Group differences in alcohol-related sickness absence and attitudes

Gender, socio-economics, family and drinker types

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Summary

This thesis is a study on group differences in alcohol-related sickness absence. It consists of four papers: The first is an extensive review article of international research on the alcohol – sickness absence association. The second and third articles present studies of group differences in alcohol-related sickness absence in Norway. The fourth article is a study of group differences in attitudes towards alcohol-related sickness absence and presenteeism in Norway.

Paper 1 is a review of the alcohol – absence association, to my knowledge the first review of studies on this topic. Following a literature search of peer reviewed journals, our inclusion criteria were met by 27 articles testing 48 associations. The study found that empirical evidence for an association between alcohol use and both long- and short-term absence was strong. All associations with a high quality score were statistically significant. The association did not vary systematically across measures of alcohol use. The association was found to apply to both genders and in all socio-economic strata, but in some instances more strongly in lower socio-economic strata.

Paper 2 is a study of a sample of employees from the Young in Norway study. Self-reported measures on alcohol-related sickness absence and various drinking measures were applied to study differences according to gender and drinker types. Men reported alcohol-related absence almost twice as often as women did. Since none of the drinking-absence associations for the three alcohol measures were significantly stronger for men, it was concluded that the gender difference in alcohol-related absence was likely due to a gender difference in drinking patterns. The heaviest drinkers reported a disproportionally large share of alcohol-related sickness absence, but the vast majority of such absence was still found among the moderate drinkers. The results indicated that the prevention paradox applies to alcohol-related sickness absence among young employees of both genders.

For paper 3 the sample used in paper 2 was merged with registry data on income, education and occupation, and differences in alcohol-related sickness absence according to socio-economics and family roles was examined. Being male, single, not having children and having a low income were associated with alcohol-related sickness absence, but the association was not significant for education and social status. Introducing drinking frequency and drinking to intoxication in the regression model attenuated some associations with

alcohol-related sickness absence, indicating that group differences are only partly a result of differences in drinking patterns.

Paper 4 examine attitudes towards alcohol-related absence and reduced efficiency at work (presenteeism) due to alcohol. Results show that employees are more restrictive towards absence than towards presenteeism. Both behaviours were condemned more strongly with frequent occurrence. Employees with a high intoxication frequency and/or own experience with these behaviours were more tolerant. Women were less tolerant of alcohol-related absence than men, and employees with a higher educational level were less tolerant of alcohol-related presenteeism than those with a low educational level.

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List of papers

1. Schou, L. & Moan, I. S. (2015). The Alcohol use - sickness absence association and the moderating role of gender and socio-economic status: A literature review. *Drug and Alcohol Review*, 35 (2), 158-169.

2. Schou, L., Storvoll, E. E. & Moan, I. S. (2014). Alcohol-related sickness absence among young employees: Gender differences and the prevention paradox. *European Journal of Public Health.* 24 (3), 480-485.

3. Schou, L. & Birkelund, G. E. (2015). Alcohol-related sickness absence in young employees in Norway - The impact of social roles and socio-economic status. *Nordic Studies on Alcohol and Drugs*, 32 (4), 411-426.

4. Schou, L., Moan, I. S. & Storvoll, E. E. (2016). Attitudes towards alcohol-related sickness absence and presenteeism: Differences across subgroups of the population? Accepted for publication by *Journal of Substance Use*.

1. Introduction

The topic of this thesis is alcohol-related sickness absence. Both sickness absence and alcohol consumption have been researched extensively, but the combination; sickness absence that is alcohol-related, has received less attention. This is an interesting object for sociological research because of its human and economic costs, and since alcohol consumption is part of important social rituals – a source of both pleasure and pain.

This introductory chapter consists of five sections: In the first section, I introduce the topic of alcohol-related sickness absence, place it in the sociological tradition and explain its relevance to society. In section 2 the main concepts used in the four articles are presented in separate chapters: alcohol use and alcohol-related harm, sickness absence, presenteeism, alcohol-related sickness absence and presenteeism, group differences in alcohol-related sickness absence – according to gender, across socio-economic groups and across social roles, and across groups of alcohol users. Finally, the theoretical model of social action is introduced. The third section presents the data and methods used in the four articles and the fourth chapter summarises the four articles and presents the empirical findings. In the fifth section, the findings are discussed in light of previous research and the theoretical model. This introductory chapter does not contain a comprehensive review of previous research, as the thesis contains an extensive review article (Schou & Moan, 2015). However, a summary of the main findings in the review article will be presented in the chapter addressing alcohol-related sickness absence and presenteeism.

The study of alcohol-related harm is an important part of the sociological tradition. In Norway, Eilert Sundt collected data on the extent and nature of alcohol misuse and its social consequences, as early as 1859. Reports from various parts of the country often debated whether drunkenness was more widespread among the working classes, and especially casual labourers who depended on temporary work and those doing “the thoughtless and most simple manual tasks” were found to be prone to drunkenness. Even then, it was a concern that drunkenness affected workers’ ability to perform their tasks and provide income for their families (Sundt, 1859: page 102).

Although the discourse has changed from the religious and moral ideals of sobriety in Sundt’s time to the more liberal, the impact of alcohol on society, as well as work places, is still an ongoing concern. Sociologists have researched and debated such topics as the relationship

between total consumption and risk of alcohol problems in the population, the effects of various types of alcohol policies and the distribution of alcohol consumption and alcohol-related harm in the population (see e.g.: Skog, 1985, Elster et al., 2006; Pedersen et al., 2015;).

This thesis is indebted to this sociological tradition, and contribute to it by providing new knowledge about one type of alcohol-related harm: Alcohol-related sickness absence. Article 1 is an extensive review of research articles published in international peer-reviewed journals from 1980-2014 addressing the alcohol use – sickness absence association. It provides an overview and identifies areas where further research is needed. Article 2 examines the prevalence of alcohol-related sickness absence in a population of young Norwegian employees, and its correlation with drinking patterns. Gender differences is the main focus, along with the question of whether or not "the prevention paradox" applies to alcohol-related sickness absence. Article 3 examines whether the prevalence of alcohol-related sickness absence varies according to social position and family situation in a population of young, Norwegian employees. Article 4 is about attitudes towards alcohol-related sickness absence and alcohol-related presenteeism in a population of Norwegian employees of all ages. This article examines the correlation between attitudes and the employees' own alcohol-related absence or presenteeism in the past, as well as their drinking behaviour.

This thesis provides new knowledge about how alcohol-related sickness absence is distributed among Norwegian employees, according to gender, socio-economic status, family situation, drinking pattern and how attitudes towards alcohol-related sickness absence varies in subgroups of the population. The closely linked phenomenon of reduced efficiency on the job (presenteeism) due to alcohol is included in article 4. More knowledge is needed about alcohol-related sickness absence because of its considerable costs, both human and economic. In order to successfully target prevention efforts, it is useful to know how the prevalence varies in sub groups of the population.

Estimates of the costs of alcohol-related absence are consistently found to be high when calculated at the national level (e.g. Pidd et al. 2006, Laslett et al., 2010). In Norway, the cost of alcohol-related sickness absence was estimated at 1.7 billion NOK, for 2001 (Gjelsvik 2004). The global cost of alcohol-related absence from work has been estimated at 30-65 billion dollars per year (Baumberg, 2006). Lost productivity due to workplace absenteeism and presenteeism are often one of the larger items in such calculations (Gjelsvik, 2004; Laslett

et al., 2010). However, the methods and validity of cost-of-alcohol studies are debated and criticized in the research community. Thus, more knowledge about the costs related to alcohol-related sickness absence from work is highly in demand (Mäkelä, 2012).

In Norway, both alcohol policies and rates of sickness absence are subject to political debate at irregular intervals. Concerns about harm to the individual drinker have often provided arguments for a public health perspective that legitimates state actions to curb consumption and prevent harm. However, it may be argued that the individual is responsible for the consequences of his/her drinking, and that the state has no right to restrict individual freedom. However, an individual's drinking may also inflict harm on other people, and under these conditions, state action is compatible even with a libertarian perspective (Skog, 1999).

Alcohol-related sickness absence and reduced efficiency at work (presenteeism) are two types of such *third party harm* from drinking. Third party harm can be inflicted on people close to the individual drinker, like family, friends and co-workers – or random victims e.g. of an accident caused by a drunk driver. The harm may also be inflicted on the community as a whole, in the form of higher costs to health and social services and to businesses and other work places having to compensate reduced efficiency and sickness absence caused by alcohol. In recent years, both policy makers and researchers have shown a renewed interest in alcohol's harm to others, rather than just harm to the individual drinker. In a 2012 policy paper from the Norwegian government on alcohol and drug policy, alcohol's harm to others is termed "passive drinking" and is an important part of the justification for alcohol regulations (Stortingsmelding 30, 2012-2013). This thesis is part of larger project on alcohol's harm to others, which was conducted by the Norwegian Institute for Alcohol and Drug Research (SIRUS).

Research on alcohol-related sickness absence is likely to be of interest to policy makers and politicians, whether they argue the need for more or less strict alcohol regulations or whether they wish to preserve or change the system of sick leave compensation. The amount of alcohol-related sickness absence that is considered legitimate or reasonable to expect will of course depend very much on the ethical and political beliefs held by the individual person. Some may argue that the survey respondents "admitting" to having had alcohol-related sickness absence is proof that the system of self-certification is abused. On the other hand, as long as alcohol is easily available to all adults, it is unrealistic not to expect any alcohol-related absence at all. The phenomenon of alcohol-related sickness absence may just as well

be used to argue the case for stricter alcohol regulations, as it can be used to argue the case for changes in the full compensation sick leave system. In any case, debates and ultimately policy decisions are better based on research than on myths and anecdotes.

2. Main concepts and theoretical model

2.1 Alcohol and alcohol-related harm

Alcohol is legal and enjoyed by the majority of the adult population in most developed countries. Nevertheless, it causes substantial harm for society and for many individuals. High alcohol consumption over time can lead to a number of illnesses, e.g. liver and heart diseases, cancer, depression and psychosis (Rehm et al., 2003, Salonsalmi et al., 2009). The short term effects of high alcohol consumption include increased risk of accidents, increased aggression and risk of violence, disturbance of public order and neglecting one's responsibilities - both as a care giver in the family and duties in relation to work (Skog, 2006, Babor et al., 2010).

Drinking is regulated as part of social relations and cultural practice, often in ways that reduce the harmful effects. In the wine drinking countries of southern Europe, alcohol is enjoyed almost daily, but in limited amounts. Drunkenness is less common. In the countries where binge drinking is accepted, like in Norway, most drinking have traditionally taken place at weekends and special occasions, to avoid interfering with work (Mäkelä et.al., 2006). Actual practices are changing however, and cultural ideals and realities are diverging.

In Norway, the total consumption of alcohol is still among the lowest in Europe, although it increased steadily from about 1990 until 2008. Since then it has been quite stable, at about 6.8 liters of pure alcohol per adult person per year, although a larger share is now from tax-free sales or bought abroad (Bergsvik, 2015). Traditionally, the Norwegian drinking pattern was one of drinking to intoxication on special occasions, but in the last decades, it has also become more common to drink more frequently and in smaller amounts (Horverak & Bye, 2007). Recent data confirm this: In 2013, 6 % of men and 3 % of women said they had drunk to intoxication at least monthly in the last year, while 43 % of men and 35 % of women had done so "a few times" in the past year. However, drinking frequency in general was at least weekly for 40 % of men and 30 % of women (Skretting et al., 2014). This suggests that drinking to intoxication on special occasions is still part of the Norwegian drinking pattern, while many people simultaneously drink in smaller amounts more regularly. Norwegians have

not become daily drinkers, however, only 4 % of men and 3 % of women said they had drunk alcohol four days a week or more often (Skretting et al., 2014).

2.2 The concepts of sickness absence and presenteeism - and their relation to alcohol

2.2.1 Sickness absence

Sickness absence is by definition absence from work attributed to sickness, either by the employee him/herself or certified by a doctor. In Norway, employees have the right to self-certify sickness absence spells of up to three days, up to four times a year. About half of the work force are part of an extended agreement between the Norwegian government, major employers' organisations and trade unions, which gives employees the right to self-certify sickness spells of up to eight days, for up to 24 days in total per year. Longer sickness absence spells require certification from a doctor. Employees receive full economic compensation for all sick days, for sickness periods lasting up to a year (up to a limit of NOK 540 408 in 2015). In the last three months of 2015, in average 6.3 % of the work force had sickness absence certified by a doctor. Figures for self-certified absence were not available, but is typically about 20 % of the absence certified by doctors. Sickness absence rates in Norway have been quite stable in recent years, adjusted for flu and seasonal variations (Statistics Norway, 2016).

The relationship between sickness and sickness absence is not straight forward, however. Employees may continue working even if feeling sick or being diagnosed with an illness, or they may think they are unfit to work for reasons others would not agree are legitimate reasons. The system of self-certification is based on trust, and in principle, it is possible for employees to call in sick even if perfectly healthy. Research on sickness absence often use the concepts of *ability* and *motivation.* Ability is determined by the employee's actual state of health, but also by physical and mental demands of their particular type of work. In some cases, work attendance is clearly impossible, but in other cases, there is a grey area, in which absence may be determined by motivation to work (Garcia-Serrano & Malo, 2009). Highly motivated employees more often overcome obstacles and discomfort. Other factors such as job satisfaction, loyalty towards employer and colleagues, and a personal sense of duty influence the degree of motivation.

Sickness absence is thus not only a function of health per se, but a complex phenomenon involving cultural, social and institutional structures as well as the objective and perceived health of an individual.

2.2.2 Presenteeism

Presenteeism is defined as being present in the work place, but having reduced efficiency on the job due to illness. In countries where employees do not enjoy full wage compensation, they may be economically forced to attend work even if sick. Even in Norway, with full wage compensation, fear of losing one's job or a strong work motivation may also lead to presenteeism. However, presenteeism has been researched very little in Norway.

2.2.3 Alcohol-related sickness absence and presenteeism

Alcohol can cause sickness absence in two different ways: First, due to the immediate effects of alcohol intoxication, which impairs the ability to work, both during the state of intoxication and due to hangover symptoms the next day. The latter has been shown in an American study (McFarlin & Fals-Stewart, 2002) where a sample of male workers had a doubled chance of sickness absence on days after drinking the night before. These immediate effects caused by episodes of heavy drinking, normally causes short-term sickness absences, in most cases one day.

Second, chronic heavy drinking is associated with an increased risk of a large number of somatic and psychiatric illnesses that may be ground for sickness absence, e.g. liver diseases, cancer and heart diseases. These illnesses normally cause long-term sickness absence. A high alcohol consumption over time can lead to many different adverse health effects (Salonsalmi et al., 2009; Upmark, Möller, & Romelsjö, 1999).

Alcohol can also cause presenteeism, usually because employees attend work with hangover symptoms from drinking the night before. Employees may also attend work while still being intoxicated or drink on the job. The diseases caused by long-term heavy drinking, as mentioned above, may also lead to presenteeism, as employees are not necessarily absent at all stages of these diseases.

Providing precise measures of alcohol-related sickness absence is difficult, for several reasons. Alcohol-related sickness absence is by most considered illegitimate and may be registered under other diagnoses. Self-certified short-term absence are rarely registered listing the cause of the absence, and employees would be reluctant to admit that alcohol was the cause, even if it was registered. Most of the analyses in this dissertation concerns sickness absence attributed to alcohol by the employees themselves, in anonymous surveys. Most of this absence is likely to be short-term alcohol-related sickness absence. For long-term sickness absence, some diagnoses are alcohol-related, but in most cases, alcohol is one of

many risk factors, and it is hard to determine which sickness absence spells can be attributed directly to alcohol. It is also possible that some absences attributed to alcohol by the respondents may have more complex causes, for example if the need to drink is linked to depression.

Previous research on the alcohol use – sickness absence association in Norway have addressed three types of research questions: The first question is whether an increase in the total consumption of alcohol in the population lead to an increase in the level of sickness absence. Data on registered sickness absence and alcohol sales in Norway between 1957-2001 has been used to show that a 1-litre increase in alcohol consumption was associated with a 13 % increase in sickness absence for men (Norström & Moan, 2009). Similar findings have been reported based on data from Sweden (Norström, 2006).

The second question is: how much of total sickness absence and short-term sickness absence that can be attributed to alcohol use? Grimsmo & Rossow (1997) estimated that 1.5 – 2.0 % of total sickness absence in Norway was alcohol-related, and that 14 – 19 % of the self-certified short-term absence and 44 – 59 % of one-day sickness absences was alcohol-related. In a study of 25 – 28 year old employees, it was estimated that 34 % of one-day absence were alcohol-related (Hammer, 1999).

Finally, the third category of studies have addressed the prevalence of alcohol-related sickness absence and presenteeism due to alcohol use among Norwegian employees (Gjerde et al., 2010; Edvardsen et al., 2014; Edvardsen et al, 2015). A secondary aim of these studies have been to examine whether the prevalence vary in different subgroups of the population. However, due to limitations of sample size and skewed gender distributions, it has not been possible to examine differences in subgroups in most studies (but see Edvardsen et al., 2015, for an exception). The most recent Norwegian study within this category was conducted among employees of all ages, in eight different lines of business. The results showed that 5.3 % reported such absence, and 24.6 % of the employees reported having alcohol-related presenteeism the past year (Edvardsen et al, 2015).

This thesis belongs to the third category of studies. *Article 1* of this thesis is a comprehensive literature review of international articles presenting studies in the third category, and represents the first review published on the alcohol use – sickness absence association (Schou & Moan, 2015). The aims of the review were to determine (1) whether there is empirical evidence for an association between alcohol use and sickness absence, (2) whether type of

measures of alcohol use and sickness absence influence the association, and (3) whether the association is moderated by gender and socioeconomic status. This review showed that the association has a fairly strong basis in research. The basis for an association to short-term absence seems somewhat stronger than for long-term absence, but there is empirical support for both. The study found no systematic differences in the alcohol use–sickness absence association across different measures of alcohol use. The studies examined in the review study also indicated that the association applied to both genders and in all socioeconomic strata, but in some cases stronger in lower socioeconomic strata. However, the review concluded that since most of the studies addressing the potentially moderating role of gender and socioeconomic status did not test the group differences properly, further research is needed to draw firm conclusions regarding these issues. *Article 2* and *article 3* of this thesis, which examine the moderating role of gender and socioeconomic status respectively (Schou, Storvoll & Moan, 2014; Schou & Birkelund, 2015), thus contribute to filling the knowledge gaps identified in article 1.

Related to variations in alcohol-related sickness absence across subgroups of the population is a fourth category of questions, i.e., "What groups of alcohol users account for the largest fraction of alcohol-related sickness absence?" The distribution of harm among drinkers is relevant for discussion around *the prevention paradox*. Two previous studies have addressed this issue and found that moderate drinkers account for the majority of alcohol-related sickness absence (Jones et al., 1995; Mangione et al., 1995). In article 2 of this thesis, we examine whether the prevention paradox applies to alcohol-related sickness absence among young employees and among women and men (See 2.4 for details).

Finally, employees' attitudes towards alcohol-related sickness absence and presenteeism have not been researched previously.

2.2.4 Attitudes towards alcohol-related sickness absence and presenteeism

More knowledge is needed to understand the mechanisms behind norm deviating behaviour such as alcohol-related sickness absence and presenteeism. This is important in order to design and target preventive efforts efficiently. In behavioural research, attitudes towards the behaviour are regarded to be among the most important indicators of how people will act (e.g., Ajzen, 1991). Attitudes are defined as "a psychological tendency that is expressed by

evaluating a particular entity with some degree of favor or disfavor" (Eagly & Chaiken, 1993, page 1).

Previous studies have shown that norms in the work place can influence drinking behaviour, including to what extent employees show up with a hangover (Ames et al., 2000). However, to my knowledge, no previous studies have examined attitudes towards alcohol-related sickness absence and presenteeism. *Article 4* (Schou, Moan & Storvoll, 2016), is thus the first study to examine this issue among Norwegian employees. After the article was submitted to the journal, one report addressing attitudes towards alcohol-related sickness absence and presenteeism among employees in Norway has been written (Moan & Halkjelsvik, 2016). Attitudes can also be expected to vary between groups in the population. According to behavioural theories (Ajzen, 1991), attitudes towards a behaviour are assumed to be a result of (among other factors) socio-demographic characteristics such as age, gender and educational level, as well as past experience with the behaviour. Article 4 therefore examined these group differences in attitudes towards alcohol-related sickness absence and presenteeism.

