non-manual and manual) with equal numbers in each age and class category. However, the list included no indication of religious denomination, and this was obtained by mailing a short screening questionnaire. Of 352 mailed, 183 were returned with almost identical proportions to the 352 in the two age strata. These 183 returns were then classified by re- ligion (protestant, Catholic and non-religious) and class (manual, non-manual), and 74 were progressively selected at random to make up each of the six combinations as equally as possible. Seventy (95%) were contacted by telephone and interviewed.

Interviews lasted from 1-2 h, and were conducted either in the respondents' own home or in the researcher's (KM's) office. Issues covered in the interviews included the respondents' health status, smoking and drinking behaviour, and their general attitudes towards health, tobacco and alcohol use. Questions on smoking ranged from amount smoked, stopping and starting, addiction, family pressure, tobacco legislation and the relationship between smoking and health. Questions on alcohol use covered amount drunk, drinking problems, changes in behaviour, reasons for drinking, drinking of peer group and family and ideas about alcoholism and drunkenness. Interviews were carried out using the techniques of qualitative interviewing (Schwartz & Jacobs, 1979). All interviews were tape recorded and transcribed verbatim.

Results

First we report bivariate relationships between religion at birth and smoking and drinking (not tabulated). Among men, born Catholics had a slightly lower proportion of non-drinkers (15%) than the rest (20%) but these results were not significant. No differences were seen for the women. Considering drinking during the week prior to interview there was a slightly greater proportion of born Catholic men (61%) than the rest (53%), who were moderate or heavy drinkers as defined by the Royal College of Psychiatrists. Again these differences were not significant, and no differences were seen between born Catholic and other women.

Turning to tobacco use, a slightly higher proportion of born Catholics smoked: 36% of Catholic men compared to 31% of the rest of the population, and 47% of Catholic women compared to 44% of the rest. Among men there was a somewhat higher percentage of heavy smokers among born

Catholics (14%) compared to the rest (8%). Again, none of these differences was significant, and there were no differences in proportions of heavy smokers among women.

The drinking and smoking behaviour of male respondents with an Irish name was then compared with other men in the sample. Again there were no significant differences on any of the four measures of alcohol and tobacco use. Thus, whether we look at Irish descent by name or by religion at birth, we find no significant differences between drinking and smoking behaviours.

To take the analysis further, however, it is important to check these findings by controlling not only for sex, but also for social class. Born Catholics were more heavily represented in manual groups (51%) than non-Catholics (34%, $p < 0.0001$). In terms of housing tenure born Catholics were also found to suffer greater disadvantage: only 48% were owner occupiers as compared to 64% for the rest of the population ($p < 0.001$).

We controlled for social class by running a series of log-linear analyses relating religious affiliation at birth and social class to each of the dependent health behaviour variables. This class analysis was carried out using the Registrar General's classification (OPCS, 1980), in this case identifying six classes: professional, intermediate non-manual, skilled non-manual, skilled manual, semi-skilled manual and unskilled manual. Due to small numbers in certain cells a few models combined professional and intermediate groups at the top of the scale and unskilled and semiskilled workers at the bottom, or simply contrasted manual and non-manual workers. As all trends remained the same regardless of classification used, for comparability and clarity of presentation the results of the manual/non-manual dichotomy are discussed.

Main effects models without interaction terms were fitted to each of the health-related behaviours in turn, and these models were all found to fit adequately ($p > 0.05$). Taking respondent's social class into account, the born Catholic men of this sample were just over 1.5 times more likely to drink than the rest of the sample (relative odds 1.6), and slightly under 1.5 (1.4) times more likely to be moderate to heavy drinkers than the rest of the sample. However, neither of these differences was significant, nor were there any significant differences for women. Born Catholic women were only slightly (1.1) more likely to drink than the rest of the sample, and just as likely to be moderate to heavy drinkers.