2.3 Group differences

2.3.1 Gender differences in alcohol-related sickness absence

In this thesis, gender is seen as a social category, a group people are sorted into mainly based on biological characteristics such as genitalia. Gender is the basis of different social gender roles. Traditionally, men and women have had unequal rights, and women have been subordinate to men in the gender hierarchy. In the famous words of the feminist writer Simone De Beauvoir, women are “the second sex”, and “one is not born, but rather becomes, a woman” (De Beauvoir, 2000). This emphasises the culturally and socially constructed aspects of gender roles. Although political struggles and social changes have led to great progress for women, especially in Norway, there are still average differences between men and women in areas such as work and family roles. The extent to which these differences also have a biological basis is an ongoing debate, but this debate is not within the scope of this thesis.

However, I will describe how previous research have found gender differences in cultural expectations and social roles in areas relevant to this thesis: alcohol-related sickness absence and alcohol consumption. I will then describe briefly the known biological differences in how male and female bodies physically react to alcohol, and the relevance of that in this context.

In the data used in this thesis, gender is a simple binary variable, and contain no information on the extent to which individuals display traits of masculinity or femininity, or how they perform gender roles. Thus, the variable used does not strictly match the definition of gender above. This is a common problem in quantitative sociology. Since the theoretical basis for this part of the thesis mainly emphasises social and cultural differences between men and women, I use the term "gender" rather than the biologically based "sex".

Women have higher rates of sickness absence than men; this pattern is found across many studies and countries (Mastekaasa and Olsen, 1998, Laaksonen et al., 2010). However, for alcohol-related sickness absence, the pattern have consistently been the opposite. In a general population study from Australia, 4.5 % of men and 2.5 % of women employees reported alcohol-related absence in the past three months (Roche et al., 2008). The same pattern was also found in two earlier Norwegian surveys, as described in article 2, and was confirmed again by a recent Norwegian study, in which 7.2 % of men and 3.9 % of women reported alcohol-related absence in the past year (Edvardsen et al., 2015).

Gender differences in alcohol-related *presenteeism* is less researched, but was found in a recent Norwegian study to be more prevalent among men, 27.8 % in the past year, than women 22.4 % (Edvardsen et al., 2015).

That men's consumption of alcohol is greater than women's, is a consistent finding in all societies surveyed, this is a universal, international pattern. However, the size of the difference and the way men and women drink varies greatly across countries (Wilsnack & Wilsnack, 1997, Holmila & Raitasalo, 2005, Mäkelä et al., 2006). Alcohol consumption and drinking practices are shaped by gender roles and cultural expectations linked to gender, it is important in the social construction of masculinity and femininity. It is generally considered masculine to be able to consume large amounts of alcohol, especially spirits. Femininity is linked to abstaining or drinking (relatively) moderately; drunkenness in women is usually condemned more strongly than in men. This is shown in several countries, including Finland and Sweden (Wilsnack & Wilsnack, 1997, Holmila & Raitasalo, 2005, Hensing & Spak, 2009). Norway is similar to Finland and Sweden in many ways, with a relatively high degree of gender equality, so these findings are likely to apply to Norway too.

In a mixed methods study of young UK students, female students reported that they drank less or changed the type of beverage they consumed in order to appear more feminine. Bare spirits and beer (especially in pints) were considered masculine, while wine and sweet cocktails were

considered feminine. Both female and male students were more condemning of excessive drinking in women than in men. These attitudes were somehow moderated by whether the students were gender conservative or equalitarian, but also the most equalitarian students thought it looked worse for a woman than a man to be very drunk. Disapproval of female drunkenness seemed to be linked to more general cultural expectations of femininity; women are not supposed to be loud, uncontrolled and impolite. The disapproval of drunken women also seems to be linked to the cultural expectation that women are to be in control of themselves and have moral responsibility in terms of sexuality. Drunk women are associated with promiscuity (de Visser & McDonell, 2011).

There are also average physical differences in how male and female bodies react to alcohol. Women show more cognitive and motor impairment at low doses of alcohol than men do, related to physical factors such as differences in average body size and the distribution of muscular tissue and fat in the body (Nolen-Hoeksema, 2004).

In addition, we examined gender differences in attitudes towards alcohol-related sickness absence and presenteeism (Article 4).

2.3.2 Differences in alcohol-related sickness absence across socio-economic groups

Alcohol consumption is part of cultural practices in most developed countries, although beverage types and drinking patterns seem to vary with socio-economic status. Very expensive alcohol can be consumed to show economic strength and symbolic social superiority, as well as high cultural competence. It can, in the words of Torstein Veblen, be part of "conspicuous consumption", (Veblen, 1899). For example, the Chinawhite nightclub in London sell a special "golden cocktail" containing very old, high quality cognac and gold leaf champagne, at a price of more than 3000 US dollars. The Skyview Bar in a Dubai hotel sell the world's most expensive cocktail, at more than 7000 US dollars (Huffington post, 2012). Consuming old and exclusive wines is a well-known way to show cultural distinction, and Bourdieu argued that the complex hierarchy of wines corresponded to the social hierarchy in France (Bourdieu, 1984).

On the other hand, uncontrolled drinking and alcohol problems have a negative stigma. International studies on socio-economic differences in alcohol consumption show that low socio-economic status is associated with binge drinking and problem drinking, at least among men. However, consistent with the observations above, high income is associated with a higher total consumption of alcohol. For women, findings on socio-economic status

differences in drinking patterns are inconclusive. In some countries, the pattern is similar to that of men, but in other countries the association between low socio-economic status and binge and problem drinking is not significant, or is even reversed (Bloomfield et al., 2006, Grittner et al., 2012). A recent Norwegian study found that youth in the most affluent districts of the city of Oslo had the highest consumption of alcohol, but youth in the less affluent districts experienced more alcohol-related harm (Pedersen et al., 2015)

For sickness absence in general, there is a social gradient; people of low socio-economic status have more sickness absence (Hansen & Ingebrigtsen, 2008). For alcohol-related sickness absence, findings are inconsistent. The association between alcohol and sickness absence in general has been found to be stronger among people with a low education, in a study on employees in Finland. The difference did not apply to female employees. (Johansson et. al., 2009). In an Australian study, Roche et.al (2008) found more self-reported alcohol-related sickness absence among workers with a high school education or less, than among workers with postgraduate qualifications (4.2 % versus 1.9 % in the last three months). They did not, however, find significant differences between blue and white-collar workers and professionals. In an earlier Norwegian study, Grimsmo and Rossow (1997) found a higher prevalence of self-reported alcohol-related sickness absence among employees of low income. Spak et al. (1998) found the association between alcohol dependence or abuse (ADA) and sickness absence to be stronger in women of low socio-economic status. In most studies on alcohol and sickness absence, however, socio-economic status is not included, or merely treated, as confounding variables, not explored further (Salonsalmi, et al., 2009; Schou & Moan, 2015, Upmark, et al., 1999).

Previous studies have used different socio-economic measures; traditional socio-economic variables such as education, income and, more rarely, the manual-/non-manual divide (i.e. the division between blue - and white collar occupations), to examine differences in alcohol-related sickness absence. In article 3 of this dissertation (Schou & Birkelund, 2015), we also used these measures, but in addition, we included social status, a more subjective measure of social stratification. Social status may be defined by reference to a set of hierarchical relations that express subjectively perceived, and to some degree accepted, social superiority, equality and inferiority among individuals (Chan & Goldthorpe, 2005). We used a version of the social status scale developed by Chan & Goldthorpe (ibid), adapted for Norway by Chan et al. (2010). (For details, see article 3). We assumed that the status scale may be more in line with

how people actually percieve social differences and social life style differences, thus perhaps also social differences in drinking patterns and alcohol-related sickness absence.

In addition, socio-economic differences in attitudes were examined in article 4.

2.3.3 Differences in alcohol-related sickness absence across social roles

To my knowledge, no previous studies have examined how parenting affects alcohol-related sickness absence. Whether or not partner status is associated with alcohol-related sickness absence have been examined in a few studies: A study on the association between alcohol intake and sickness absence showed that respondents who were married had less alcohol-related sickness absence than those who were single (Johansson, et al., 2009). In an Australian study on self-reported alcohol-related sickness absence (Roche, et al., 2008), workers who were never married or divorced/separated reported higher rates of alcohol-related absence in the last three months (8.5 % and 4.3 % respectively) than workers who were married or in a *de facto* relationship (1.7 %).

Alcohol-related sickness absence differ with family roles mostly because children and partner status influence people's drinking patterns. People tend to reduce their drinking after getting married because they have less need to socialise with other singles and do not frequent bars, night clubs and parties as often as before. There is also some evidence of a selection effect; people who drink less tend to marry earlier (O'Mally, 2005).

In research on health inequality and alcohol consumption, the main emphasis has often been on social stratification for men and family roles for women. However, one European comparative study found both to be an important influence on alcohol consumption for both genders, although there were differences between countries (Kuntche et al., 2006). Considering this finding and also the high rate of labour market participation among Norwegian women, I found it reasonable to expect both family situation and socio-economic status to influence alcohol-related sickness absence, for both men and women. I therefore included socio-economic and family roles in article 3 of this thesis (Schou & Birkelund, 2015). This study contributes to filling an important gap in knowledge, since it examines the importance of parenting and partner status as well as several measures of socio-economic status for alcohol-related sickness absence.

2.3.4 Differences across groups of alcohol users

In Article 1, the so-called prevention paradox is central. In epidemiology, this concept refers to the fact that disease prevention efforts targeted at the whole population may often be more effective than prevention targeted only at high-risk individuals. This applies to diseases distributed in such a way that the majority of cases are found outside of particular high risk groups. However, although the benefits are great for society as a whole, the benefits in terms of reduced risk for each individual is small, because the risk for many was small to begin with. This paradox is called the prevention paradox (Rose, 1985).

This concept has also been used in relation to alcohol. The majority of alcohol-related harm in the population is usually attributable to the larger group of moderate drinkers, although the heaviest drinkers are individually most at risk. It may seem logical to target prevention strategies at the heaviest drinkers, but since this group is small, strategies that target all drinkers may often be more effective. This point made by Skog (1999) is challenging to popular ideas about alcohol and drinkers, since alcohol-related harm often is thought of in relation to heavy drinkers, people perceived to be "addicts" or "alcoholics".

Previous research has found the distribution of alcohol-related sickness absence in the population to be in line with the prevention paradox. A study from New Zealand conducted among 14 - 65 year old employees, found that the 10 % drinking most heavily were responsible for 41 % of the sickness absence, i.e. the majority of the absence (59 %) was attributable to the more moderate drinkers (Jones et al., 1995). Similarly, an American study found that the majority of alcohol-related workplace problems, such as alcohol-related absence, were attributable to moderate drinkers (Mangione et al., 1995).

The concept of a prevention paradox is based on the premise that prevention efforts have an effect. To what extent this is proven for different types of prevention, and what type of prevention is preferable, is debated (e.g. Werch et al., 2000, Marlatt & Witkiewitz, 2002). If and how alcohol-related sickness absence best can be prevented is a topic for future research, outside the scope of this thesis. However, this thesis is the first to examine whether alcohol-related sickness absence in Norway is distributed in a way that makes the prevention paradox applicable, among young employees and among both genders.

2.5 Explaining social behaviour

Explanations of social phenomena have to somehow include the human actors whose individual behaviour generate phenomena on a macro level. According to Skog (2006), both

causal and *intentional* explanations are needed in the social sciences, unlike in the natural sciences, where no human actors are involved. The basis of intentional explanations are human actors trying to achieve some sort of outcome in the future. Their physical and social environment determines their possibilities and options, or rather, how they perceive their environment. These actors are not necessarily rational or acting only out of self-interest. Some actions are the result of habits or learnt social norms and values, which does not require conscious considerations. The study of irrational actions is particularly important to understand deviant behaviour, such as problematic alcohol use (Skog, 2006).

Hedström and Swedberg (1998) argue that the advancement of social theory requires an analytical approach. Social science often provide mere descriptions and labels of social phenomena, rather than explanations. In their view, social science should focus on providing mechanism-based explanations, which identifies the social mechanisms linking individual actions with social phenomena. They quote Merton's idea of middle range theories; since attempts to formulate grand theories or laws have proved useless in the social sciences, and individualistic explanations are insufficient, sociologists should focus on the middle ground, providing explanations of mechanisms. Social science sometimes provide "black box" explanations, where a set of variables leading to an outcome is described, but not explained: "What characterises a black box explanation is that the link between input and output, or between *explanans* and *explanandum*, is assumed to be devoid of structure, or at least, whatever structure there may be is considered to be of no inherent interest." (Hedström & Swedberg, 1998, page 9).

For example, if the finding that gender influences alcohol-related sickness absence had been described only, and not explained any further, it could have fallen into the "black box" trap. The mechanism of this relationship have to be sought by first providing meaningful explanations as to why some people have alcohol-related sickness absence, and then to seek the systematic differences according to gender which produces the relationship between these two variables on a macro level.

2.5.1 An analytical approach – Desires, Beliefs and Opportunities

There are many available theories that can provide explanations of human behaviour such as alcohol-related sickness absence. Desires, Beliefs and Opportunities-theory (DBO-theory) offers one such approach to explain the social mechanisms linking individual actions and

social phenomena. This theory has become quite widely used in sociology, and was developed in part as a modified rational choice theory, answering the need to better analyse and understand how social behaviour form social mechanisms (Elster, 2007). It provides tools to understand how individual actions come about and how they are influenced by other actors and the social structure around them. In this model, actions are determined by the desires, beliefs and opportunities of the actor. It seeks to link mechanism-based theories of individual action to social outcomes (Hedström, 2006).

In DBO-theory, actors are assumed to pursue their *desires,* defined as wishes for something to happen (or not happen). Desires are exogenously given, the theory is not concerned with whether the desires themselves are rational or not, but actors are assumed to pursue them in rational ways. *Beliefs* are the actors' views and opinions about the world. *Opportunities* are the possible actions an actor might choose from, given the possibilities and limitations in the world around him/her (ibid). Therefore, in terms of alcohol-related sickness absence, the mechanism could for example be the following: The desire to drink with friends that evening, and the belief that one would still manage to get up and get to work on time, could lead to alcohol-related absence if the belief was mistaken. In fact, this could be an example of a particular mechanism exemplified by Elster, *wishful thinking* (Elster, 2007), but in terms of DBO-theory seen as the actor's desire influencing and changing his/her belief (Hedström, 2006). Simply put, if the desire to drink is strong enough, it may lead the actor to falsely believe he/she will go to work early despite drinking until late.

DBO-theory is also developed to explain how groups of actors influence each other's actions. This can happen through influencing either the desires, the beliefs or the opportunities of other actors. One such mechanism is *rational-imitation*, in which the actions of other actors influence the beliefs of an actor, and thus in turn their actions (Hedström, 2006). In line with the example above, about alcohol-related sickness absence, an actor's belief that it is possible to get to work in the morning despite drinking, might be the result of observing colleagues staying on and drinking.

The empirical analyses for this thesis was conducted with existing data, which did not include survey questions of desires, beliefs or opportunities of the respondents. It was therefore not the aim of this dissertation to perform any sort of testing of DBO-theory or its usefulness in empirically explaining research findings on alcohol-related sickness absence. However, in the discussion section, I will use DBO-theory to suggest possible mechanisms which could

explain the phenomenon of alcohol-related sickness absence and group variations in its prevalence. In doing so, I attempt to avoid "black box" explanations which merely describe – and not explain – associations. I also suggest how this theory can be applied in future studies addressing alcohol-related sickness absence in chapter 5.3 Suggestions for future research.

3. Data and methods

The data used in this dissertation comes from three sources: The fourth wave of The Young in Norway Longitudinal Study (2005), the TNS Gallup web-survey (2013) and register data from Statistics Norway (2005). Articles 2 and 3 of this dissertation used data samples from the fourth wave of the Young in Norway Longitudinal Study (2005). In article 3, information from register data from Statistics Norway was added to the sample. Article 4 used a sample from the TNS Gallup web survey. Article 1 is a comprehensive literature review, in which the results of systematic literature searches and selected scientific articles published in 1980-2014 was the study material.

3.1 The Young in Norway Longitudinal Study

The Young in Norway Longitudinal Study is a nationally representative survey of the youth population in Norway, conducted in four waves. The first wave was conducted in 1992; a national sample of 12,287 lower and upper secondary school pupils from 67 schools were selected to participate. The pupils attended grades 7-12, and were 12-20 years of age. Every school in Norway was included in the register from which the schools were selected. Schools were stratified to ensure representativeness on the urban-rural dimension, and for upper secondary schools (grades 10-12) to ensure representativeness between schools with general studies courses, occupational courses and schools with both types of courses. Pupils with a lack of reading skills in Norwegian (e.g. youth with some types of disabilities and newly arrived refugees and immigrants) were excluded. (Strand & von Soest, 2007).

The response rate was 97 %. The non-responders had either not consented to participate, their parents had not consented, they were untraceable or they were unable to participate due to prolonged sickness. Pupils who had obviously given incorrect or humorous answers, or very incomplete questionnaires, were excluded. The resulting net sample was n = 11,985, equally distributed according to sex and age, 12 - 20 years of age. (Strand & von Soest, 2007)

Waves 2 and 3 were conducted in 1994 and 1999. All those who participated in one or both of these follow-ups and had consented to future follow-ups, were invited to participate in the

fourth wave of the study in 2005 (t4). Addresses for participants were updated through the Norwegian Central Population Register (Det sentrale folkeregisteret), because many participants had moved. The respondents could choose to fill out the questionnaire in a paper version (89%), be interviewed by phone (1%) or complete a web-based version (10%). In all, 2,890 of 3,507 potential participants completed the questionnaire, setting the response rate at t4 to 82.4%. (ibid). Being male, frequently involved in deviant behaviours, having poor school performance and vocational training have been found to be associated with attrition from the study (Storvoll & Wickstrøm, 2003).

The fourth wave of the study was the only time a question about alcohol-related sickness absence was included in the questionnaire. For this reason, only data from t4, in 2005, were used. For the purpose of the two studies in this dissertation, respondents missing information about gender (n = 24), respondents who were not employed or who were partly studying (n = 1012) and respondents who were not drinking alcohol (n = 92), were excluded. Since this study focuses on sickness absence from work, and the outcome variable was measured using the survey question: "Have you been absent from work *or school* due to alcohol?" (Italics added), all students had to be removed to ensure the absence measured was from work only. Abstainers cannot possibly have alcohol-related sickness absence, and were removed to avoid this source of bias.

After these adjustments, the sample for article 2 consisted of 1762 employees, with slightly more women (n = 887) than men (n = 875). The respondents were between 25 and 37 years of age, but the vast majority (97 %) was between 26 and 32. The mean age was 28.3. There were no gender differences in the distribution of age.

For the sample in article 3, additional information about income, occupation and education from the register at Statistics Norway was added. In this process, some respondents were lost due to lack of consent to connect to other data sources, or technical issues (n = 287). The same exclusion procedure as for article 2, above, was followed. Numbers in the excluded categories were lower, due to respondents lost in the connection process. The sample after these adjustments consisted of 1611 respondents (n = 804 men and 807 women). The respondents were 25-37 years of age, (99.3 % were 26-35 years of age), and the mean age was 28.6.

3.2 Register data

The sample for article 3 was connected to register data from Statistics Norway. Administrative register data for the entire population, with unique person identification numbers, was used to add individual register information to each individual respondent in the Young in Norway survey (t4). Records of income after tax, occupation and education were obtained for the year 2005. This corresponds only roughly to the data collection period of the survey, which was from late summer 2005 until spring 2006. Register information is only available per calendar year, but this sort of information will in most cases be quite stable and any changes are unlikely to be systematic. Occupation and education are registered by detailed codes of up to seven digits, which were used to define broader categories suitable for analysis.

3.3 The TNS Gallup web survey

The web-survey was conducted among respondents in Norway in 2013. The study was commissioned by The Norwegian Institute for Alcohol and Drug Research (SIRUS) from TNS Gallup. A sample of 4 000 18-69 year olds was drawn from an online panel comprising more than 50 000 citizens. To avoid selection bias, the sample was stratified according to figures from Statistics Norway on gender, age (4 groups), geographic region (4 groups), and education (2 groups). Of the original sample, 2182 (55%) participated. The net sample was weighted to reflect the distribution of gender, age and education in the population. All reported findings were calculated in the weighted sample. We were primarily interested in the attitudes of employees, thus only respondents who were employed (full or part time) were included in the analyses (N = 1 407). Of this sample, 47.2 % were women and the average age was 43.69 years (SD = 12.05). A higher educational level was reported by 38.1% of the respondents.

3.5 Statistical methods

The three empirical studies in this dissertation are all based on different regression models, in combination with other types of calculations. In articles 2 and 3, the outcome variable is dichotomous and very skewed: having had alcohol-related sickness absence or not in the past year. Assumptions on which linear regression is based are thus violated, and logistic regression analyses were used for the main analyses. In article 4, the outcome variables are

indices for attitudes towards alcohol-related sickness absence and presenteeism, and linear regression analysis was used.

In articles 2 and 3, the idea was to examine group differences in alcohol-related sickness absence, and whether these differences between men and women (article 1) or according to social status and social roles (article 3), could be attributed to differences in drinking patterns between groups. In article 2, this was done by including an interaction term in the regression model, to examine whether there was any gender difference in the drinking-absence association. In article 3, group differences were examined by using the «two step model». In this model, variables for alcohol consumption is introduced in the regression model as a second stage, to test if family, socio-economic status or other background variables are associated with alcohol-related harms directly – or if they only influence alcohol consumption which in turn influences the alcohol-related harm in question. This is an approach often used while researching alcohol-related harm (Selin, 2005).

However, comparing different models in logistic regression may be problematic. Unobserved heterogeneity is not only a problem if the unobserved variables are correlated with the independent variables, as is the case in linear regression. The unobserved heterogeneity is likely to vary between models with different independent variables, making it problematic to compare log-odds ratios or odds ratios across models. Because of this problem, it is recommended to use the linear probability model instead, even if assumptions made with linear models are violated (Mood, 2010).

In article 3, we tried the linear probability model with the same variables as in the logistic model, to see if results were substantially different. We found that the results were very similar, and that the choice of method did not influence the conclusions drawn from the study.

In article 2, it was also tested whether the prevention paradox applied to alcohol-related sickness absence, and if it applied for both men and women. This was done by calculating the distribution of alcohol-related sickness absence episodes among heavy episodic drinkers and among others. The idea was to see whether a larger number of absence episodes could be attributed to the group of moderate drinkers than to the relatively small group of heavy drinkers.

In article 4, the outcome was attitudes towards alcohol-related sickness absence and alcohol-related presenteeism. Linear regression was used to analyse how other factors were associated with degree of tolerance for these two types of alcohol-related harm.

3.6 Review method

The aim of article 1 was to identify and examine all studies on the alcohol use-sickness absence association published in peer-reviewed journals between 1980 and 2014, using individual-level data. We designed a search strategy covering several different databases across various academic disciplines: Psych info, Embase, Socindex, Web of Knowledge, Medline, Amed and Svemed+. Only studies that tested the association between some measure of alcohol use and some measure of sickness absence, using a well-known statistical procedure, such as regression analyses or cross-tabs with chi-squares, were included. We identified 27 articles including 28 studies, testing a total of 48 associations, that met our inclusion criteria. We decided not to perform a meta-analysis, since the diversity of methods was too large and the information provided in some of the papers was insufficient. Instead, we decided to assess the associations systematically on quality criteria.

The inclusion criteria constituted the first part of the quality assessment. The second part was ranking the associations found in the studies according to four quality criteria; measures of (1) alcohol use and (2) sickness absence, and sample (3) type and (4) size. On each parameter, either 0 or 1 point was given, thus each association could get between 0 and 4 points. Associations with a sum score of 0–3 points were categorised as low–medium-quality (level 1) and associations with a sum score of 4 points were categorised as high quality (level 2). Measures were assessed as low quality if definitions were too wide or inaccurate, or so strict that they were likely to exclude too many cases. Associations using a selected sample not representative of the general population (e.g. police officers) or a relatively small sample size of fewer than 500 participants, were categorised as low quality. Since sickness absence because of alcohol is a low prevalent phenomenon, samples need to be quite large in order to give credible results.

The third step of the quality assessment was only relevant for studies addressing the possible moderating effect of gender and socioeconomic status. We examined whether the moderating effect was actually tested, that is using an interaction term, by comparing the beta-coefficients in separate analyses or by examining whether the confidence intervals for the respective genders and socioeconomic groups overlapped.

4. Empirical findings

Article 1: The Alcohol use - sickness absence association and the moderating role of gender and socio-economic status: A literature review.
Co-authored with Inger Synnøve Moan and published 2015 in Drug & Alcohol Review.

The purpose of this extensive review was to examine the available empirical evidence for an association between alcohol use and sickness absence. A search strategy was designed to find studies on the alcohol use–sickness absence association using individual-level data, published in peer-reviewed journals from 1980-2014. Only studies in English, using a form of established statistical method, were examined. Our inclusion criteria were met by 27 papers containing 28 separate studies, testing 48 associations. We found empirical evidence for an association between alcohol use and both long- and short-term absence. Associations were scored on quality criteria and given 0 – 4 points: The size and type of sample used, and measures of both sickness absence and alcohol consumption.

The results showed that high-quality associations were statistically significant in 100% of the cases. Among low–medium quality associations, alcohol was less consistently related to long-term than to short-term absence (significant in 25% and 100% of the cases, respectively). The studies examined used several different types of alcohol measures, but the association did not vary systematically across measures of alcohol use. We also found that the association applied to both genders and in all socioeconomic strata, but in a few studies it applied more strongly in lower socio-economic strata. The conclusion of the review study is that the alcohol use–sickness absence association is well founded in research. The association may be moderated by gender and socioeconomics, as shown in a few of the studies, but more research is needed to draw firm conclusions on this issue.

Article 2: Alcohol-related sickness absence among young employees: Gender differences and the prevention paradox.
Co-authored with Elisabet E. Storvoll and Inger Synnøve Moan, and published 2014 in European Journal of Public Health

This article sought to examine whether there were gender differences in the prevalence of alcohol-related sickness absence and in the alcohol use - sickness absence association, and whether the prevention paradox applied for both genders among Norwegian young adults. A

sample of employed young adults, 49.7 % male (N = 1762), was obtained from a general population survey of Norwegians. Self-reported measures on alcohol-related sickness absence and various drinking measures were applied. A total of 8.1 % reported having had alcohol-related sickness absence at least once in the past year. Men reported such absence from work almost twice as often as women did, 10.5 % and 5.7 % respectively.

There was a statistically significant gender difference in the drinking-absence association only for one of the three alcohol measures, frequency of drinking 5 or more units of alcohol, showing a stronger relationship among women. For drinking to intoxication and general drinking frequency, there were no significant gender differences.

Number of absence episodes was calculated, and the heaviest drinkers (about 6 % of the sample) reported a disproportionally large share of alcohol-related sickness absence (19 %). The vast majority of the alcohol-related absence was thus found among the moderate drinkers (81 %). This was also true for both genders, when absence episodes were calculated for men and women separately. Thus, this finding implies that the prevention paradox applied to alcohol-related sickness absence, among young employees and among women and men.

Article 3: Alcohol-related sickness absence in young employees in Norway - The impact of social roles and socio-economic status.
Co-authored with Gunn Elisabeth Birkelund and published 2015 in Nordic Studies on Alcohol and Drugs.

The aim was to establish whether there were differences in alcohol-related sickness absence according to socio-economic status and family situation, among young employees in Norway. A sample of employed young adults was obtained from the fourth wave of the Young in Norway study (2005) and connected to registry data from Statistics Norway (N =1611). Data was analysed with cross tables and logistic regression analysis. Alcohol-related sickness absence was regressed on socio-economic and family variables in steps, and then drinking pattern (frequency of drinking and frequency of heavy drinking). Consistent with findings in article 2, being male was strongly associated with alcohol-related sickness absence. Income was also associated with such absence; the risk was 48.8 and 46.9 percent lower for those with medium and high income compared to low income. Controlled for family situation, the association changed to 43.1 and 37.1 percent lower risk for medium and high income.

Education and social status, however, were not significantly associated with alcohol-related sickness absence. Children and partner reduced the risk of alcohol-related sickness absence, by 50.1 and 62.5 percent respectively. In the male and female sub samples however, children did not have a significant effect, probably because the effect of having a partner was stronger for women, 68.5 versus 59.4 percent reduced risk. Introducing frequencies of drinking and drinking to intoxication in the regression model attenuated some associations with alcohol-related sickness absence. In sum, this study showed that alcohol-related sickness absence was more common in people who were single and without children, and more common in men than women. With the exception of income, socio-economic factors did not seem to be important. The differences between groups appeared to be only partly a result of different drinking patterns.

Article 4: Attitudes towards alcohol-related sickness absence and presenteeism: Differences across subgroups of the population?
Co-authored with Inger Synnøve Moan and Elisabet E. Storvoll, submitted.

This study focused on employees' *attitudes* towards alcohol-related sickness absence and presenteeism. Data was collected using a web-survey among 18-69 year old Norwegians (N = 1407). The respondents evaluated six situations with alcohol-related sickness absence and two situations describing presenteeism due to alcohol. The response scales were: completely unproblematic (coded 4), quite unproblematic (3), quite problematic (2) and very problematic (1). Based on the responses, each respondent were given a mean score ranging from 1-4 on each index. The higher the score, the higher the tolerance for alcohol-related absence or presenteeism. The employees' own drinking habits, alcohol-related sickness absence and presenteeism were mapped.

Attitudes towards alcohol-related absence were more restrictive than attitudes towards presenteeism. In the sample as a whole, mean scores were 2.59 and 1.50 respectively. Both behaviours were condemned more strongly with frequent occurrence. Analyses showed that attitudes towards alcohol-related absence were more liberal among those who drank to intoxication frequently, more liberal among men than women, and among those who reported having such absence themselves. Attitudes towards presenteeism were also more liberal with increasing frequency of intoxication, more liberal among men and among those who reported experiencing reduced efficiency several times themselves. People with a lower educational level were also more tolerant towards presenteeism than those with a higher education. The

most important indicator of attitudes was past behaviour, both in terms of people's own drinking behaviour and their experience with alcohol-related absence and presenteeism.

5.0 Discussion and conclusion

Alcohol-related sickness absence in Norwegian employees, as shown in articles 2 – 3 of this thesis, is far from uncommon. In article 2, a study on young employees below 35 years of age, 8.1 % reported at least one day's absence due to alcohol in the past year (Schou, Storvoll, & Moan, 2014).

The data was collected in 2005, and it is not clear whether this finding still applies to young employees in Norway. The amount of alcohol sold in Norway increased from 6.4 liters of pure alcohol per adult in 2005 till about 6.8 liters in 2008, but has since then fallen till below 2005 level (Skretting et al., 2014). However, an increase in taxfreee sales and sales abroad means the total consumption of alcohol in Norway has been relatively stable since 2008 (Bergsvik, 2015), i.e. on a higher level than in 2005. A higher consumption of alcohol in the population makes an increase in alcohol-related sickness absence likely. However, in a recent study of employees of all ages, in eight different lines of business, 5.3 % reported alcohol-related absence (Edvardsen et al., 2015). The lower figure could be explained by the difference in age spans between the samples, since young employees under 35 probably binge drink more often than older employees.

Alcohol's relation to sickness absence is complex, and is likely to vary across subgroups. There are a number of influences on the health of individuals, and sickness absence is not always in a straightforward sense related to sickness. This dissertation contains, to my knowledge, the first review of individual-level studies addressing the alcohol use-sickness absence association. It provides new knowledge regarding the association per se, how different measures influenced the alcohol use - sickness absence association, and whether existing research provides empirical support for a moderating role of gender and socio-economic status. The 27 articles that satisfied our inclusion criteria in the review article tested a total of 48 associations, 83.3 % being statistically significant. All associations of high quality were significant. The non-significant associations had shortcomings that partly explained the non-significant results. However, the vast majority of the studies in our review study used cross-sectional data, which does not allow for conclusions regarding a possible causal relationship between alcohol use and sickness absence. Nevertheless, the four

longitudinal studies included did provide some support for the contention that there is a causal relationship between alcohol use and sickness absence, both for short- and long-term absence.

Article 4 represents the first study on employees' attitudes towards alcohol-related sickness absence and presenteeism. After the article was submitted to the journal, a report addressing this issue has been written (Moan & Halkjelsvik, 2016). Article 4 (Schou, Moan & Storvoll, 2016) showed that attitudes towards alcohol-related presenteeism were more tolerant than towards absence, and that attitudes became more restrictive with increased frequency of absence and presenteeism. These findings are consistent with the findings of Moan and Halkjelsvik (2016). In article 4, gender differences in attitudes were examined revealing that women were more restrictive towards both absence and presenteeism than men were.

I will attempt to suggest possible mechanisms explaining the alcohol – sickness absence association, using the framework of DBO- theory developed by Hedström (2006), discussed on page 22. Alcohol-related sickness absence is of two types – long term, because high consumption of alcohol can cause a number of serious illnesses, or short term, due to the immediate effects of alcohol intoxication. The two types of alcohol-related sickness absence can more meaningfully be discussed as two different kinds of outcomes. It seems unreasonable to consider long term alcohol-related sickness absence an outcome that was desired by an actor. People do not normally desire serious illness. In Hedström's view, some degree of rationality is assumed on part of the actors. For many frequent drinkers, however, the increased risk of future illness will be quite small. A rational and informed actor may well decide that the networking benefits of drinking with colleagues or simply the enjoyment of intoxication are worth any marginal long-term health risks.

On the other hand, it is difficult to draw a clear line for when drinking is so frequent and problematic and the risks increased so much that the behaviour can be seen as irrational. In Skog's view (1985), irrationality is an important factor in understanding problematic substance use. Long-term alcohol-related sickness absence could be interpreted as an unforeseen consequence of fulfilling one's desire to drink often, and in large amounts over long periods of time. The desire to drink often could be linked to an alcohol addiction, which developed gradually, and which the actor was only semi-consciously aware of. Drinking alcohol is also a learnt social practice. It may develop into a habit not consciously reflected over, even if amounts and frequency increases over time. One relevant form of irrationality is the tendency to postpone realising one has a problem, because it is more comfortable in the

short term. Irrationality could also be linked to beliefs. People could choose not to believe information about the risks of high alcohol consumption, dismissing it as exaggerated and motivated by religious or moralist agendas, for example. Actors could falsely believe that they are more in control of their drinking than they really are, or systematically underestimate the amounts they drink. This could be interpreted as a case of wishful thinking, a mechanism in which desire (to drink often) influences the belief about the harmfulness of alcohol.

In the case of short-term alcohol-related sickness absence, it may also be linked to false beliefs, in a similar way as above: The desire to drink with one's friends on a night before a work day and the belief that one will manage to limit the amount of alcohol and still be able to work in the morning, may result in alcohol-related sickness absence if the belief was mistaken; one did not manage to limit the amount sufficiently to go to work in the morning. This could be a case of wishful thinking, if the desire (to drink) influence the belief.

On the other hand, short-term alcohol-related sickness absence could be a chosen action if one's desire to drink with friends is stronger than the desire to go to work, even if one believes this will cause sickness absence. Alternatively, s/he may believe that s/he will be able to have absence/presenteeism undetected, for example because her/his supervisor is very busy or on holiday. If this belief is correct, there is also an opportunity to have absence or reduced efficiency undetected.

All of these possible mechanisms could be part of what explains the alcohol use – sickness absence association, in varying degrees. However, to draw any firm conclusions regarding these issues, future studies need to include measures of desires, beliefs and opportunities along with measures of alcohol use and alcohol-related sickness absence.

The analyses of attitudes, performed in article 4, can be interpreted as a small step in the direction of explaining the mechanisms behind the phenomena of alcohol-related absence and presenteeism. Specific beliefs are often interpreted as part of what forms attitudes, e.g. if you believe that heavy alcohol consumption is harmful, your attitude towards colleagues who have alcohol-related absence or presenteeism is likely to be more restrictive.

5.1 Group differences in alcohol-related sickness absence and presenteeism

Gender

In article 2 of this thesis, men reported alcohol-related sickness absence from work almost twice as often as women, 10.5 % and 5.7 % respectively (Schou, Moan & Storvoll, 2014). A gender difference of this proportion, with men almost twice as often absent, was also found in the Australian study (Roche et al., 2008), an earlier Norwegian study (Grimsmo & Rossow, 1997) and was confirmed again by a recent Norwegian study, in which 7.2 % of men and 3.9 % of women reported alcohol-related absence in the past year (Edvardsen et al., 2015). The results in article 2 are thus in line with the pattern found in other studies.

It was an aim not only to examine gender differences in the prevalence of alcohol-related sickness absence, but also to examine gender differences in the strength of the association between alcohol consumption and alcohol-related absence. A significant gender difference was found only for alcohol consumption measured in number of units, five or more. The association was stronger for women, probably reflecting that drinking five or more units would make the average woman more intoxicated than the average man, and thus more likely lead to absence the next day. For the measures of self-perceived drinking to intoxication and frequency of drinking, there were no gender differences, probably because women generally drink less than men do on each drinking occasion. Women seem to adjust for their higher alcohol sensitivity. Since none of the associations between alcohol measures and alcohol-related absence were significantly stronger for men, article 2 concluded that these findings are most probably due to men's higher consumption of alcohol, rather than men being more likely absent after drinking than women, i.e. a gender differences in drinking patterns. To my knowledge, this has not been researched in other studies.

In light of DBO-theory (Hedström, 2006), actions are the result of a combination of desires, beliefs and opportunities, which makes the action seem reasonable for the individual actor. Differences between men and women in drinking behaviour and alcohol-related sickness absence may thus be explained by systematic variations in any of these three factors.

First, there is likely a difference in beliefs between men and women about alcohol and appropriate drinking styles for themselves. The consumption of alcohol is linked to cultural perceptions of masculinity and femininity; it is often considered masculine to consume large amounts of alcohol, especially beverages such as whisky. Drunkenness is in some ways contrary to cultural perceptions of femininity; women are not supposed to be loud and unable

to control themselves. It is also linked to the cultural expectation that women have moral responsibility in terms of sexuality. Drunk women are associated with promiscuity (DeVisser & McDonnell, 2011). These gendered cultural perceptions are likely to shape individuals' beliefs about the social acceptability of drunkenness for themselves and for their gender in general. Another gender difference in beliefs is related to perceptions of risk. Women may believe that consuming large amounts of alcohol decreases their ability to defend themselves from unwanted sexual attention or assaults, a less prominent concern for most men (Noelen-Hoeksema, 2004). Recent studies has also shown that women experience more unwanted sexual attention by people who have been drinking than men (Moan & Halkjelsvik, 2016; Storvoll, Moan & Lund, 2016)

Second, opportunities vary by gender. The difference in risk perception described above may be interpreted as a gender difference in beliefs, but if these beliefs are assumed true, it can be seen as a difference in actual opportunity to drink to intoxication. Opportunities also vary by gender in other ways. Women are advised by health authorities not to drink, and especially not in large amounts, while pregnant and breast-feeding. This advice has also been extended to women trying to conceive (FHI, 2014). Women are also more often the primary care giver for young children after infancy. Men more often have managerial positions, which means more responsibility, but usually also more trust and self-supervision, which may give opportunity for undetected absence.

The desire to drink to intoxication vary between men and women as it is influenced by beliefs, but drinking to intoxication may also be more desirable to men as it gives greater benefits. For men, heavy drinking with male friends and colleagues may be a male bonding experience that gives social advantages. Although women can engage in similar behaviour, beverages will more often be be wine, and the amounts consumed likely to be smaller.

The possible mechanisms described above could explain the observed gender differences in alcohol-related sickness absence, but again, no firm conclusions can be drawn without data on people's desires, beliefs and oppertunities. However, the well documented gendered cultural perceptions of drunkenness are very likely to shape men's and women's beliefs about appropriate drinking behaviour (for themselves) in different ways. Furthermore, the drinking of (bare) spirits is seen as a masculine activity, as described above, and there is also empirical research showing that the sale of spirits influence sickness absence rates for men, but not for

women: In a macro level study of Norway, increased alcohol consumption over time was associated with an increase in the sickness absence rate for men. In beverage specific analyses, spirits was significant for men, but not beer and wine. The authors suggested that drinking spirits could be an indicator of a risky drinking pattern (Norström & Moan, 2009). The gender difference in opportunity to drink to intoxication due to child bearing is also quite clear in that period of life, at least if we assume that most people follow the advice from health authorities.