With cigarette smoking, taking social class into account, born Catholic men were no more likely to smoke than the rest of the sample, and they were only slightly, but not significantly, more likely (1.4 times) to be heavy to moderate smokers than the rest of the sample. Similarly for women, taking social class into account, no significant differences were found for the two tobacco variables by religious affiliation at birth. The same was true with regard to both the alcohol and tobacco variables for men with an Irish name.

There were no significant differences, then, between born Catholics and others, and thus between respondents of Irish descent and the rest of the population, with regard to alcohol and tobacco use even after controlling for class.

Current religion and alcohol and tobacco use— Twenty-07 Study

We now turn to the relationship between current denominational affiliation at age 35 years, and alcohol and tobacco use. Before proceeding, however, we should note the high proportion who were affiliated at birth but are no longer affiliated to their denominational group among Protestants in comparison with Catholics: 44% as opposed to 20%. The proportion of Catholics converting to Protestantism is similar to that of Protestants converting to Catholicism: 5% compared to 3%.

Current affiliation was related to alcohol and tobacco in a number of ways. Although the proportion of self-rated regular drinkers did not vary much, significant differences were seen for both men and women between current denomination and the number of units drunk last week. Forty-nine per cent of Protestant men were moderate or heavy drinkers compared with 64% for Catholic and 60% for

non-religious men ($p < 0.05$). Thirty-two per cent of Protestant women were moderate or heavy drinkers compared to 37% of Catholics and 49% of the non-religious ($p < 0.05$).

Fewer Protestant men rated themselves as smoking (24%), compared with both Catholics (40%) and those professing no religion (37%) ($p < 0.05$). A similar pattern was seen for women (36% of Protestants, 49% of Catholics and 55% of the non-religious were self-rated smokers) ($p < 0.001$). Among men more Catholics (13%) were heavy daily smokers (21 + cigarettes per day) than Protestants (8%) and the non-religious (9%) ($p < 0.05$). Among women, both moderate and heavy smoking was more common among the non-religious (42% and 12%) than among Protestants (26% and 9%) and Catholics (39% and 9%) ($p < 0.005$).

Again, as with affiliation at birth, there was a strong social class bias in respondents' stated religion at the time of survey. Fifty-one per cent of Catholics were in the manual social groups compared with 41% of those professing no religion and only 30% of Protestants ($p < 0.001$).

To assess the independent effects of current religious affiliation and social class a series of log-linear analyses were again conducted on each of the dependent health behaviour variables (Tables 1a and 1b). The results are expressed in terms of odds ratios with one value of each independent variable set at 1.00. This series of log-linear analyses moved from saturated bivariate models testing religion and class independently, through multivariate models with interaction terms to those with only main effects. Tables 1a and 1b display the original bivariate results and the final main effect solutions. These main effects models without interaction terms were run on each of the health behaviours in turn, all were found to fit adequately ($p > 0.05$).

Table 1a. Relative odds of being a drinker, a moderate to heavy drinker, a smoker or a moderate to heavy smoker by religious affiliation and occupational class (sample size = 418)

Males	Drinker	Moderate to heavy drinker	Smoker	Moderate to Heavy smoker
Religion alone				
Protestant	0.71	0.55*	0.47*	0.59
Catholic	1.00	1.00	1.00	1.00
Non-religious	1.02	0.85	0.87	0.67
Occupational class alone				
Non-manual	1.10	0.80	0.41*	0.34*
Manual	1.00	1.00	1.00	1.00
Religion allowing for class				
Protestant	0.66	0.56*	0.59	0.75
Catholic	1.00	1.00	1.00	1.00
Non-religious	0.97	0.85	0.97	0.82
Occupational class allowing for religion				
Non-manual	1.28	0.88	0.42*	0.34*
Manual	1.00	1.00	1.00	1.00
Goodness of fit				
	$X^2 = 1.2517$	$X^2 = 0.81391$	$X^2 = 4.653$	$X^2 = 1.648$
	df = 2	df = 2	df = 2	df = 2
	$p = 0.535$	$p = 0.666$	$p = 0.098$	$p = 0.439$