Socio-economics

Article 3 of this thesis showed that the association between alcohol intake and alcohol-related sickness absence was stronger in low-income men. However, there were no significant differences according to any other socio-economic variables, which is not in line with other studies, as shown in article 1. Several other studies have found differences in alcohol-related sickness absence according to education and other socio-economic measures (Schou & Moan, 2015). Consistently, where differences are found, the association is stronger in lower socio-economic strata. It may seem curious that educational level has been found to matter in other studies (Johansson, et al., 2009; Roche, et al., 2008), but not in article 3. This may reflect less socio-economic differentiation in alcohol habits and norms in Norway, probably reflecting the relatively high level of social equality in Norwegian society.

In terms of DBO-theory, low-income jobs may give less opportunity for undetected alcohol-related absence. These jobs may be physically more demanding and harder to perform while having a hangover and lower ranked employees might be monitored more closely. High-income employees may more often have privileges such as private offices and the option to work from home, which gives greater opportunity for alcohol-related absence and absenteeism to go undetected.

There may also be differences in the outcomes desired by individuals in low-income jobs and those in higher income jobs. Low-income employees may more often have jobs they see as temporary, and not desire to build a career from that position. This could lead to less work loyalty and a lower threshold for calling in sick when having the symptoms of a hangover. Beliefs about the harmfulness of alcohol, i.e. risk perceptions, may vary according to socio-economics. Educated people may be assumed to have more knowledge about the risks of high alcohol consumption. This is partly in line with empirical results from the review study, as mentioned above, since some of the studies find more alcohol-related sickness absence among

people with a low education, but others find no educational differences (Schou & Moan, 2015). However, it is not in line with results from article 3 of this thesis, where only income, and not education, was found to matter. Analyses with data including information about desires, beliefs and opportunities could provide some explanations of socio-economic differences.

Social roles

In article 3 (Schou & Birkelund, 2015) respondents who were single and without children reported the highest percentage of alcohol-related sickness absence, while those with both a partner and children had the lowest, 14.8 % and 2.9 % respectively. Respondents with a partner and no children less often had alcohol-related absence, 6.0 %, than those who were parents and had no partner, 12.5 %. Controlled for gender, age and socio-economics, associations were slightly attenuated, but family status was still important. Children reduced the risk of alcohol-related sickness absence by 50.1 %. The effect of having a partner was stronger for women than for men, 68.5 % versus 59.4 % reduced risk of alcohol-related absence.

The findings in article 3 are thus in line with other studies on alcohol-related sickness absence which have found a protective effect of having a partner (Roche et al., 2008, Johansson et al., 2009). To my knowledge, article 3 is the first study to examine the importance of children for alcohol-related sickness absence.

Both partners and children obviously influence the opportunity for binge drinking. Partners represent social support as well as social control, which may both reduce a person's desire to binge drink and help a person to get up and go to work despite having a hangover. Singles desire to go out to social venues that serve alcohol more often, both from a need to socialise and to look for a potensial partner. That partners have a stronger protective effect than children, is probably because single parents have the same needs as other singles, and have the opportunity to go out when the child is with the other parent or a babysitter.

Again, to draw any conclusions on which mechanisms explain the observed differences according to social roles, future studies would have to include information on desires, beliefs and opportunities.

5.2 Methodological considerations

This thesis used cross-sectional data only, which does not allow for causal explanations. Longitudinal studies would also have made it possible to study developments over time, for example, how a change in family situation or marriage status is associated with changes in drinking patterns and risks of alcohol-related absence. The samples were not of sufficient size to study variations between specific occupations or variations between geographical regions.

5.2.1 Representativity

The sample of young working adults used in articles 2 - 3 stem from a nationally representative school survey with a high response rate. However, the levels of heavy and problematic drinking are usually higher among those who do not participate in such studies. (Johnson, 2014). Being male, frequently involved in deviant behaviours, having poor school performance and vocational training, have been found to be associated with attrition from the study (Storvoll & Wickstrøm, 2003). This is particularly important in this context, since these traits are also likely associated with heavy and problematic alcohol use. This suggests that levels of alcohol-related sickness absence are higher among the respondents who did not participate in the longitudinal study's fourth wave in 2005. Levels of alcohol-related sickness absence in the same age group in the population may thus be somewhat higher than found in articles 2 and 3.

In the TNS Gallup survey, the response rate was lower, 55 %, and the sample was drawn from a web panel. Also in this survey, it is likely that people with problematic alcohol use declined to participate more often than others, which means that levels of heavy drinking and experiences with alcohol-related absence and presenteeism may be lower in the sample than in the population. Since alcohol use and alcohol-related sickness absence was associated with more tolerant attitudes towards alcohol-related sickness absence and presenteeism, attitudes may be slightly more restrictive in the sample used in article 4, than in the population of Norwegian employees.

5.2.2 Validity and reliability

Validity refers to whether a research instrument measures what it claims to measure (skog, 2004). If a survey question can be interpreted in different ways by respondents, or understood differently than intended, its validity is reduced. Self-report in surveys are also prone to various types of biases, influencing the respondents' answers. Participants may underestimate

their own drinking. A study using both self-report and analysis of oral fluid to assess the prevalence of heavy drinking during the last 24 hours, found that respondents tended to underreport their drinking (Gjerde, et al., 2010). It is likely that this also applies to self-report of alcohol-related absence in the last year. The stigma attached to problematic alcohol use and alcohol-related harm, may make respondents reluctant to admit this, even in confidential surveys. Moreover, the greater stigma attached to female drunkenness (De Visser & McDonnell, 2011), may have resulted in more underreporting among women than among men. Thus, the gender differences in heavy drinking and alcohol-related sickness absence may have been somewhat overestimated.

A consideration with survey data is whether the survey questions are sufficiently clear. The measure of alcohol-related sickness absence used in articles 2 - 3 was rough. Since the respondents were asked only how many times they had been absent from work, we do not know the length of the periods. Moreover, it is difficult to know how the respondents interpreted "one time", i.e. whether they referred to one day or one period of sick leave. However, in a group of young employees most of the absence is probably short-term and in most cases one day. Using a period of one year may result in reduced accuracy due to recall bias, as people usually remember their actions in the last few months more correctly than further back in time. However, asking about a low prevalent phenomenon such as alcohol-related sickness absence using a shorter time-period would increase the risk of excluding employees with only occasional alcohol-related sickness absence.

Reliability refers to the accuracy and stability of a measuring instrument (Skog, 2004). In article 4, the outcome variables were two constructed indices of attitudes towards alcohol-related sickness absence and presenteeim. The higher the score, the higher the tolerance for alcohol-related absence or presenteeism. Cronbach's Alpha was used to measure the internal consistency of the index for tolerance towards alcohol-related sickness absence, and it was mesured to 0.75. Since the index for attitude towards presenteeism consisted of only two items, we could not use Cronbach's, but the two items were correlated at 0.65. Thus, the internal consistency of the attitude measures were satisfactory (cf., Nunnally, 1978).

5.3 How can alcohol-related sickness absence and presenteeism be reduced?

In article 2, we found that the majority of alcohol-related sickness absence among this group of young employees was found in the majority of drinking employees, not in the small group

of heavy drinkers (Schou, Storvoll & Moan, 2014). This is consistent with findings in previous studies addressing this issue using data from employees in all age groups (Jones et al., 1995, Mangione et al., 1998). The implication of this finding is that preventive strategies will be more effective if targeted at all drinking employees, and not just those who are individually most at risk. In article 4, attitudes were found to be strongly associated with the individuals' own experiences with alcohol-related sickness absence and presenteeism. People seem to practice what they preach, to some extent. This implies that preventive efforts aimed at influencing people's attitudes, could also have effect. Although it is not certain which comes first, the attitudes or the actions.

Precisely what type of preventive efforts will be most effective is subject to debate and outside the scope of this thesis. This could take many forms, including media campaigns, interventions and courses offered by employers or trade unions and more knowledge about alcohol-related work place problems included in management training programs.

Furthermore, accessibility and affordability of alcohol is known to influence alcohol consumption, and the extent of alcohol-related harm in society (Babor et al., 2010, Skog, 2006). This is applicable to political policies on a macro level, but likely also for practices in companies and organisations. Social gatherings in the work place, social events in trade unions and professional associations, business dinners and representation – many drink in relation to work and on social events semi-related to work. It has been suggested that these kinds of work-related drinking situations have become more widespread (Nesvåg, 2004). In a recent study among Norwegian employees, 90% reported having had the opportunity to drink in work-related settings the past 12 months, and around 20% of all drinking episodes the past year occurred in work-related settings (Moan & Halkjelsvik, 2016).

Since economic cost is an important factor in limiting people's drinking, opportunities to drink without personal expense may contribute to more excessive drinking. Practices such as free bar and unlimited drinking at company events may also be seen as a signal of acceptability of heavy drinking. The influence of such practices could be explored in future research.

5.4 Suggestions for future research

More research into group differences, for example across gender, socioeconomics, occupations and age, could prove valuable. There are probably differences between occupations, due to different occupational cultures and traditions, as well as differences in

opportunity to have alcohol-related sickness absence undetected. In a recent Norwegian study of employees in 8 different lines of business, alcohol-related sickness absence was found to vary between 0.9 % and 20.6 % and alcohol-related presenteeim between 12,2 and 65,6 % (Edvardsen et al., 2015). This indicates that occupational differences are also very likely. In occupations where sobriety is an absolute requirement, such as driving or operating machinery, rates of alcohol-related absence might be high since it would be irresponsible to go to work with traces of intoxication. Studies of specific occupations, also qualitative and mixed methods studies, could prove valuable to understand how employees relate to the risk of alcohol-related sickness absence. Little is known about attitudes towards alcohol-related sickness absence across occupations.

More longitudinal studies are needed to explore causal mechanisms. The lack of longitudinal studies shown in the review study (article 1) underline this gap in knowledge. Longitudinal studies could answer such questions as whether attitudes influence actions in relation to alcohol-related sickness absence, or if attitudes are adjusted to justify behaviour. Longitudinal studies could also shed light on how changes in family situation, such as getting married or divorced, or having children, influences drinking behaviour and the risk of alcohol-related absence.

By including measures of desires, beliefs and opportunities, future studies could identify some of the mechanisms explaining associations between alcohol intake and sickness absence, and group differences in this association. Other variables such as moral considerations, perceived norms, values and risk perceptions could also prove useful in this context. Identifying the underlying mechanisms in this context could prove valuable for designing preventive efforts, by identifying e.g. to what extent alcohol-related sickness absence is a result of mistaken beliefs about the risks of drinking alcohol.

References

Babor T, Caetano R, Casswell S, et al. (2010) Alcohol: no ordinary commodity. Research and public policy. 2nd edition. Oxford: Oxford University Press.

Baumberg B. (2006). The global economic burden of alcohol: a review and some suggestions. Drug & Alcohol Review. 25 (6), 537-51.

Bergsvik, D. (2015). Endringer i alkoholomsetningen og taxfree salg før og etter kvoteendringen. Fakta-ark fra Sirus. [Changes in alcohol sales and taxfree sales before and after the quota change. Fact sheet from Sirus]. Downloaded from: http://www.sirus.no/endringer-i-alkoholomsetningen-og-taxfree-salg-for-og-etter-kvote-endringen/

Bloomfield, K., Grittner, U., Kramer, S., & Gmel, G. (2006). Social inequalities in alcohol consumption and alcohol-related problems in the study countries of the EU concerted action 'Gender, Culture and Alcohol Problems: a Multi-national Study', *Alcohol & Alcoholism,* 41 (1), 26-36.

Bourdieu, P. (1984) Distinction: A Social Critique of the Judgement of Taste. London: Routledge.

Chan, T., Birkelund, G., Aas, A., & Wiborg, O. (2010). Social Status in Norway. *European Sociological Review,* 1 (18).

Chan, T., & Goldthorpe, J. (2005). The social stratification of theatre, dance and cinema attendance. *Cultural Trends,* 14, 193-212.

De Beauvoir, S. (2000). Det annet kjønn [The second sex], Norwegian translation, Oslo: Pax forlag.

De Visser, R.O. & McDonnell, E.J. (2011) "That's ok, he's a guy": A mixed methods study of gender double standards for alcohol use. *Psychology and Health,* 27 (12), 618-639.

Elster, J., Gjelsvik, O., Hylland A. and Moene, K. (Editors): Understanding choice, explaining behaviour – Essays in honour of Ole-Jørgen Skog. Oslo: Unipub forlag. 1986

Elster, J. (2007). Explaining social behaviour – More nuts and bolts for the social sciences. Cambridge: Cambridge University Press.

Edvardsen, H. M. E., Karinen, R., Moan, I. S., Øiestad, E. L.Christophersen, A. S., & Gjerde, H. (2014). Use of alcohol and drugs among health professionals in Norway: a study using questionnaires and samples of oral fluid. *Journal of occupational medicine and toxicology* 9: 8

Edvardsen, H. M. E., Moan, I. S., Christophersen, A. S., & Gjerde, H. (2015). Use of alcohol and drugs by employees in selected business areas in Norway: a study using oral fluid testing and questionnaires. *Journal of occupational medicine and toxicology* 10: 46

Garcia-Serrano, C. & Malo, M.A. (2009). The impact of Union direct voice on voluntary and involuntary absenteeism. *The Journal of Socio-Economics,* 38, 372-383

Gjerde, H., Christophersen, A. S., Moan, I. S., Yttredal, B., Walsh, J. M & Normann, P. T. (2010). Use of alcohol and drugs by Norwegian employees: a pilot study using questionnaires and analysis of oral fluid. *Journal of occupational medicine and toxicology* 5: 13.

Gjelsvik R. (2004). Utredning av de samfunnsmessige kostnadene relatert til alkohol [Estimation of the societal costs of alcohol]. Series of reports on health economy, 07/04. Bergen: Stein Rokkan Center for Social Studies.

Grimsmo A., Rossow, I.M. (1997). Alkohol og sykefravær [Alcohol and sickness absence] SIFA rapport. Oslo: The National Institute for Alcohol and Drug Research 1997 3/97

Grittner, U., Kuntsche, S., Gmel, G., & Bloomfield, K. (2012). Alcohol consumption and social inequality at the individual and country levels - results from an international study. *European Journal of Public Health,* 23 (2), 332-339.

Hammer T. (1999). Sykefravær og rusmiddelbruk blant unge i arbeid [Sickness absence and the use of alcohol and drugs among young workers], NOVA-rapport. Oslo: Norwegian Social Research, 6/99.

Hansen, H. & Ingebrigtsen, T. (2008). Social Class and Sickness Absence in Norway. *Acta Sociologica* 51 (4), 309 – 327

Hedström, P. & Swedberg, R. (1998). Social mechanisms: An introductory essay. In Hedström, P. & Swedberg, R. Social Mechanisms: An Analytical Approach to Social Theory, Cambridge: Cambridge University Press.

Hedström, P. (2006). Explaining Social Change: An Analytical Approach*. *Papers* 80: 73 – 95.

Huffington Post, 08.08.2012, downloaded from: http://www.huffingtonpost.com/2012/08/08/olympics-drink-cocktail-free-athletes_n_1752852.html. Last accessed 27.05.16

Hensing G. & Spak F. (2009). Introduction: Gendring Socio Cultural Alcohol and Drug research. *Alcohol & Alcoholism,* 44, 602 – 606.

Holmila, M. & Raitasalo, K. (2005). Gender differences in drinking: Why do they still exist? *Addiction,* 100, 1763 – 1769.

Horverak, Ø. & Bye, E. (2007). Det norske drikkemønsteret. En studie basert på intervjudata 1973 – 2004. SIRUS-rapport 2/2007 Oslo: SIRUS.

Johansson, E., Bockerman, P., & Uutela, A. (2009). Alcohol consumption and sickness absence: evidence from microdata. *European Journal of Public Health,* 19 (1), 19-22.

Johnson, T.P. (2014) Sources of Error in Substance Use Prevalence Surveys. *International Scholarly Research Notices*, 21.

Jones S, Casswell S, Zhang J. (1995). Economic costs of alcohol-related absenteeism and reduced productivity among the working population of New Zealand. *Addiction,* 90, 1455-61.

Kunstche, S. Knibbe, R. & Gmel, G. (2009) Social roles and alcohol consumption: A study of 10 industrialized countries. *Social Science and Medicine,* 68, 1263-1270.

Laaksonen M, Mastekaasa A, Martikainen P, Rahkonen O, Piha K, Lahelma E. (2010). Gender differences in sickness absence – the contribution of occupation and Workplace. *Scandinavian Journal of Work, Environment and Health,* 36, 394-403.

Laslett AM, Catalano P, Chikritzhs Y, et al. (2010). The Range and Magnitude of Alcohol's Harm to Others. Fitzroy, Victoria: AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health.

Mangione TW, Howland J, Lee M. (1998). New perspectives for worksite alcohol strategies: Results from a corporate drinking study. Boston MA: JSI Research and Training Institute.

Marlatt, G.A. & Witkiewitz, K. (2002). Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive Behaviours,* 27 (6), 867–886.

Mastekaasa, A. and Olsen, KM. (1998). Gender, Absenteeism and Job Characteristics. *Work & Occupations,* 25, 195 – 228.

Mood, C. (2010). Logistic Regression. Why We Cannot Do What We Think We Can Do, and What We Can Do About It. *European Sociological Review,* 26 (1), 67-82.

Mäkelä, P., Gmel, G., Grittner, U., Kuendig, H., Kuntsche, S., Bloomfield, K. and Room, R. (2006). Drinking patterns and their gender differences in Europe. *Alcohol & Alcoholism,* 41 (1), 8–18.

Mäkelä, K. (2012). Cost-of-alcohol studies as a research programme. *Nordic Studies on Alcohol and Drugs*, 29(4), 321–343.

McFarlin, S. K., & Fals-Stewart, W. (2002). Workplace absenteeism and alcohol use: a sequential analysis. *Psychology of Addictive Behaviors,* 16 (1), 17-21.

Moan, I. S. & Halkjelsvik, T. (2016). Alkohol og arbeidsliv. En undersøkelse blant norske arbeidstakere. [Alcohol and working life: A survey among Norwegian employees]. Rapport, Folkehelseinstituttet.

Nesvåg, S. (2004). Alkoholkulturer i norsk arbeidsliv. ”You could be yourself, but where`s the Comfort in that" RF-Rapport 2004/255. Stavanger: Rogalandsforskning.

Neve, R.J.M., Lemmens, P. & Drop, M.J. (1997). Gender differences in alcohol use and alcohol problems: mediation by social roles and gender-role attitudes. *Substance Use and Misuse,* 32 (11), 1439–1459.

Nolen-Hoeksema, S. (2004). Gender differences in risk factors and consequences for alcohol problems. *Clinical Psycology Review,* 24, 981–1010.

Norström, T. (2006). Per capita alcohol consumption and sickness absence. *Addiction,* 101(10), 1421–7.

Norström, T. & Moan, I.S. (2009). Per capita alcohol consumption and sickness absence in Norway. *European Journal of Public Health* 19 (4), 383–388.

Norwegian Institute of Public Health. Alcohol and other psychoactive substances - Public Health Report 2014. Downloaded from http://www.fhi.no/artikler/?id=86717 Published 05.11.2010, updated 04.02.2016

Nunnally, J.C. (1978). Psychometric theory. New York: McGraw-Hill.

O'Mally, P. (2005). Maturing out of heavy alcohol use. *Alcohol Research & Health,* 28 (4), 202–204.

Pedersen, W., Bakken, A. & von Soest, T. (2015). Adolescents from affluent city districts drink more alcohol than others. *Addiction,* 110 (10), 1595–1604.

Pidd K.J., Berry J.G., Roche A.M., Harrison J.E. (2006). Estimating the cost of alcohol-related absenteeism in the Australian workforce: The importance of consumption patterns. *Medical Journal of Australia,* 185 (11), 637 - 41.

Rehm J., Room R., Graham K., Monteiro M., Gmel G & Sempos C. (2003). The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease – an overview. *Addiction,* 98, 1209–1228.

Roche AM, Pidd K, Berry JG & Harrison JE. (2008). Workers' drinking patterns: The impact on absenteeism in the Australian work place. *Addiction,* 103, 738–748.

Rose G. (2001). Sick individuals and sick populations. *International Journal of Epidemiology,* 30, 427–432.

Salonsalmi, A., Laaksonen, M., Lahelma, E., & Rahkonen, O. (2009). Drinking habits and sickness absence: the contribution of working conditions. *Scandinavian Journal of Public Health,* 37, 8, 846–854.

Schou, L. & Birkelund, G. E. (2015). Alcohol-related sickness absence in young employees in Norway - The impact of social roles and socio-economic status. *Nordic Studies on Alcohol and Drugs*, 32 (4), 411-426.

Schou, L. & Moan, I. S. (2015). The Alcohol use - sickness absence association and the moderating role of gender and socio-economic status: A literature review. *Drug and Alcohol Review*, 35 (2), 158-169.

Schou, L., Storvoll, E. E. & Moan, I. S. (2014). Alcohol-related sickness absence among

young employees: Gender differences and the prevention paradox. *European Journal of Public Health.* 24 (3), 480-485.

Schou, L., Moan, I. S. & Storvoll, E. E. (2016). Attitudes towards alcohol-related sickness absence and presenteeism: Differences across subgroups of the population? Submitted

Skog, O.J. (1985). The collectivity of drinking cultures. A theory of the distribution of alcohol consumption. *British Journal of Addiction,* 80, 83–99.

Skog, O.J. (1999). The prevention paradox revisited. *Addiction*, 94, 751–757.

Skog, O.J. (2004). Å forklare sosiale fenomener – en regresjonsbasert tilnærming [To explain social phenomena – a regression based approach]. Oslo: Gyldendal Akademisk.

Skog, O.J. (2006). Skam og skade – Noen avvikssosiologiske temaer [Shame and harm – Issues in the sociology of deviance]. Oslo: Gyldendal Akademisk.

Statistics Norway (2016): Sickness absence Q4 2015 Downloaded from: http://www.ssb.no/en/arbeid-og-lonn/statistikker/sykefratot/kvartal Last accessed 27.05.16

Stortingsmelding 30 (2012-2013) Se meg! En helhetlig rusmiddelpolitikk: alkohol - narkotika- doping. [See me! A comprehensive drug and alcohol policy. White paper, report to The Storting]. Oslo: Helse- og omsorgsdepartementet.

Strand N.P. & von Soest T. (2007). Young in Norway – longitudinal. Documentation of design, variables, and scales. Norwegian Social Research (NOVA).

Storvoll, E. E., Moan, I. S. & Lund, I. O. (2016). Negative Consequences of Other People's Drinking: Prevalence, Perpetrators and Locations. *Drug and Alcohol Review*. DOI: 10.1111/dar.12376.

Storvoll E, & Wickstrøm L. (2003). Gender differences in changes in and stability of conduct problems from early adolescence to early adulthood. *Journal of adolescence,* 26, 413–429.

Sundt, E.: Om Ædrulighedstilstanden i Norge [About the state of sobriety in Norway]. Registreringssentralen for historiske data, RHD, University of Tromsø. Retrived from: http://www.rhd.uit.no/sundt/bind5/eilert_sundt_bd5.html (Original published 1859)

Skretting, A., Lund K.E. & Bye, E.K. (eds). Rusmidler i Norge 2013. Oslo: Statens Institutt for Rusmiddelforskning (SIRUS), 2014.

Upmark, M., Möller, J., & Romelsjö, A. (1999). Longitudinal, population-based study of self reported alcohol habits, high levels of sickness absence, and disability pensions. *Journal of Epidemiological Community Health,* 53(4), 223-229.

Veblen, T. (2008). The Theory of the Leisure Class: An economic study of institutions. Oxford World's Classics, Oxford University Press, USA. (Original published 1899, New York: Macmillian).

Werch, C. E., Pappas, D.M., Carlson, J.M., DiClemente, C.C., Chally, P.S. & Sinder, J.A. (2000). Results of a social norm intervention to prevent binge drinking among first-year residential college students. *Journal of American College Health*, 49 (2), 85–92.

Wilsnack, R. & Wilsnack, S. (eds) (1997). Gender and alcohol: Individual and social perspectives. New Brunswick, NJ: Rutgers Center for Alcohol Studies.

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Du var en av de 12 000 unge som i 1992 deltok i første runde av undersøkelsen Ung i Norge. Etter dette så har du deltatt i 1994 og i 1999. Vi takker for at du har stilt opp så langt. Nå kommer det aller siste spørreskjemaet. Vi har fått mye nyttig kunnskap, og resultatene har vært brukt av mange som arbeider for unge. Undersøkelsen er finansiert av blant annet Utdanningsdepartementet, Barne- og familiedepartementet, Norges Forskningsråd, Kulturrådet og Norges idrettsforbund.

Tidligere har de aller fleste av dere valgt å være med. Vi ber om at du også denne gangen tar deg tid til å svare på skjemaet. Det vil ta rundt en halv time å fylle det ut. Nå er vi interessert i ting som er viktige i den fasen av livet dere nå er inne i, som utdanning og yrkesvalg, barn, seksualitet og samliv. Som før er det også spørsmål om personlig utvikling, vennskap og psykisk helse.

Svarene dine blir som tidligere behandlet konfidensielt. Listen med navn og adresse er sikret i NOVAs arkiv der kun vi tre har tilgang. Etter at vi har mottatt svarene fra dere vil listen bli slettet hos oss og overført til Norsk samfunnsvitenskapelig datatjeneste (NSD), som Datatilsynet har utpekt til å ta vare på slik informasjon.

Premie:

Kr. 50 000,- til valgfri feriereise!

Lurer du på noe, så ikke nøl med å ta kontakt med oss på NOVA: www.nova.no, e-post: unginorge@nova.no, tlf. 22 54 12 18.

Vennlig hilsen

Lars Wichstrøm	Willy Pedersen	Tilmann von Soest
professor, dr.philos	professor, dr.philos	forskningsstipendiat

UTFYLLING AV SPØRRESKJEMAET:

Denne gangen skal spørreskjemaet leses maskinelt. Derfor er det viktig at du *følger instruksjonene* nedenfor:

1. Bruk *sort eller blå kulepenn* ved utfyllingen av skjemaet.
2. Hvis du krysser av i feil rute, må du fylle ruta helt igjen slik: ■ og sette kryss i den riktige ruta.
3. Sett et *tydelig kryss inne i ruta* for det riktige svaralternativet du velger.

Eksempel 1 – RIKTIG

Liker du sjokolade? ☒ Nei ☐ Ja

Eksempel 1 – GALT

Liker du sjokolade? ☒ Nei ☐ Ja

4. Alle tall skal være *hele tall*, ikke bruk komma eller bindestrek. Det skal bare stå ett tall (fra 0 til 9) i hver rute. Tallet skal skrives *inne i ruta*, det må ikke komme i berøring med selve ruta du skriver i. Se eksempel 2:

Eksempel 2 – RIKTIG

Hvor gammel tror du at du blir? ca. ☐ 9 7 år gammel

Eksempel 2 – GALT

Hvor gammel tror du at du blir? ca. ☐ 7 7 år gammel

SAMTYKKEERKLÆRING

Jeg har mottatt informasjon om oppfølgingsdelen av Ung i Norge og er informert om formålet med undersøkelsen. Jeg er også kjent med at opplysninger om meg blir behandlet strengt fortrolig og at undersøkelsen er godkjent av Datatilsynet. Undersøkelsen er forelagt Den regionale komité for medisinsk forskningsetikk. Jeg er videre kjent med at det ikke er satt noen spesiell tidsbegrensning for hvor lenge opplysningene om meg kan lagres. Jeg kan på et senere tidspunkt be om å bli slettet fra registeret uten å oppgi noen grunn.

Jeg samtykker i at dataene, etter godkjenning fra Datatilsynet, på senere tidspunkter kan kobles med opplysninger om meg i FD trygd, med folketellingsdata, Dødsårsaksregisteret, Medisinsk fødselsregister, straffe- og bøteregistrene, Kreftregisteret, sesjonsdata og Reseptbasert legemiddelregister. Denne informasjonen er uten navn eller fødselsnummer. ☐ Ja ☐ Nei

Kjønn ☐ Mann ☐ Kvinne

Når er du født? Dag ☐☐ Måned ☐☐ Årstall 19☐☐

Hvor høy er du? ca. ☐☐☐ cm

Hvor mye veier du? ca. ☐☐☐ kg

Hva ville du helst veid dersom du kunne velge (dersom du var like høy som du er nå)? ☐☐☐ kg

ARBEID OG UTDANNING

Vi vil gjerne vite hvilke skoler du har gått på, hva slags utdanning du har fullført (fått avgangsvitnemål fra), hva slags utdanning du planlegger å ta seinere og eventuelt hva slags skole du går på nå.

	Går på nå	Påbegynt, men sluttet før endelig eksamen	Fullført	Planlegger å begynne på
Videregående skole, studieforberedende	☐	☐	☐	☐
Videregående skole, yrkesforberedende	☐	☐	☐	☐
1–2 års utdannelse etter videregående	☐	☐	☐	☐
3-årig høgskole	☐	☐	☐	☐
4-årig høgskole	☐	☐	☐	☐
Grunnfag eller mellomfag på universitetet	☐	☐	☐	☐
Cand.mag. grad, bachelorgrad	☐	☐	☐	☐
Hovedfag, mastergrad, embetsstudium på universitetet, diplomstudium på høgskole	☐	☐	☐	☐

Har du avsluttende eksamen fra noen utdanning etter ungdomsskolen? ☐ Nei ☐ Ja

Beskriv hvilken høyeste utdanning du har: *("fagbrev snekker", "Cand. Mag.", "ungdomsskole", "lærerhøgskolen")* .....

For koding ☐☐☐☐

Tar du for tiden noen utdanning? ☐ Nei ☐ Ja

Beskriv hvilken utdanning du er i ferd med å ta: *("Legesekretær", "Mastergrad i historie", "Politihøgskolen")* ..... For koding ☐☐☐☐

Hvilket yrke tror du det er **mest sannsynlig** at du har når du er **40 år**? *Selv om du ikke er sikker, så skriv det du tror eller gjetter på.* ..... For koding ☐☐☐☐

Hvilket yrke **ønsker** du deg når du blir 40 år? ..... For koding ☐☐☐☐

Hva er din **hoved**beskjeftigelse nå?
Sett ett kryss

- ☐ I heltidsstilling (35 timer eller mer per uke)
- ☐ I deltidsstilling (mellom 15 og 35 timer per uke)
- ☐ I mindre deltidsstilling (mellom 5 og 15 timer per uke)
- ☐ Arbeidsløs eller på sysselsettingstiltak
- ☐ Svangerskapspermisjon
- ☐ Hjemmeværende
- ☐ I militæret (verneplikt)
- ☐ Under utdanning

Hva har du levd av de siste **12 månedene?**
Sett så mange kryss som passer

- ☐ Forsørget av foreldre
- ☐ Studielån, stipend
- ☐ Egen inntekt
- ☐ Sosialhjelp
- ☐ Svangerskapstrygd
- ☐ Attføringstrygd
- ☐ Uførhetstrygd
- ☐ Arbeidsløshetstrygd/dagpenger
- ☐ Svart arbeid
- ☐ Forsørget av ektefelle/samboer
- ☐ Annet

Dersom hovedbeskjeftigelsen din er heltids- eller deltidsarbeid (mer enn 5 timer per uke), hvilket yrke har du? ..... yrke

Fortell hva du gjør på jobben: .....

..... For koding ☐☐☐☐

Mottar eller har du mottatt kontantstøtte for egne barn?

- ☐ Ja, har mottatt i løpet av de siste 12 månedene
- ☐ Ja, har mottatt før, men ikke i løpet av de siste 12 mnd
- ☐ Nei, aldri

Hva var din samlede inntekt før skatt i 2004 inklusive eventuell trygd? *(**Ikke** regn med evt. partners inntekt.)* ☐☐☐☐☐ 000 kroner

Har du flyttet fra hjemmefra? ☐ Nei ☐ Ja

Hvor gammel var du da du flyttet hjemmefra for første gang?
Hvis du har vært utvekslingsstudent, hatt ett års opphold i militære eller lignende, men så flyttet hjem igjen, skal du ikke regne med dette. Jeg var ☐☐ år

Hvem bor du sammen med nå?

- ☐ Mor og/eller far
- ☐ Alene
- ☐ Bofellesskap
- ☐ Ektefelle/samboer
- ☐ Annet

SAMLIV OG BARN

Parforhold

- ☐ Gift
- ☐ Samboende
- ☐ Har kjæreste, men bor ikke sammen
- ☐ Enslig

Hvis du har en partner (kjæreste/samboer/ektefelle), er vedkommende mann eller kvinne?

- ☐ Mann
- ☐ Kvinne

Hvor gammel er partneren din? ☐☐ år

For de som er eller har vært samboende/gift i 1999 eller senere

Kan du tidfeste alle samboerforhold og ekteskap du har hatt eller lever i fra og med 1999? *Om dere levde i samboerforhold før dere giftet dere, regner vi denne perioden som et eget samliv. Start med situasjonen da vi kontaktet deg forrige gang, dvs. 1999.*

Samliv	Inngått		Type		Opphørt		Opphørsgrunn		
Nr.	Mnd.	Årstall	Samboerskap	Ekteskap	Mnd.	Årstall	Giftet oss	Flyttet fra hverandre	Død
1.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
2.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
3.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
4.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
5.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
6.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
7.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐
8.	☐☐	☐☐☐☐	☐	☐	☐☐	☐☐☐☐	☐	☐	☐

Har du egne barn? ☐ Nei ☐ Ja, jeg har ☐☐ (antall) egne barn

Hvis ja, når ble de/det født?

	Mnd.	Årstall
Nr. 1	☐☐	☐☐☐☐
Nr. 2	☐☐	☐☐☐☐
Nr. 3	☐☐	☐☐☐☐
Nr. 4	☐☐	☐☐☐☐
Nr. 5	☐☐	☐☐☐☐

Hvor mange av disse barna bor du sammen med 50% eller mer av tiden? ☐☐ (antall)

Har din samboer/ektefelle barn som ikke er felles og som bor hos dere 50% eller mer av tiden? ☐ Nei ☐ Ja, ☐☐ (antall)

Er du gravid nå? ☐ Nei ☐ Ja, jer er ☐☐ uker på vei

STØTTE OG HJELP

De følgende spørsmålene handler om mennesker rundt deg som kan gi deg støtte eller hjelp. Dersom det mest passende svaret på et spørsmål er "ingen", skal du likevel krysse av for hvor tilfreds du er alt i alt. *Sett så mange kryss som passer*.

Tenk deg at du hadde et personlig problem og følte deg utafor og trist. Hvem er det sannsynlig at du ville snakke med, søke hjelp hos?

☐ Ingen ☐ Mor ☐ Far ☐ Partner/kjæreste ☐ Søsken
☐ Venn(er) ☐ Slektning(er) ☐ Nabo(er) ☐ Andre

Hvor tilfreds er du alt i alt med denne støtten/hjelpen?

☐ Svært tilfreds
☐ Nokså tilfreds
☐ Nokså lite tilfreds
☐ Svært lite tilfreds

Tenk deg at du er tatt i å gjøre noe ulovlig. Du kan bli anmeldt til politiet. Du trenger hjelp og råd. Hvem er det sannsynlig at du ville gått til?

☐ Ingen ☐ Mor ☐ Far ☐ Partner/kjæreste ☐ Søsken
☐ Venn(er) ☐ Slektning(er) ☐ Nabo(er) ☐ Andre

Hvor tilfreds er du alt i alt med denne støtten/hjelpen?

☐ Svært tilfreds
☐ Nokså tilfreds
☐ Nokså lite tilfreds
☐ Svært lite tilfreds

Hvem kan du virkelig regne med at kan få deg til å føle deg bedre når du er "langt nede" og "helt på felgen"?

☐ Ingen ☐ Mor ☐ Far ☐ Partner/kjæreste ☐ Søsken
☐ Venn(er) ☐ Slektning(er) ☐ Nabo(er) ☐ Andre

Hvor tilfreds er du alt i alt med denne støtten/hjelpen?

☐ Svært tilfreds
☐ Nokså tilfreds
☐ Nokså lite tilfreds
☐ Svært lite tilfreds

Tenk deg at du i morgen måtte velge hvilken utdanning du skulle satse på eller si "ja" eller "nei" til et jobbtilbud. Du er svært usikker på hva du skal velge. Hvem er det sannsynlig at du ville gå til for å få råd og hjelp?

☐ Ingen ☐ Mor ☐ Far ☐ Partner/kjæreste ☐ Søsken
☐ Venn(er) ☐ Slektning(er) ☐ Nabo(er) ☐ Andre

Hvor tilfreds er du alt i alt med denne støtten/hjelpen?

☐ Svært tilfreds
☐ Nokså tilfreds
☐ Nokså lite tilfreds
☐ Svært lite tilfreds

Hvem godtar deg fullt og helt – både dine gode og dårlige sider?

☐ Ingen ☐ Mor ☐ Far ☐ Partner/kjæreste ☐ Søsken
☐ Venn(er) ☐ Slektning(er) ☐ Nabo(er) ☐ Andre

Hvor tilfreds er du alt i alt med denne støtten/hjelpen?

☐ Svært tilfreds
☐ Nokså tilfreds
☐ Nokså lite tilfreds
☐ Svært lite tilfreds

Vi vil be deg om å tenke på dine to beste venner. Vi kan kalle disse venn 1 og venn 2. Dersom du har kjæreste/partner, merk også av for dette. Vi ber deg om å krysse av ja eller nei for om de:

	VENN 1		VENN 2		KJÆRESTE/ PARTNER	
	Nei	Ja	Nei	Ja	Nei	Ja
Røyker fast	☐	☐	☐	☐	☐	☐
Drikker seg vanligvis beruset en gang i uka eller oftere	☐	☐	☐	☐	☐	☐
Har brukt hasj siste år	☐	☐	☐	☐	☐	☐
Har brukt ecstasy	☐	☐	☐	☐	☐	☐
Har brukt annen narkotika	☐	☐	☐	☐	☐	☐
Kommer helt sikkert til å gå på, går på eller har fullført høgskole eller universitet	☐	☐	☐	☐	☐	☐
Har i løpet av siste år vært i kontakt med politiet på grunn av noe ulovlig de har gjort	☐	☐	☐	☐	☐	☐

Samhørighet

	Aldri	Sjelden	Av og til	Ofte
Jeg føler meg på bølgelengde med folk rundt meg	☐	☐	☐	☐
Jeg kan finne noen å være sammen med hvis jeg ønsker det	☐	☐	☐	☐
Jeg har følelsen av at ingen kjenner meg særlig godt	☐	☐	☐	☐
Jeg synes at folk er rundt meg, men ikke sammen med meg	☐	☐	☐	☐
Jeg føler meg ensom	☐	☐	☐	☐

UTSEENDE, MAT OG VEKT

Hvor fornøyd eller misfornøyd er du med:	Svært misfornøyd	Ganske misfornøyd	Ikke helt fornøyd	Fornøyd	Svært fornøyd
Ansiktet	☐	☐	☐	☐	☐
Hoftene og baken	☐	☐	☐	☐	☐
Magen	☐	☐	☐	☐	☐
Bryst	☐	☐	☐	☐	☐
Musklene	☐	☐	☐	☐	☐
Vekten	☐	☐	☐	☐	☐
Høyden	☐	☐	☐	☐	☐

Vil du si om deg selv at du er

- ☐ Svært tykk
- ☐ Ganske tykk
- ☐ Omtrent som andre
- ☐ Ganske tynn
- ☐ Svært tynn

Hva er det meste du har veid i det siste året? ☐☐☐ kg

Hva er det minste du har veid i det siste året? ☐☐☐ kg

Hva er det største vekttapet du har hatt siste året? ☐☐ kg

Skjedde dette med vilje? ☐ Nei ☐ Ja

Faster du noen ganger en hel dag?