* $p < 0.05$

Table 1b. Relative odds of being a drinker, a moderate to heavy drinker, a smoker or a moderate to heavy smoker by religious affiliation and occupational class (sample size = 418)

Females	Drinker	Moderate to heavy drinker	Smoker	Moderate to Heavy smoker
Religion alone				
Protestant	0.85	0.81	0.59*	0.93
Catholic	1.00	1.00	1.00	1.00
Non-religious	1.17	1.68*	1.28	1.36
Occupational class alone				
Non-manual	1.13	0.95	0.42*	0.42*
Manual	1.00	1.00	1.00	1.00
Religion allowing for class				
Protestant	0.84	0.79	0.67	1.10
Catholic	1.00	1.00	1.00	1.00
Non-religious	1.25	1.71*	1.35	1.42
Occupational class allowing for religion				
Non-manual	1.12	0.99	0.44*	0.42*
Manual	1.00	1.00	1.00	1.00
Goodness of fit				
	$X^2 = 4.93325$	$X^2 = 5.49195$	$X^2 = 3.1037$	$X^2 = 5.74$
	df = 2	df = 2	df = 2	df = 2
	$p = 0.085$	$p = 0.064$	$p = 0.212$	$p = 0.57$

* $p < 0.05$

Class effects on drinking were not significant for men. Current Protestant men were significantly less likely (odds ratio 0.56, $p < 0.05$) to be moderate to heavy drinkers in comparison to current Catholics, the effects of class being held constant. Significant class differences ($p < 0.05$) were found for the two smoking variables among men, with non-manual groups less likely to smoke, or to be moderate or heavy smokers than manual groups. Once these class differences were taken into account, there were no significant differences in smoking between current religious affiliations.

Class effects on drinking were also not significant for women. Current Protestant women were also less likely than Catholics to be moderate to heavy drinkers (odds ratio 0.79), but not significantly so. However, Catholics were significantly less likely to be moderate to heavy drinkers than the non-religious women (odds ratio for non-religious 1.71, $p < 0.05$). Significant class differences ($p < 0.05$) were also found for the two smoking variables among women, with non-manual groups again less likely to smoke, or to be moderate or heavy smokers than manual groups. Once these class differences were taken into account, there were again no significant differences in smoking between current religious affiliations.

Differential class composition of denominations thus affected overall current denominational levels of smoking; but in so far as class composition had such an effect, it had itself been affected by religious selection. Of 'born' Protestants 60% were retained at adulthood in the non-manual groups compared to 48% in the manual groups. By contrast, of 'born' Catholics 78% were retained in the non-manual groups compared to 82% in the manual groups. Thus while 'born' Protestants were more likely than Catholics to leave their church in both class groupings, this was particularly true in the manual group, who were more likely to smoke.

Qualitative findings

Turning to the results from the qualitative study we find that a logical connection was recognized between Protestant church discipline and the moral injunction not to smoke or drink. A man who described himself as a non-attending Roman Catholic remarked that:

(R101)I think [someone from] a religious background tends naturally [that way, in] the way they look towards smoking and drinking, because of some religions that it is against their religion to smoke.

The term ‘tends naturally in the way they look towards...’ here describes an attitude derived from a black and white belief—it is ‘against their religion’. Such beliefs were confirmed by Protestants as being actively promoted by particular types of minister or congregational groupings:

(R306) It [religion] probably has [affected my beliefs] to a certain extent, yes, more so in the last few years in that we have more an evangelical type of ministry within the church, which tends to be rather puritan, ‘and thou shall not drink, smoke or whatever’. I probably do tend more to think about what I am doing you know.

(R317) It’s the Presbyterian thing that you’re accountable...yeah, the smoking was the same to a lesser degree [than drinking]. You could smoke, but a lot of people in the congregation didn’t like the smoking. You know, I mean outside on the pavement, they still looked at you ‘you’re not a Christian’ and that type of thing.

There might be some tolerance, but it was evidently a tolerance towards members who were as yet, in these respects, ‘not Christian’, and who could therefore expect to be held accountable for further progress in self-discipline as they became more Christian. While the connecting link between these disciplines and being Christian is not spelt out in these particular quotations, the general character of the relevant theological link as ‘evangelical’, ‘puritan’ or ‘Presbyterian’ is clear. Examples of suitable links were in fact provided by others—for example a Christadelphian:

(R809) I think we have a duty to the body we are given, although susceptible to pain suffering and death, it is one which is God given, one which is marvellous and miraculous and beautiful in its abilities to conceive and understand and to operate. It is one that should be looked after, in fact it is the temple of the living God and what you do to your body, you are fast diminishing many of the spiritual aspects of my religion by abusing the body that I own. So it is part of my beliefs.

This was echoed in the Church of Scotland:

(R889) The idea of your body as being a temple for the holy spirit here on earth and therefore the way that you look after it is in there somewhere.

As one Baptist described the results of his conversion to the denomination:

(R841) I became a Christian; I realised that the kind of lifestyle that I lived generally was not all that good for me. I became convinced of the whole Christian morality and so I stopped drinking after that...As a Christian I felt I had some responsibility to look after my body as well as my soul.

According to an evangelical, puritan or Presbyterian theology, then, the sacredness of a body which has become the temple of the Holy Spirit was interpreted as precluding smoking and drinking, and although tolerance would be extended to allow for moral progress, that progress would have to be accounted for. It followed from these assumptions that if progress was halted or decline set in, the will or willpower of the person concerned came into question. As one Church of Scotland member stated:

(R918) Well I don’t really have any respect for them [drunks] at all. If you are drunk you are not capable in your actions and you are then easily led, so you are not master of your own fate. Someone else is going to take it over from you.

Even when thinking about others who had no commitment to such a theology and who drank, the will was seen by this type of Protestant as the critical thing:

(R158) (frequent attender in the Church of Scotland): There is a distinction between a heavy drinker and an alcoholic. The alcoholic must be less strong willed. A strong willed

person might know what they were leading themselves onto if they continued to drink excessively a lot of the time.

Arguments from practising Catholics, on the other hand, did not accept prohibitions against drinking and smoking as authoritative:

(R313) (frequent attender): The Roman Catholic Church does not advocate smoking or non-smoking, or drinking or non-drinking.

They interpreted the implications of being a Christian not in terms of a ban but in terms of a judicious mean:

(R302) (frequent attender): I mean, clearly I was brought up in a, you know I will just use the word Christian, in a, in a Christian environment, where I was obviously taught... moderation in all things.

The link here was not theological but prudential. For church-attending Catholics drunks were 'foolish', and because it was assumed that a Christian should act wisely, and therefore with control and dignity, it was seen as 'humiliating' for a person to have lost control through drink. Moderation was a matter of good sense:

(R504) Well I don't see any sense in punishing your body...too much alcohol is bad for you, it obviously leads to dehydration.

Although the reasons were prudential, the religious quality of the Catholic argument came through in the pervasive concern that others should be wise for their own sakes:

(R156) I don't think it is a good idea to start drinking too young...They have not fully developed and I would think they would really need to develop fully into adulthood before they start drinking on a regular basis. I think they could stand it better and it would give their body time to develop properly. Later on there would be less chance of them being alcoholics.

All these were Catholic comments; for the non-religious, by contrast, prudential considerations might apply in their own case, but their view of others was governed by an agnostic liberalism. Drunks might be 'daft' or 'sad' from a prudential point of view, but they would be left to their own devices so long as they did not bother the speaker.