- ☐ Nei, aldri
- ☐ Har gjort det en gang
- ☐ Av og til
- ☐ 1 gang i uka
- ☐ 2–3 ganger i uka
- ☐ Hver annen dag

Nedenfor er en del utsagn om mat og spisevaner. *Kryss av for hva som passer for deg.*

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg er svært redd for å bli fet	☐	☐	☐	☐
Jeg spiser store mengder mat fort (mellom måltidene)	☐	☐	☐	☐
Jeg skammer meg over spisevanene mine	☐	☐	☐	☐
Jeg er bekymret over ikke å kunne styre spisingen min	☐	☐	☐	☐

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg trøstespiser	☐	☐	☐	☐
Jeg kan la noe av maten ligge igjen på tallerken etter et måltid	☐	☐	☐	☐
Jeg lurer andre mennesker med hensyn til hvor mye jeg spiser	☐	☐	☐	☐
Det er hvor sulten jeg er som bestemmer hvor mye jeg spiser	☐	☐	☐	☐
Hvis jeg forspiser meg, får jeg stor skyldfølelse	☐	☐	☐	☐
Jeg spiser noen ganger i smug	☐	☐	☐	☐
Spisevanene mine er normale, slik jeg ser dem	☐	☐	☐	☐
Jeg er en ”tvangsspiser”	☐	☐	☐	☐
Vekten min varierer med mer enn 2–3 kg i løpet av en uke	☐	☐	☐	☐
Jeg spiser etter et bestemt mønster hver dag	☐	☐	☐	☐
Jeg driver av og til med hard slanking	☐	☐	☐	☐
Jeg føler meg mislykket hvis jeg bryter med slankeprogrammet (hvis du driver med slanking)	☐	☐	☐	☐
Jeg teller kaloriene i alt jeg spiser, selv når jeg ikke slanker meg	☐	☐	☐	☐
Mitt spisemønster ødelegger livet mitt	☐	☐	☐	☐
Maten styrer livet mitt	☐	☐	☐	☐
Noen ganger spiser jeg så mye at jeg må stoppe fordi det er ubehagelig	☐	☐	☐	☐
Det er perioder hvor jeg bare tenker på mat	☐	☐	☐	☐
Jeg spiser fornuftig når andre er til stede, men ”tar igjen” når jeg er alene	☐	☐	☐	☐
Jeg kan slutte å spise når jeg vil	☐	☐	☐	☐
Jeg føler noen ganger en overveldende trang til å spise	☐	☐	☐	☐
Jeg spiser mye når jeg er engstelig	☐	☐	☐	☐
Jeg er opptatt av å bli tynnere	☐	☐	☐	☐
Jeg prøver å holde diett	☐	☐	☐	☐
Jeg føler ubehag etter at jeg har spist søtsaker	☐	☐	☐	☐
Jeg trimmer for å gå ned i vekt	☐	☐	☐	☐
Jeg kaster opp etter at jeg har spist	☐	☐	☐	☐
Når jeg først har begynt å spise, kan det være vanskelig å stoppe	☐	☐	☐	☐
Jeg bruker for mye tid til å tenke på mat	☐	☐	☐	☐
Jeg føler at maten kontrollerer livet mitt	☐	☐	☐	☐
Når jeg spiser, skjærer jeg maten opp i små biter	☐	☐	☐	☐
Jeg bruker lengre tid enn andre på et måltid	☐	☐	☐	☐
Andre mennesker synes at jeg for tynn	☐	☐	☐	☐
Jeg føler at andre presser meg til å spise	☐	☐	☐	☐

Bruker du noen ganger følgende til å hjelpe deg for å gå ned i vekt?

	Aldri	Av og til	1 gang i uka	2–3 ganger i uka	Mer enn 5 ganger i uka	Daglig	2–3 ganger per dag
Slanketabletter/slankepulver	☐	☐	☐	☐	☐	☐	☐
Avføringsmidler	☐	☐	☐	☐	☐	☐	☐
Vanndrivende medikamenter	☐	☐	☐	☐	☐	☐	☐
Tvinger meg til å kaste opp	☐	☐	☐	☐	☐	☐	☐
Trener kraftig	☐	☐	☐	☐	☐	☐	☐

Har menstruasjonen uteblitt mer enn to ganger i løpet av de **to siste årene** uten at det skyldtes graviditet eller p-pillebruk?

☐ Nei ☐ Ja

Fråtser du i store mengder mat noen ganger?

☐ Aldri
☐ Nesten aldri
☐ En gang i måneden
☐ En gang i uka
☐ 2–3 ganger i uka
☐ Daglig
☐ 2–3 ganger om dagen

Besvares bare av de som fråtser

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg føler meg elendig etter at jeg har fråtset	☐	☐	☐	☐
Jeg fråtser bare når jeg er alene	☐	☐	☐	☐
Jeg ville gjøre store anstrengelser for å tilfredsstille trangen til fråtsing	☐	☐	☐	☐

KOSMETISK KIRURGI

Har du noen gang tatt en kosmetisk operasjon?

☐ Nei
☐ Ja, én kosmetisk operasjon
☐ Ja, flere kosmetiske operasjoner

Antall operasjoner: ☐☐

Hvis ja, hvilken type kosmetisk operasjon har du tatt? *(Skriv også kroppsdelen hvis det ikke går fram av operasjonstypen)*

.....

.....

.....

For koding ☐☐☐☐

Når gjennomførte du (den siste) operasjonen? ☐☐ (måned) ☐☐☐☐ (årstall)

TRENING

Hvor mange timer brukte du på fysisk trening sist uke (**siste 7 dager**)?

☐☐ timer og ☐☐ minutter

☐ Jeg trente ikke

	Nei	1–2 ganger	3–8 ganger	9–16 ganger	Mer enn 17 ganger
Har du trent (eller konkurrert) i idrettslag/klubb **siste måned (siste 30 dager)**?	☐	☐	☐	☐	☐
Har du trent i helsestudio/treningssenter **siste måned**?	☐	☐	☐	☐	☐
Har du trent hjemme hos deg selv, hjemme hos andre eller utendørs **siste måned** (ikke med idrettslag)?	☐	☐	☐	☐	☐

Deltar du i idrettskonkurranser?

☐ Ja
☐ Nei, men jeg deltok før
☐ Nei

På hvilket nivå deltar/deltok du (oppgi høyeste nivå)?

☐ Lokalt (klubbmesterskap etc.)
☐ Kretsnivå
☐ Nasjonalt nivå (landsstevne, norgesmesterskap)
☐ Internasjonalt nivå

I hvilken eller hvilke idretter er/var dette?

..... (mest aktiv) For koding ☐☐☐☐

..... (nest mest aktiv) For koding ☐☐☐☐

For alle

Driver du med trening eller sport der du **ikke** konkurrerer?

☐ Ja
☐ Nei, men jeg deltok før
☐ Nei

I hvilken eller hvilke idretter er/var dette?

..... (mest aktiv) For koding ☐☐☐☐

..... (nest mest aktiv) For koding ☐☐☐☐

SEKSUALITET OG SAMLIV

Har du noen gang hatt fast kjæreste eller partner? ☐ Nei ☐ Ja

	måned	årstall
Tenk på din siste kjæreste/partner, når ble dere sammen?	☐☐	☐☐☐☐
Hvis dere **ikke** er sammen lenger, når ble det slutt?	☐☐	☐☐☐☐

Har du noen gang hatt samleie? ☐ Nei ☐ Ja

Hvis ja, hvor gammel var du første gang? Jeg var ☐☐ år gammel

Hvor mange personer har du hatt samleie med? *Skriv antallet.* Totalt ☐☐☐ personer

Hvor mange personer har du hatt samleie med **siste 12 måneder**? ☐☐☐ personer

I løpet av **siste halvår,** hvor ofte har du hatt fantasier eller drømmer om…	Flere ganger daglig	En gang per dag	2–6 ganger per uke	1–5 ganger per måned	Sjeldnere enn 1 gang per måned	Aldri
Erotiske deler av en mann/kvinnes kropp (ansikt, bryster, kjønnsorganer)	☐	☐	☐	☐	☐	☐
Erotiske opplevelser med en annen person	☐	☐	☐	☐	☐	☐
Å ha samleie, oral sex eller bli kjærtegnet til orgasme	☐	☐	☐	☐	☐	☐

I løpet av **siste halvår**, hvor ofte har du deltatt i følgende seksuelle aktiviteter…	En eller flere ganger per dag	4–6 ganger per uke	2–3 ganger per uke	1–5 ganger per måned	Sjeldnere enn 1 gang per måned	Aldri
Masturbering, onani (av deg selv)	☐	☐	☐	☐	☐	☐
Kyssing og kjæling	☐	☐	☐	☐	☐	☐
Samleie, oral sex og lignende	☐	☐	☐	☐	☐	☐

I løpet av **siste halvår**, hvor fornøyd har du vært med…	Kunne ikke ha vært bedre	Svært bra	Tilfredsstillende	Litt utilfredsstillende	Klart utilfredsstillende	Har ikke hatt noen sexpartner
Din egen evne til å gi deg hen når du har sex	☐	☐	☐	☐	☐	☐
Din egen evne til å oppleve seksuell lyst	☐	☐	☐	☐	☐	☐
Kvaliteten på ditt sexliv	☐	☐	☐	☐	☐	☐
Hele ditt forhold til din nåværende eller siste sexpartner	☐	☐	☐	☐	☐	☐

Har du hatt noen form for seksuelt samvær med personer av samme kjønn som deg selv? ☐ Nei ☐ Ja

Hvis ja, hvor gammel var du første gang? Jeg var ☐☐ år gammel

Hvor gammel var du siste gang? Jeg var ☐☐ år gammel

Hvor mange av samme kjønn har du hatt seksuelt samvær med? Totalt ☐☐ personer

Er du seksuelt interessert i menn eller kvinner (seksuelt tiltrukket av, seksuelle fantasier om)?
Sett kun ett kryss.

☐ Bare kvinner	☐ Hovedsakelig kvinner, en sjelden gang menn	☐ Hovedsakelig kvinner, men noen ganger menn	☐ Omtrent like ofte kvinner som menn	☐ Hovedsakelig menn, men noen ganger kvinner	☐ Hovedsakelig menn, men en sjelden gang kvinner	☐ Bare menn

Hvordan vil du i dag plassere deg på en skala fra bare heterofil til bare homofil/lesbisk?
Sett kun ett kryss.

Bare heterofil	Hovedsakelig heterofil, i meget liten grad homofil/lesbisk	Hovedsakelig heterofil, i noen grad homofil/lesbisk	Omtrent like homofil/lesbisk som heterofil	Hovedsakelig homofil/lesbisk, men i noen grad heterofil	Hovedsakelig homofil/lesbisk, i meget liten grad heterofil	Bare homofil/lesbisk
☐	☐	☐	☐	☐	☐	☐

Dersom du **ikke** oppfatter deg som utelukkende heterofil, hvor gammel var du da du ble klar over dette? Jeg var ☐☐ år gammel

For kvinner

Har du noen gang tatt (provosert) abort? ☐ Nei ☐ Ja, ☐☐ ganger

	måned	årstall
Hvis ja, når skjedde dette første gang?	☐☐	☐☐☐☐
Når skjedde dette siste gang?	☐☐	☐☐☐☐

Ved siste abort, hvem var faren?

- ☐ Min nåværende kjæreste / samboer / ektemann
- ☐ Min daværende kjæreste / samboer / ektemann
- ☐ En tidligere kjæreste / samboer / ektemann som jeg ikke lenger var sammen med da jeg tok abort
- ☐ En mann som jeg aldri har hatt et fast forhold til

Har du noen gang tatt "angrepille"? ☐ Nei ☐ Ja, ☐☐ ganger

	måned	årstall
Hvis ja, når skjedde dette første gang?	☐☐	☐☐☐☐

BRUDD PÅ REGLER OG LOVER

Her er det beskrevet en del handlinger som har å gjøre med brudd på regler og lover i skole, arbeidsliv og samfunn. Andre spørsmål gjelder ting som er ulovlige eller på grensen til det ulovlige, men som mange gjør allikevel. Vi ber deg både krysse av for om du siste 12 månedene har vært med på/ gjort noe av dette, og om du noen gang har vært med på/gjort noe av dette.

	Siste 12 måneder						Hele livet	
	0 ganger	1 gang	2–5 ganger	6–10 ganger	11–50 ganger	50 ganger eller mer	Har du noen gang gjort det? Nei	Ja
Tatt saker til en verdi av mer enn 100 kr fra en butikk eller kiosk uten å betale	☐	☐	☐	☐	☐	☐	☐	☐
Lurt deg fra å betale på kino, buss, tog eller lignende	☐	☐	☐	☐	☐	☐	☐	☐
Stukket av fra regningen på hotell eller utested (f.eks. kafé eller pub)	☐	☐	☐	☐	☐	☐	☐	☐

	Siste 12 måneder						Hele livet	
	0 ganger	1 gang	2–5 ganger	6–10 ganger	11–50 ganger	50 ganger eller mer	Har du noen gang gjort det? Nei	Ja
Krevd mer i forsikringserstatning enn du hadde krav på	☐	☐	☐	☐	☐	☐	☐	☐
Fått økonomisk støtte (f.eks. stipend eller trygdeytelser) som du ikke hadde rett til	☐	☐	☐	☐	☐	☐	☐	☐
Kjøpt eller tatt i mot noe du visste eller trodde var stjålet	☐	☐	☐	☐	☐	☐	☐	☐
Kjøpt seksuelle tjenester	☐	☐	☐	☐	☐	☐	☐	☐
Kjørt bil uten gyldig førerkort	☐	☐	☐	☐	☐	☐	☐	☐
Kjørt bil og overskredet fartsgrensen med mer enn 40 km	☐	☐	☐	☐	☐	☐	☐	☐
Kjørt motorkjøretøy i beruset tilstand (av alkohol)	☐	☐	☐	☐	☐	☐	☐	☐
Kjøret motorkjøretøy i ruset tilstand (av tabletter eller narkotika, evt. i kombinasjon med alkohol)	☐	☐	☐	☐	☐	☐	☐	☐
Brukt tabletter (legemidler) for å få rus	☐	☐	☐	☐	☐	☐	☐	☐
Drukket så mye at du har følt deg tydelig beruset	☐	☐	☐	☐	☐	☐	☐	☐
Drukket 5 drinker eller mer på en kveld (tilsvarer fem ½ flasker pils eller 1/1 flaske vin)	☐	☐	☐	☐	☐	☐	☐	☐
Brukt hasj eller marihuana	☐	☐	☐	☐	☐	☐	☐	☐
Brukt ecstasy-stoffer	☐	☐	☐	☐	☐	☐	☐	☐
Brukt amfetamin	☐	☐	☐	☐	☐	☐	☐	☐
Brukt annen narkotika (som heroin, kokain, LSD osv.)	☐	☐	☐	☐	☐	☐	☐	☐
Bannet til eller skjelt ut noen på skole eller jobb	☐	☐	☐	☐	☐	☐	☐	☐
Mobbet eller plaget andre	☐	☐	☐	☐	☐	☐	☐	☐
Truet noen med vold	☐	☐	☐	☐	☐	☐	☐	☐
Klort eller lugget noen	☐	☐	☐	☐	☐	☐	☐	☐
Fiket til noen	☐	☐	☐	☐	☐	☐	☐	☐
Slått eller sparket noen	☐	☐	☐	☐	☐	☐	☐	☐

Hvis du har klort, lugget, fiket til, slått eller sparket noen siste 12 måneder: Hvilket forhold hadde du til vedkommende (da dette skjedde)?
Sett så mange kryss som passer

- ☐ Partner (kjæreste / samboer / ektefelle)
- ☐ Tidligere partner
- ☐ Andre du kjente godt
- ☐ Bekjent(e)
- ☐ Fremmede

Har du blitt **utsatt for noe** av det følgende **det siste året** (siste 12 mnd)?
*Sett **ett** kryss for hver linje.*

	0 ganger	1 gang	2-5 ganger	Mer enn 5 ganger
Trusler om vold (slik at du ble redd)	☐	☐	☐	☐
Slag eller spark som ikke ga synlige merker	☐	☐	☐	☐
Vold som førte til merker eller skader uten at du trengte legehjelp	☐	☐	☐	☐
Vold som førte til skader slik at du trengte legehjelp	☐	☐	☐	☐
Tvunget eller truet til seksuelle handlinger (som du ikke ønsket)	☐	☐	☐	☐

Hvis du har blitt skadet som følge av vold **det siste året** (siste 12 mnd): Hvilket forhold hadde du til den som skadet deg (da dette skjedde)?
Sett så mange kryss som passer.

- ☐ Partner (kjæreste / samboer / ektefelle)
- ☐ Tidligere partner
- ☐ Andre du kjente godt
- ☐ Bekjent(e)
- ☐ Fremmed(e)

Hvis du har blitt tvunget til seksuelle handlinger **det siste året** (siste 12 mnd): Hvilket forhold hadde du til den som gjorde det (da dette skjedde)?
Sett så mange kryss som passer.

- ☐ Partner (kjæreste / samboer / ektefelle)
- ☐ Tidligere partner
- ☐ Andre du kjente godt
- ☐ Bekjent(e)
- ☐ Fremmed(e)

BRUK AV HELSETJENESTER

Har du noen gang blitt henvist eller søkt profesjonell hjelp for atferdsmessige (f.eks. rus), følelsesmessige (f.eks. depresjon) eller relasjonelle problemer (f.eks. ekteskapsproblemer)?

- ☐ Nei, aldri
- ☐ Ja, en gang
- ☐ Ja, flere ganger

Mener du at du noen gang har hatt behov for å få profesjonell hjelp for slike problemer?

- ☐ Ja, i løpet av de siste 12 månedene
- ☐ Ja, tidligere
- ☐ Nei, aldri

årstall

Når var det du **sist** fikk slik hjelp/behandling? ☐☐☐☐

Når var **første gangen** du fikk slik hjelp/behandling? ☐☐☐☐

For hvilket eller hvilke problem ble du henvist/søkte du hjelp?
Sett så mange kryss som passer.

	Første gangen du ble henvist eller fikk hjelp	**Siste** gangen du ble henvist eller fikk hjelp
Angst	☐	☐
Depresjon	☐	☐
Selvmordsproblematikk eller selvskading	☐	☐

For hvilket eller hvilke problem ble du henvist/søkte du hjelp?
Sett så mange kryss som passer.

	Første gangen du ble henvist eller fikk hjelp	**Siste** gangen du ble henvist eller fikk hjelp
Selvbilde eller identitet	☐	☐
Spiseproblemer	☐	☐
Atferdsproblemer eller aggresjon	☐	☐
Rus	☐	☐
Ensomhet	☐	☐
Konflikter med partner	☐	☐
Konflikter med foreldre	☐	☐
Ettervirkninger etter traumer (død, overgrep etc.)	☐	☐
Konsentrasjonsvansker eller hyperaktivitet	☐	☐
Annet	☐	☐

Hvem fikk du hjelp/behandling av?
Sett så mange kryss som passer.

	Første gangen du ble henvist eller fikk hjelp	**Siste** gangen du ble henvist eller fikk hjelp
Psykiater	☐	☐
Allmennlege/fastlege	☐	☐
Psykolog	☐	☐
Sosionom	☐	☐
Sykepleier	☐	☐
Annet helsepersonell	☐	☐
Alternativ medisin (homøopat, healer etc.)	☐	☐
Selvhjelpsgruppe	☐	☐
Annet	☐	☐

Hvor var det du fikk slik hjelp/behandling?
Sett så mange kryss som passer.

	Første gangen du ble henvist eller fikk hjelp	**Siste** gangen du ble henvist eller fikk hjelp
Psykiatrisk poliklinikk	☐	☐
Psykiatrisk klinikk (sengeavdeling)	☐	☐
Privatpraktiserende	☐	☐
Sosionom	☐	☐
Krisesenter	☐	☐
Pedagogisk-psykologisk tjeneste (gjennom skolen)	☐	☐
Gjennom bedriften (bedriftslege, bedriftspsykolog, AKAN-kontakt)	☐	☐
Sosialtjenesten/sosialkontoret	☐	☐
Barnevernet	☐	☐
Annet	☐	☐

SKADE SEG SELV

Har du noen gang med vilje tatt en overdose av piller eller på annen måte forsøkt å skade deg selv?

☐ Nei, aldri
☐ Ja, en gang
☐ Ja, flere ganger

Hvis "ja", hvor lenge er det siden du sist forsøkte å skade deg selv?

☐☐ år og ☐☐ måneder siden

Har du noen gang forsøkt å ta ditt eget liv?