From this brief survey of the range of arguments invoked on the topic of drinking and smoking by participants in the qualitative study, it is apparent that a direct theological argument leading to a prohibition on drinking and smoking by any person who was fully Christian was to be found only in the evangelical, puritan or Presbyterian camps of Protestantism. A collective concern not for prohibition but for prudent and moderate use of these stimulants by oneself and others was denuded as Christian in Catholic contexts. Outside the Protestant and Catholic contexts, the only arguments concerning use of these stimulants related to one's own self-interest, whether in avoiding the consequences of ill-advised use oneself, or in keeping out of the way of others whose behaviour might cause one nuisance. Thus in Glasgow the arguments for control were merely self-interested among the non-religious, self-interested and prudentially moral among Catholics, and self-interested, moral and theological, backed by ministerial and congregational sanctions, among Protestants—an ascending order of reinforcement and seriousness.

Discussion

These results show slight but not statistically significant differences in alcohol and tobacco use between born Catholics of Irish descent and the general population, but significant differences between current Catholics, Protestants and non-religious affiliations, with the multivariate analysis showing alcohol use to be more strongly related to current religious affiliation than tobacco use

when class is taken into account. These findings occur at an age when smoking and drinking are on a high life-time plateau, and thus provide a good test of typical differences. Meanwhile qualitative findings reveal strong but varied logical links between current religion and attitudes to smoking and drinking. What are the implications of these results?

First, they serve to qualify the idea found in the popular and some research literature that the descendants of Irish migrants are typically heavy drinkers, whatever may be true of subgroups among them. Much of this literature is American, and our results probably reflect important differences both in the comparative cultural situation of the Irish in Britain and in the definition of Irish descent. In Britain the Irish are not compared with Italians or Jews, and the British population with strong Protestant prohibitionist affiliations is small (cp. Greeley, 1980). Moreover in Ireland itself the patterns of drinking and smoking are not dissimilar from those in Britain (O'Connor, 1978; O'Connor & Daly, 1985; Walsh, 1987a,b), and this is probably reflected in the fact that Irish migrants do not differ much from English migrants in American cities (Greeley et al., 1980). Secondly, Irish descent here includes many groups who would, as an expression of political loyalty and commitment, identify themselves as Scots but who are descended from Irish progenitors through strong patterns of endogamy within an overwhelmingly Irish-recruited Clydeside Catholic church (Williams, 1993): this is in contrast with many American studies in which Irishness is self-defined, with the accompanying uncertainty whether descent alone or descent plus political identification is being assessed.

In Britain the evidence of heavy drinking among the Irish is limited to first and second generation migrants, and our findings qualify the seminal work of O'Connor (1978) who found that the heaviest drinking took place among the young second generation Irish migrants, and suggested that they were ambivalent about drinking, being exposed to two contradictory sets of norms formed by their parent and host societies. Our own findings did not show such a relationship between people of Irish descent in Glasgow, most of whom will have been third or fourth generation. Although first and second generation migrants may well drink and smoke more than the general population (Pearson et al., 1991) our findings suggest that longer-established descendants must be so moderate in these respects that the population of Irish descent overall shows no differences. They have thus either recovered the Irish pattern found in Ireland (which differs little from the British) or become assimilated into the indigenous drinking culture.

Why do high levels of consumption exist among some descendants of Irish migrants? A theory of migrant stress, such as that presented by O'Connor (1978), could explain the high levels of alcohol consumption and problems in first and second generation migrants, due to the difficulties experienced in acculturation both in Britain and America (Greeley et al., 1980). There remains, too, a role for Stivers' (1978) theory in explaining Irish myths, for it is likely that the descendants of migrants who remain politically identified with Ireland commemorate aspects of home culture selectively (in this case emphasizing rituals related to drinking and smoking which legitimate their migrant experience) which they then adopt as a badge of ethnicity. However, today, although there may remain a tendency to equate alcohol and tobacco consumption among those who continue to assert their Irish identity in Scotland, Irish descent generally is no longer associated with the reality of high alcohol consumption.

It is, however, important to ask whether the general population in Glasgow and the West of Scotland has a more marked heavy drinking and smoking culture than elsewhere, and whether this may be affecting levels of drinkers and smokers among descendants of Irish migrants, who are disproportionately represented in the area, thus causing them to appear as heavy drinkers and smokers in national statistics, although not in the statistics of the area. A study by Plant & Pirie (1979) considered alcohol consumption in four Scottish towns, and produced a ranking which placed Inverness top, followed by Glasgow, then Aberdeen and finally Ayr—a ranking which is neither consistent with an industrialization thesis of heavy drinking, nor with the idea that areas particularly associated with the Irish (Glasgow, Ayr) are high consumption regions. Analysis of data from the Health and Lifestyle Survey (Duncan et al., 1993) has also found levels of alcohol consumption for Strathclyde to be similar to London and lower than industrial North East England.

The pattern with regard to tobacco use is that levels of smoking for both men and women are higher in Glasgow than the rest of Scotland, and that levels in Scotland as a whole are slightly higher than those for England and Wales (HMSO, 1988; Scottish Health Statistics, 1988; Smith et al., 1989; Tunstall-Pedoe et al., 1989). This pattern, in contrast to that for alcohol use, adds support to the thesis that high national rates of smoking among the descendants of Irish migrants may be partly explained by the fact that they live in areas with heavy smoking cultures.

It remains only to explain why significant differences are found with respect to adult religious affiliation but not affiliation at birth. A possible explanation of this is the concept of religious mobility. We have shown the high proportion of Protestants who have disaffiliated in comparison to Catholics. The proportion of lapsed Catholics and converts from Catholic to other churches is by comparison small. In other words the categories 'religion born into' and 'religion now', have a more similar composition for Catholics than for Protestants.

Although there are no differences between born Catholics and the rest of the population in terms of alcohol and tobacco use, current Catholics do differ from current Protestants and the non-religious. This is probably because Protestants are a more self-selected group than Catholics, with drinkers rejecting, or being rejected from, denominational affiliation, while at the same time abstainers are retained, and possibly other abstainers and moderate drinkers attracted to membership. Our qualitative findings confirm this possibility, showing that it was respondents from the most evangelical style of Protestantism who were the most proscriptive in their attitudes towards alcohol and tobacco use. The health-related behaviours of the Protestants and the non-religious therefore become polarized, while the Catholics hold within their church a broad spectrum of drinking and smoking styles. These findings highlight the possible strength of religious influences in accounting for selection of members by drug-taking behaviours, and in the Scottish context, and among current and former members of churches, also justify Pittman's (1967, Pittman & Snyder, 1962) hypothesis that Protestantism produces ambivalent drinking cultures, while Catholicism leads to permissive drinking cultures. However, our findings indicate that a more apt definition would be 'moderate' drinking cultures, as 'permissive' carries implications of permitting drunkenness which our qualitative material does not support.

Again the religious typifications of alcohol and tobacco consumption, although correct, are based on current membership and lack of awareness concerning those who disaffiliate. O'Carroll (1979) falls into the trap of seeing Catholicism as producing drunkenness (by cycles of rebellion and forgiveness), and does not observe that the Catholic church may be less likely to lose those of its members whose drinking and smoking goes beyond prescribed bounds. O'Carroll's view corresponds to Protestant critiques of Catholicism which unconsciously depend on amnesia about born Protestants who no longer attend, among whom drinkers and smokers are disproportionately represented.

To conclude this discussion, we find that religious stereotypes of Catholics as heavy drinkers and smokers, and ethnic stereotypes along the same lines of people of Irish descent, while they have a basis in observed behaviour, are also overgeneralized and overlook similarities between the Irish in Ireland and the British, a return to greater moderation among third and subsequent generations of Irish migrants, and processes of selective disaffiliation of the less moderate from Protestant churches, which render them essentially false. Such problems as there are arise within quite specific contexts which need further exploration and careful definition.

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