☐ Nei, aldri
☐ Ja, en gang
☐ Ja, flere ganger

Hvis "ja", hvor lenge er det siden du sist forsøkte å ta ditt eget liv?

☐☐ år og ☐☐ måneder siden

For alle

Kjenner du noen som har skadet seg selv med vilje (selvskading)?

☐ Nei ☐ Ja

Kjenner du noen som har **prøvd** å ta livet sitt?

☐ Nei ☐ Ja

Hvis ja, når var siste gang?

☐☐☐☐ (årstall)

Kjenner du noen som har **tatt** livet sitt?

☐ Nei ☐ Ja

Hvis ja, når var siste gang?

☐☐☐☐ (årstall)

HVORDAN ER DU?

Nedenfor er noen spørsmål om hvordan du syns du selv er.
Kryss av for det som passer best for deg.

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg synes det er ganske vanskelig å få venner	☐	☐	☐	☐
En dag har jeg ett syn på meg selv, en annen dag et helt annet syn	☐	☐	☐	☐
Jeg er ikke fornøyd med utseendet mitt	☐	☐	☐	☐
Jeg er snarsint	☐	☐	☐	☐
Jeg klarer å få virkelig nære venner	☐	☐	☐	☐
Jeg er ofte skuffet over meg selv	☐	☐	☐	☐
Jeg trekker meg tilbake fra folk når jeg blir sint	☐	☐	☐	☐
Jeg har mange venner	☐	☐	☐	☐

Kryss av for det som passer best for deg.

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg er en impulsiv person	☐	☐	☐	☐
Jeg ønsker at kroppen min var annerledes	☐	☐	☐	☐
Jeg har "kort lunte"	☐	☐	☐	☐
Min oppfatning av meg selv pleier å forandre seg en god del	☐	☐	☐	☐
Jeg er ofte sintere enn jeg er villig til å innrømme	☐	☐	☐	☐
Jeg har en nær venn som jeg kan dele hemmeligheter med	☐	☐	☐	☐
Jeg gjør sjelden noe uforsiktig	☐	☐	☐	☐
Jeg liker **ikke** den måten jeg lever livet mitt på	☐	☐	☐	☐
Jeg er en hissigpropp	☐	☐	☐	☐
Jevnaldrende har vanskelig for å like meg	☐	☐	☐	☐
Jeg ønsker at jeg så annerledes ut	☐	☐	☐	☐
Jeg har merket at mitt syn på meg selv kan forandre seg	☐	☐	☐	☐
Ofte koker det inne i meg, selv om det ikke synes	☐	☐	☐	☐
Jeg har en venn som jeg kan dele ting med	☐	☐	☐	☐
Jeg er stort sett fornøyd med meg selv	☐	☐	☐	☐
Jeg handler ut fra øyeblikkets innskytelse	☐	☐	☐	☐
Jeg er populær blant jevnaldrende	☐	☐	☐	☐
Jeg synes jeg ser bra ut	☐	☐	☐	☐
Jeg tar sjelden sjanser	☐	☐	☐	☐
Jeg synes det er vanskelig å få venner som jeg virkelig kan stole på	☐	☐	☐	☐
Jeg går lett av skaftet	☐	☐	☐	☐
Jeg liker meg selv slik jeg er	☐	☐	☐	☐
Jeg føler at jevnaldrende godtar meg	☐	☐	☐	☐
Jeg liker utseende mitt veldig godt	☐	☐	☐	☐
Jeg bærer ofte nag til andre	☐	☐	☐	☐
Av og til har jeg et positivt syn på meg selv, av og til et svært negativt syn	☐	☐	☐	☐
Jeg har ikke noen god venn som jeg kan dele virkelig personlige ting med	☐	☐	☐	☐
Jeg er svært fornøyd med hvordan jeg er	☐	☐	☐	☐
Når jeg har det skikkelig artig, så tenker jeg ikke på konsekvensene	☐	☐	☐	☐
Når jeg skal ut å reise, så liker jeg å planlegge reiserute og tidspunkter nøye på forhånd	☐	☐	☐	☐
Jeg er kjapp til å bestemme meg	☐	☐	☐	☐

PLAGER

Nå følger en liste over forskjellige plager og problemer som man av og til kan ha. Har du i løpet av **den siste uka** ikke vært plaget i det hele tatt, litt plaget eller veldig mye plaget av noe av dette?
Sett ett kryss i den ruta som passer for deg.

	Ikke plaget i det hele tatt	Litt plaget	Ganske mye plaget	Veldig mye plaget
Plutselig redd uten grunn	☐	☐	☐	☐
Stadig redd eller engstelig	☐	☐	☐	☐
Matthet eller svimmelhet	☐	☐	☐	☐
Nervøsitet, indre uro	☐	☐	☐	☐
Lett for å gråte	☐	☐	☐	☐
Lett for å klandre deg selv	☐	☐	☐	☐
Følt at alt er et slit	☐	☐	☐	☐
Hatt søvnproblemer	☐	☐	☐	☐
Følt deg ulykkelig, trist eller deprimert	☐	☐	☐	☐
Følt håpløshet med tanke på framtida	☐	☐	☐	☐
Følt deg stiv eller anspent	☐	☐	☐	☐
Bekymret deg for mye om ting	☐	☐	☐	☐
Tenkt på å gjøre slutt på livet	☐	☐	☐	☐

RØYKING

Røyker du?

- ☐ Har aldri røykt
- ☐ Har aldri røykt fast og røyker ikke i det hele tatt nå
- ☐ Har røykt fast, men har sluttet helt nå
- ☐ Røyker, men ikke daglig
- ☐ Røyker daglig, ca ☐☐ sigaretter

For de som røyker

Hvor lang tid går det fra du står opp om morgenen til du røyker din første sigarett?

- ☐ 5 minutter
- ☐ 6 – 30 minutter
- ☐ 31 – 60 minutter
- ☐ Mer enn en time

Syns du det er vanskelig ikke å røyke på steder der det er forbudt (f.eks. kino, biblioteker, restaurant, puber o.l.)?

- ☐ Nei
- ☐ Ja

Hvilken sigarett ville du ha størst vansker med å kutte ut?

- ☐ Den første
- ☐ En av de andre

Røyker du oftere de første timene etter at du har våknet enn du gjør resten av dagen?

- ☐ Nei
- ☐ Ja

Røyker du selv om du er så syk at du er sengeliggende?

☐ Nei
☐ Ja

Har du noen gang begynt å røyke for å gå ned i vekt?

☐ Nei, aldri
☐ Ja, en gang
☐ Ja, flere ganger

Dersom du sluttet å røyke, tror du at du ville lagt på deg?

☐ Nei Ja, ca ☐☐ kg

ALKOHOL

I de siste 12 månedene, omtrent hvor ofte har du drukket mer enn et par slurker alkohol?

☐ Hver dag eller nesten hver dag
☐ 2–4 ganger i uka
☐ Omtrent 1 gang i uka
☐ 2–3 ganger i måneden
☐ Omtrent 1 gang i måneden
☐ 5–10 ganger i året
☐ 1–4 ganger i året
☐ Har ikke drukket alkohol siste år
☐ Har aldri drukket alkohol

Hvor mange ganger har du i løpet av de **fire siste uker** drukket mer enn et par slurker alkohol?

☐☐ (antall) ganger
☐ Ingen ganger

Siste gang du drakk alkohol, hvor mange alkoholenheter drakk du da? *Som en alkoholenhet regnes ½ flaske pils, 1 glass vin, 1 drink brennevin (ca. 4 cl).*

Jeg drakk ca. ☐☐ alkoholenheter

Hvor mange alkoholenheter drikker du vanligvis når du drikker?

☐ 1-2
☐ 3-4
☐ 5-6
☐ 7-9
☐ 10 eller flere

Tenk tilbake på siste år, **siste 12 måneder**, hvor ofte har du:

	Aldri	Sjeldnere enn månedlig	Noen ganger i måneden	Noen ganger i uken	Daglig eller nesten daglig
- drukket seks alkoholenheter eller mer?	☐	☐	☐	☐	☐
- ikke vært i stand til å stoppe og drikke etter at du hadde begynt?	☐	☐	☐	☐	☐
- unnlatt å gjøre noe du skulle gjort på grunn av drikking?	☐	☐	☐	☐	☐
- trengt alkohol om morgenen for å komme i gang etter du hadde drukket mye dagen før?	☐	☐	☐	☐	☐
- hatt skyldfølelse eller angret på noe som følge av drikking?	☐	☐	☐	☐	☐
- ikke husket hva som hendte kvelden før på grunn av drikking?	☐	☐	☐	☐	☐

	Nei	Ja, men ikke i løpet av siste år	Ja, i løpet av siste år
Har du eller noen annen kommet til skade som følge av din drikking?	☐	☐	☐
Har en slektning eller venn, eller lege (eller annen helsearbeider) engstet seg over drikkingen din, eller antydet at du burde redusere drikkingen?	☐	☐	☐

Tenk tilbake på de siste 12 månedene. Hvor ofte i løpet av denne tiden har du opplevd følgende problemer i forbindelse med at du har brukt alkohol?

Hvis du ikke har drukket, hopper du over disse spørsmålene.

	Aldri	1 gang	2–4 ganger	5–10 ganger	11 eller flere ganger
Vært borte fra skole eller arbeid på grunn av drikking	☐	☐	☐	☐	☐
Vært beruset på skole eller arbeid	☐	☐	☐	☐	☐
Slått eller sparket noen mens du var beruset	☐	☐	☐	☐	☐
Blitt utsatt for vold mens du var beruset, slik at du trengte legehjelp	☐	☐	☐	☐	☐
Blitt skadet som følge av uhell/ulykke mens du var beruset slik at du trengte legehjelp	☐	☐	☐	☐	☐
Havnet i en situasjon der du ikke klarte å forhindre samleie mot din vilje på grunn av beruselse	☐	☐	☐	☐	☐

Omtrent hvor mange ganger har du satset penger på følgende pengespill **det siste året** (siste 12 mnd)?

*Sett **ett** kryss på hver linje*

	Hver dag eller nesten hver dag	Flere ganger i uka	1 gang i uka	Flere ganger i måneden	Sjeldnere enn 1 gang per måned	Har **ikke** spilt siste år
Spilleautomat (med pengepremie)	☐	☐	☐	☐	☐	☐
Pengespill på internett	☐	☐	☐	☐	☐	☐
Sportsspill (oddsen) og veddeløp	☐	☐	☐	☐	☐	☐
Bingo	☐	☐	☐	☐	☐	☐
Andre pengespill	☐	☐	☐	☐	☐	☐

Omtrent hvor gammel var du **første gang** du satset penger på et pengespill?

Jeg var ☐☐ år gammel

☐ Har aldri gjort det

Har du i løpet av **de siste 12 månedene** ...

	Ja	Nei
- følt at du måtte spille for mer og mer penger?	☐	☐
- løyet til familie og venner om hvor mye penger du har brukt på pengespill?	☐	☐

Tenk deg at du har vunnet 100.000,- (hundre tusen) kroner i et lotteri, men ikke får utbetalt pengene før om ett år. Hvis noen ville kjøpe vinnerloddet ditt for et lavere beløp, slik at du fikk penger med en gang, hva er det **laveste** beløpet du ville solgt det for?

Ville solgt det for: ☐ 99.000,- ☐ 95.000,- ☐ 90.000,- ☐ 80.000,- ☐ 75.000,- eller mindre

☐ Ville ikke solgt vinnerloddet, men ventet ett år og fått 100.000,- kroner

Takk for at du ville delta i undersøkelsen!

TNS Gallup

arsak - Kan du oppgi hva som er årsaken til at du ikke ønsker å delta i denne undersøkelsen?

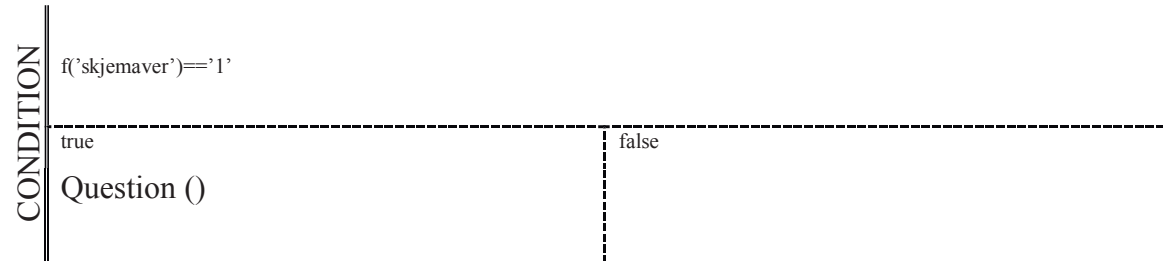
Kan du oppgi hva som er årsaken til at du ikke ønsker å delta i denne undersøkelsen?

- ❍ Er ikke i den oppgitte målgruppen
- ❍ Ønsker ikke å delta

Welcome

Denne spørreundersøkelsen handler om ditt syn på bruk av alkohol og andre rusmidler.

document.getElementById("whiteheader").style.backgroundImage="url('^f('LogoLT')^')";



Q1a - Q1a

Bør det være forbudt å selge vin i dagligvarebutikker?

- ❍ Ja (1)
- ❍ Nei (2)

Q2a - Q2a

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

Q3a - Q3a

Bør det være forbudt å røyke tobakk i parker og andre offentlige uteområder?

- ❍ Ja (1)
- ❍ Nei (2)

Q4a - Q4a

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

Q5a - Q5a

Bør det være forbudt å bruke marihuana/hasj/cannabis som rusmiddel?

- ❍ Ja (1)
- ❍ Nei (2)

Q6a - Q6a

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

END

Condition f('skjemaver')=='1'

CONDITION

f('skjemaver')=='2'

true

Question ()

false

Q1b - Q1b

Bør det være tillatt å selge vin i dagligvarebutikker?

- ❍ Ja (1)

- Nei (2)

Q2b - Q2b

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

Q3b - Q3b

Bør det være tillatt å røyke tobakk i parker og andre offentlige uteområder?

- ❍ Ja (1)
- ❍ Nei (2)

Q4b - Q4b

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

Q5b - Q5b

Bør det være tillatt å bruke marihuana/hasj/cannabis som rusmiddel?

- ❍ Ja (1)
- ❍ Nei (2)

Q6b - Q6b

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

END

Condition f('skjemaver')=='2'

CONDITION

f('skjemaver')=='3'

true

Question ()

false

Q1c - Q1c

Det bør være forbudt å selge vin i dagligvarebutikker.

- ❍ Enig (1)

- Uenig (2)

Q2c - Q2c

Hvor sterke er dine meninger om dette spørsmålet?

- Ikke sterke (1)
- Middels sterke (2)
- Svært sterke (3)

Q3c - Q3c

Det bør være forbudt å røyke tobakk i parker og andre offentlige uteområder.

- Enig (1)
- Uenig (2)

Q4c - Q4c

Hvor sterke er dine meninger om dette spørsmålet?

- Ikke sterke (1)
- Middels sterke (2)
- Svært sterke (3)

Q5c - Q5c

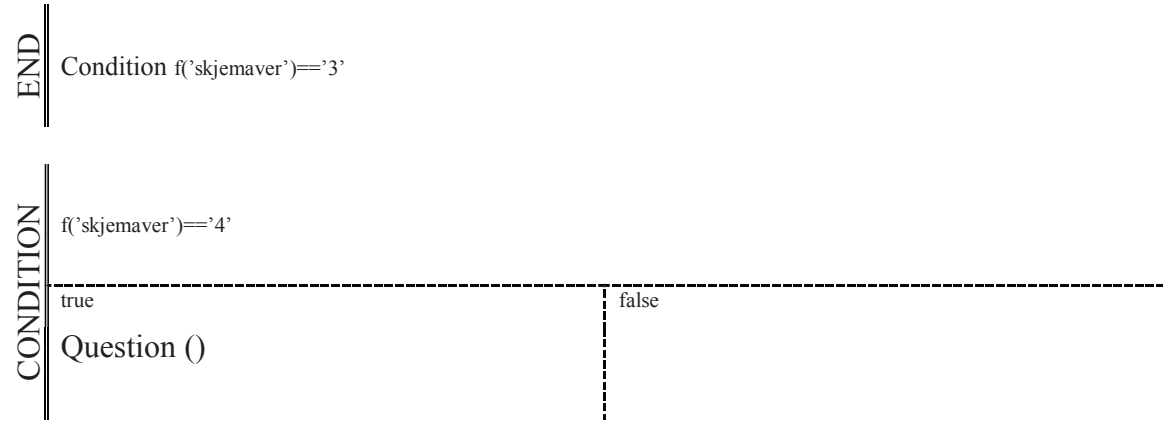
Det bør være forbudt å bruke marihuana/hasj/cannabis som rusmiddel.

- Enig (1)
- Uenig (2)

Q6c - Q6c

Hvor sterke er dine meninger om dette spørsmålet?

- Ikke sterke (1)
- Middels sterke (2)
- Svært sterke (3)



Q1d - Q1d

Det bør være tillatt å selge vin i dagligvarebutikker.

- ❍ Enig (1)
- ❍ Uenig (2)

Q2d - Q2d

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

Q3d - Q3d

Det bør være tillatt å røyke tobakk i parker og andre offentlige uteområder.

- ❍ Enig (1)
- ❍ Uenig (2)

Q4d - Q4d

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

Q5d - Q5d

Det bør være tillatt å bruke marihuana/hasj/cannabis som rusmiddel.

- ❍ Enig (1)
- ❍ Uenig (2)

Q6d - Q6d

Hvor sterke er dine meninger om dette spørsmålet?

- ❍ Ikke sterke (1)
- ❍ Middels sterke (2)
- ❍ Svært sterke (3)

END Condition f('skjemaver')=='4'

CONDITION f('skjemaver').any('1','4')

true

Question ()

false

Q7ad - Q7ad

Samlet sett, vil du si at myndighetenes politikk for å begrense skadene av alkohol er for mild, omtrent passe eller for streng?

- For mild (1)
- Omtrent passe (2)
- For streng (3)

Q8ad - Q8ad

Hvor enig eller uenig er du i følgende påstander?

Dagens begrensninger på salg og skjenking av alkohol er for strenge.

- Helt enig (1)
- Delvis enig (2)
- Verken enig eller uenig (3)
- Delvis uenig (4)
- Helt uenig (5)

Q9ad - Q9ad

Vin bør kun selges på Vinmonopolet.

- Helt enig (1)
- Delvis enig (2)
- Verken enig eller uenig (3)
- Delvis uenig (4)
- Helt uenig (5)

Q10ad - Q10ad

Brennevin bør kun selges på Vinmonopolet.

- Helt enig (1)
- Delvis enig (2)
- Verken enig eller uenig (3)
- Delvis uenig (4)
- Helt uenig (5)

Q11ad - Q11ad

Det bør fortsatt være begrensninger i hvor lenge utestedene kan skjenke alkohol.

- Helt enig (1)
- Delvis enig (2)
- Verken enig eller uenig (3)
- Delvis uenig (4)
- Helt uenig (5)

Q12ad - Q12ad

Avgiftene på alkohol bør økes.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

Q13ad - Q13ad

Det bør fortsatt være forbud mot reklame for alkohol.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

Q14ad - Q14ad

Holdningskampanjer for ansvarlig bruk av alkohol er fornuftig bruk av ressurser.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

END Condition f('skjemaver').any('1','4')

Q15 - Q15

I Norge er det flere begrensninger på salg og skjenking av alkohol (F.eks. selges vin og brennevin kun på vinmonopolet og utesteder har begrensninger i skjenketider).

I hvilken grad har begrensninger på salg og skjenking av alkohol...

	I svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	I svært stor grad 7 (7)
...positive konsekvenser for de som drikker (f.eks. bedre helse, færre ulykker)? (1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...positive konsekvenser for samfunnet (f.eks. mindre vold, mindre jobbfravær)? (2)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...positive konsekvenser for barn (f.eks. mindre omsorgssvikt, færre negative opplevelser)? (3)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...negative konsekvenser for folk som vil kjøpe alkohol (f.eks. mindre utvalg, får ikke kjøpt når man vil)? (4)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...negative konsekvenser for butikker, skjenkesteder og produsenter (f.eks. lavere omsetning,	⌐	⌐	⌐	⌐	⌐	⌐	⌐

	I svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	I svært stor grad 7 (7)
handelslekkasje)? (5)							

Q16 - Q16

Hvor sterke er dine meninger om begrensninger på salg og skjenking av alkohol?

	Ikke sterke i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Svært sterke 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q17 - Q17

Vin kan kun kjøpes på Vinmonopolet og ikke i dagligvarebutikker.

I hvilken grad har det at vin kun selges på vinmonopolet...

	I svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	I svært stor grad 7 (7)
...positive konsekvenser for de som drikker (f.eks. bedre helse, færre ulykker)? (1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...positive konsekvenser for samfunnet (f.eks. mindre vold, mindre jobbfravær)? (2)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...positive konsekvenser for barn (f.eks. mindre omsorgssvikt, færre negative opplevelser)? (3)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...negative konsekvenser for folk som vil kjøpe alkohol (f.eks. mindre utvalg, får ikke kjøpt når man vil)? (4)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...negative konsekvenser for butikker og produsenter (f.eks. lavere omsetning)? (5)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q18 - Q18

Hvor sterke er dine meninger om det at vin kun selges på vinmonopolet?

	Ikke sterke i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Svært sterke 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q19 - Q19

Myndighetene gjennomfører jevnlige holdningskampanjer for ansvarlig bruk av alkohol.

I hvilken grad har holdningskampanjer for ansvarlig bruk av alkohol...

	I svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	I svært stor grad 7 (7)
...positive konsekvenser for de som drikker (f.eks. bedre helse, færre ulykker)? (1)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...positive konsekvenser for samfunnet (f.eks. mindre vold, mindre jobbfravær)? (2)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...positive konsekvenser for barn (f.eks. mindre omsorgssvikt, færre negative opplevelser)? (3)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...negative konsekvenser for folk som vil kjøpe alkohol (f.eks. dårlig samvittighet, «stemples» som dårlig person, annet)? (4)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...negative konsekvenser for butikker, skjenkesteder og produsenter (f.eks. lavere omsetning, handelslekkasje)? (5)	⌙	⌙	⌙	⌙	⌙	⌙	⌙

Q20 - Q20

Hvor sterke er dine meninger om holdningskampanjer for ansvarlig bruk av alkohol?

	Ikke sterke i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Svært sterke 7 (7)
(1)	⌙	⌙	⌙	⌙	⌙	⌙	⌙

Q21 - Q21

I dag er det ekstra avgifter på alkoholholdig drikke (alkoholavgift).

I hvilken grad har alkoholavgiften...

	I svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	I svært stor grad 7 (7)
...positive konsekvenser for de som drikker (f.eks. bedre helse, færre ulykker)? (1)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...positive konsekvenser for samfunnet (f.eks. mindre vold, mindre jobbfravær)? (2)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...positive konsekvenser for barn (f.eks. mindre omsorgssvikt, færre negative opplevelser)? (3)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...negative konsekvenser for folk som vil kjøpe alkohol (f.eks. færre rimelige alternativer, dårligere råd)? (4)	⌙	⌙	⌙	⌙	⌙	⌙	⌙
...negative konsekvenser for butikker, skjenkesteder og produsenter (f.eks. lavere omsetning, handelslekkasje)? (5)	⌙	⌙	⌙	⌙	⌙	⌙	⌙

Q22 - Q22

Hvor sterke er dine meninger om alkoholavgiften?

	Ikke sterke i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Svært sterke 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

CONDITION

f('skjemaver').any('2','3')

true	false
Question ()	

Q7bc - Q7bc

Samlet sett, vil du si at myndighetenes politikk for å begrense skadene av alkohol er for mild, omtrent passe eller for streng?

- For mild (1)
- Omtrent passe (2)
- For streng (3)

Q8bc - Q8bc

Hvor enig eller uenig er du i følgende påstander?

Dagens begrensninger på salg og skjenking av alkohol er for strenge.

- Helt enig (1)
- Delvis enig (2)
- Verken enig eller uenig (3)
- Delvis uenig (4)
- Helt uenig (5)

Q9bc - Q9bc

Vin bør kun selges på Vinmonopolet.

- Helt enig (1)
- Delvis enig (2)
- Verken enig eller uenig (3)
- Delvis uenig (4)
- Helt uenig (5)

Q10bc - Q10bc

Brennevin bør kun selges på Vinmonopolet.

- Helt enig (1)
- Delvis enig (2)

- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

Q11bc - Q11bc

Det bør fortsatt være begrensninger i hvor lenge utestedene kan skjenke alkohol.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

Q12bc - Q12bc

Avgiftene på alkohol bør økes.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

Q13bc - Q13bc

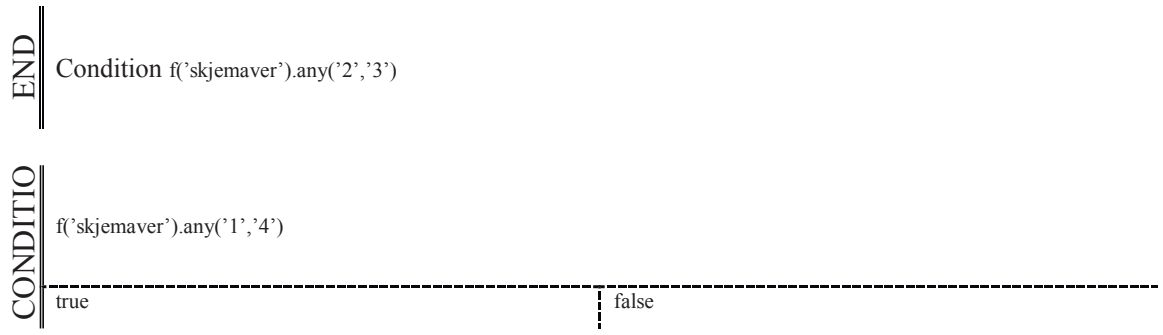
Det bør fortsatt være forbud mot reklame for alkohol.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)

Q14bc - Q14bc

Holdningskampanjer for ansvarlig bruk av alkohol er fornuftig bruk av ressurser.

- ❍ Helt enig (1)
- ❍ Delvis enig (2)
- ❍ Verken enig eller uenig (3)
- ❍ Delvis uenig (4)
- ❍ Helt uenig (5)



Question Q23(Q23)

Q23 - Q23

Når det gjelder regulering av alkoholbruk...

	Ikke viktig i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	Ekstremt viktig 9 (9)
...hvor viktig er det å begrense negative konsekvenser alkohol kan ha på den som drikker (f.eks. helse, ulykker)? (1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...hvor viktig er hensynet til barn (f.eks. omsorgssvikt, negative opplevelser)? (2)	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...hvor viktig er hensynet til butikker, skjenkesteder og produsenter (f.eks. omsetning, handelslekkasje)? (3)	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...hvor viktig er hensynet til samfunnet (f.eks., vold, jobbfravær)? (4)	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...hvor viktig er hensynet til folk som vil kjøpe alkohol (f.eks. utvalg, kjøpe når man vil)? (5)	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐	⌐

END Condition f('skjemaver').any('1','4')

CONDITION f('skjemaver').any('2','3')

true

Question Q24(Q24)

false

Q24 - Q24

Angi hvilke parter du synes det er viktigst å ta hensyn til når det gjelder regulering av alkoholbruk. Gi verdien 1 til den du synes er viktigst å ta hensyn til 2 for nest viktigst osv.:

____ Den som drikker (f.eks. helse, ulykker) (1)
____ Barn (f.eks. omsorgsvikt, negative opplevelser) (2)
____ Butikker, skjenkesteder og produsenter (f.eks. omsetning, handelslekasje) (3)
____ Samfunnet (f.eks., vold, jobbfravær) (4)
____ Folk som vil kjøpe alkohol (f.eks. utvalg, kjøpe når man vil) (5)

END Condition f('skjemaver').any('2','3')

Q25 - Q25

Hvor mye vil du si at dine holdninger til alkoholpolitikk er påvirket av...

	I svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	I svært stor grad 7 (7)
...dine erfaringer med eget eller andres alkoholbruk? (1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...dine bekymringer for negative konsekvenser av alkoholbruk? (2)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...holdningene til dine venner og/eller din familie? (3)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
...dine grunnleggende verdier (om f.eks. valgfrihet, solidaritet)? (4)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q26 - Q26

Ta stilling til følgende utsagn:

I følge mitt livssyn/religion bør man ikke drikke alkohol.

	Stemmer ikke i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q27 - Q27

Ta stilling til følgende påstander

	Helt uenig 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Helt enig 7 (7)
Det er generelt for mye statlig innblanding og regulering i dagens samfunn. (1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
Folk bør få gjøre hva de vil, uten innblanding fra staten. (2)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
Mange er ikke i stand til å ta fornuftige valg selv. Det er derfor viktig at staten setter begrensninger på visse områder. (3)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

i121 - De følgende spørsmålene handler om din generelle holdning til det å drikke alkohol.

De følgende spørsmålene handler om din generelle holdning til det å drikke alkohol.

Q28 - Q28

Dersom du ser bort fra de positive sidene ved alkohol, hvor negativ er din oppfatning av det å drikke alkohol?

	Ikke negativ i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Svært negativ 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q29 - Q29

Dersom du ser bort fra de negative sidene ved alkohol, hvor positiv er din oppfatning av det å drikke alkohol?

	Ikke positiv i det hele tatt 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Svært positiv 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q30 - Q30

Alt i alt ser jeg på det å drikke alkohol som...

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
fornuftig (1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
dumt (2)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
farlig (3)	⌐	⌐	⌐	⌐	⌐	⌐	⌐
harmløst (4)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

i125 - De følgende spørsmålene handler om din generelle holdning til folk som er lettere beruset av alkohol, eller "brisen".

De følgende spørsmålene handler om din generelle holdning til folk som er lettere beruset av alkohol, eller "brisen".

Q31 - Q31

Jeg liker ikke å møte personer som er lettere beruset av alkohol.

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q32 - Q32

Jeg synes ofte det er ubehagelig å møte folk som er lettere beruset av alkohol.

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q33 - Q33

Jeg synes ofte at folk er ekle når de er lettere beruset av alkohol.

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q34 - Q34

Jeg synes ofte at folk er morsomme og festlige når de er lettere beruset av alkohol.

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q35 - Q35

Jeg opplever personer som er lettere beruset av alkohol som trivelige og vennlige.

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

Q36 - Q36

Jeg liker å møte personer som er lettere beruset av alkohol.

	Stemmer i svært liten grad 1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	Stemmer i svært stor grad 7 (7)
(1)	⌐	⌐	⌐	⌐	⌐	⌐	⌐

CONDITION

f('skjemaver').any('3','4')

true

Question ()

false

Q38a - Q38a

Angi i hvilken grad du mener at situasjonen som er beskrevet under er problematisk eller uproblematisk.

	Helt uproblematisk (1)	Nokså uproblematisk (2)	Nokså problematisk (3)	Svært problematisk (4)
En kvinne i 40-årene drikker seg lettere beruset (dvs. blir mer pratsom og livlig enn hun vanligvis er) sammen med venner en lørdags kveld (1)	⌐	⌐	⌐	⌐
En kvinne i 40-årene drikker seg tydelig beruset (dvs. begynner å snakke utydelig og gå ustødig) sammen med venner en lørdags kveld (2)	⌐	⌐	⌐	⌐

Q39 - Q39

Angi i hvilken grad du mener at situasjonen som er beskrevet under er problematisk eller uproblematisk.

	Helt uproblematisk (1)	Nokså uproblematisk (2)	Nokså problematisk (3)	Svært problematisk (4)
Mor drikker ett glass vin et par ganger i året mens hennes 10 år gamle barn er tilstede (1)	⌐	⌐	⌐	⌐
Mor drikker ett glass vin et par ganger i måneden mens hennes 10 år gamle barn er tilstede (2)	⌐	⌐	⌐	⌐
Mor drikker ett glass vin et par ganger i uken mens hennes 10 år gamle barn er tilstede (3)	⌐	⌐	⌐	⌐
Mor drikker seg lettere beruset (dvs. blir mer pratsom og livlig enn hun vanligvis er) et par ganger i året mens hennes 10 år gamle barn er tilstede (4)	⌐	⌐	⌐	⌐
Mor drikker seg lettere beruset et par ganger i måneden mens hennes 10 år gamle barn er tilstede (5)	⌐	⌐	⌐	⌐
Mor drikker seg lettere beruset et par ganger i uken mens hennes 10 år gamle barn er tilstede (6)	⌐	⌐	⌐	⌐
Mor drikker seg tydelig beruset (dvs. begynner å snakke utydelig og gå ustødig) et par ganger i året mens hennes 10 år gamle barn er tilstede (7)	⌐	⌐	⌐	⌐
Mor drikker seg tydelig beruset et par ganger i måneden mens hennes 10 år gamle barn er tilstede (8)	⌐	⌐	⌐	⌐
Mor drikker seg tydelig beruset et par ganger i uken mens hennes 10 år gamle barn er tilstede (9)	⌐	⌐	⌐	⌐

END

Condition f('skjemaver').any('3','4')

CONDITION

f('skjemaver').any('1','2')

true

Question ()

false

Q38b - Q38b

Angi i hvilken grad du mener at situasjonen som er beskrevet under er problematisk eller uproblematisk.

	Helt uproblematisk (1)	Nokså uproblematisk (2)	Nokså problematisk (3)	Svært problematisk (4)
En mann i 40-årene drikker seg lettere beruset (dvs. blir mer pratsom og livlig enn han vanligvis er) sammen med venner en lørdags kveld (1)	⌐	⌐	⌐	⌐
En mann i 40-årene drikker seg tydelig beruset (dvs. begynner å snakke utydelig og gå ustødig) sammen med venner en lørdags kveld (2)	⌐	⌐	⌐	⌐

Q40 - Q40

Angi i hvilken grad du mener at situasjonen som er beskrevet under er problematisk eller uproblematisk.

	Helt uproblematisk (1)	Nokså uproblematisk (2)	Nokså problematisk (3)	Svært problematisk (4)
Far drikker ett glass vin et par ganger i året mens hans 10 år gamle barn er tilstede (1)	⌐	⌐	⌐	⌐
Far drikker ett glass vin et par ganger i måneden mens hans 10 år gamle barn er tilstede (2)	⌐	⌐	⌐	⌐
Far drikker ett glass vin et par ganger i uken mens hans 10 år gamle barn er tilstede (3)	⌐	⌐	⌐	⌐
Far drikker seg lettere beruset (dvs. blir mer pratsom og livlig enn han vanligvis er) et par ganger i året mens hans 10 år gamle barn er tilstede (4)	⌐	⌐	⌐	⌐
Far drikker seg lettere beruset et par ganger i måneden mens hans 10 år gamle barn er tilstede (5)	⌐	⌐	⌐	⌐
Far drikker seg lettere beruset et par ganger i uken mens hans 10 år gamle barn er tilstede (6)	⌐	⌐	⌐	⌐
Far drikker seg tydelig beruset (dvs. begynner å snakke utydelig og gå ustødig) et par ganger i året mens hans 10 år gamle barn er tilstede (7)	⌐	⌐	⌐	⌐
Far drikker seg tydelig beruset et par ganger i måneden mens hans 10 år gamle barn er tilstede (8)	⌐	⌐	⌐	⌐
Far drikker seg tydelig beruset et par ganger i uken mens hans 10 år gamle barn er tilstede (9)	⌐	⌐	⌐	⌐

END Condition f('skjemaver').any('1','2')

Angi i hvilken grad du mener at situasjonen som er beskrevet under er problematisk eller uproblematisk.

	Helt uproblematisk (1)	Nokså uproblematisk (2)	Nokså problematisk (3)	Svært problematisk (4)
En kontoransatt er mindre produktiv på jobb enn han/hun vanligvis er et par dager i året fordi han/hun har drukket alkohol kvelden før (1)	⌐	⌐	⌐	⌐
En kontoransatt er mindre produktiv på jobb enn han/hun vanligvis er et par dager i måneden fordi han/hun har drukket alkohol kvelden før (2)	⌐	⌐	⌐	⌐
En kontoransatt kommer et par timer for sent på jobb et par ganger i året fordi han/hun har drukket alkohol kvelden før (3)	⌐	⌐	⌐	⌐
En kontoransatt kommer et par timer for sent på jobb et par ganger i måneden fordi han/hun har drukket alkohol kvelden før (4)	⌐	⌐	⌐	⌐
En kontoransatt er borte fra jobb en hel arbeidsdag et par ganger i året fordi han/hun har drukket alkohol kvelden før (5)	⌐	⌐	⌐	⌐
En kontoransatt er borte fra jobb en hel arbeidsdag et par ganger i måneden fordi han/hun har drukket alkohol kvelden før (6)	⌐	⌐	⌐	⌐

Q42 - Q42

Angi i hvilken grad du mener at situasjonen som er beskrevet under er problematisk eller uproblematisk.

	Helt uproblematisk (1)	Nokså uproblematisk (2)	Nokså problematisk (3)	Svært problematisk (4)
En person blir holdt våken om natten av fyllebråk i nabolaget eller på gata et par ganger i året (1)	⌐	⌐	⌐	⌐
En person blir holdt våken om natten av fyllebråk i nabolaget eller på gata et par ganger i måneden (2)	⌐	⌐	⌐	⌐
En person blir holdt våken om natten av fyllebråk i nabolaget eller på gata et par ganger i uken (3)	⌐	⌐	⌐	⌐
En person blir utskjelt eller utsatt for grove fornærmelser fra noen som er alkoholpåvirket (4)	⌐	⌐	⌐	⌐
En person får uønsket seksuell oppmerksomhet fra noen som er alkoholpåvirket (5)	⌐	⌐	⌐	⌐
En person får ødelagt klær eller andre eiendeler av verdi av noen som er alkoholpåvirket (6)	⌐	⌐	⌐	⌐
En person blir redd for at noen som er alkoholpåvirket skal skade han/henne (7)	⌐	⌐	⌐	⌐
En person blir fysisk skadet av noen som er alkoholpåvirket (8)	⌐	⌐	⌐	⌐

i137 - **Vi vil nå stille deg noen spørsmål om hvorvidt du i løpet av de siste 12 måneder har opplevd følgende i forbindelse med andre personers alkoholbruk.**

Vi vil nå stille deg noen spørsmål om hvorvidt du i løpet av de siste 12 måneder har opplevd følgende i forbindelse med andre personers alkoholbruk.

Q43 - Q43

Har du i løpet av de siste 12 måneder blitt holdt våken om natten av fyllebråk i nabolaget eller på gata?

- ❍ Nei, (1)
- ❍ Ja, 1-2 ganger (2)
- ❍ Ja, 3 ganger eller mer (3)
- ❍ Vil ikke svare (4)

CONDITION

f('Q43').any('2','3')

true

Question Q44(Q44)

false

Q44 - Q44

Hvor problematisk opplevde du at dette var?

- Helt uproblematisk (1)
- Nokså uproblematisk (2)
- Nokså problematisk (3)
- Svært problematisk (4)

END Condition f('Q43').any('2','3')

Q45 - Q45

Har du i løpet av de siste 12 måneder blitt utskjelt eller utsatt for grove fornærmelser fra noen som var alkoholpåvirket?

- Nei, (1)
- Ja, 1-2 ganger (2)
- Ja, 3 ganger eller mer (3)
- Vil ikke svare (4)

CONDITION f('Q45').any('2','3')

true

Question Q46(Q46)

false

Q46 - Q46

Hvor problematisk opplevde du at dette var?

- Helt uproblematisk (1)
- Nokså uproblematisk (2)
- Nokså problematisk (3)
- Svært problematisk (4)

END Condition f('Q45').any('2','3')

Q47 - Q47

Har du i løpet av de siste 12 måneder blitt utsatt for uønsket seksuell oppmerksomhet av noen som var alkoholpåvirket?

- ❍ Nei, (1)
- ❍ Ja, 1-2 ganger (2)
- ❍ Ja, 3 ganger eller mer (3)
- ❍ Vil ikke svare (4)

CONDITION f('Q47').any('2','3')

true	false
Question Q48(Q48)	

Q48 - Q48

Hvor problematisk opplevde du at dette var?

- ❍ Helt uproblematisk (1)
- ❍ Nokså uproblematisk (2)
- ❍ Nokså problematisk (3)
- ❍ Svært problematisk (4)

END Condition f('Q47').any('2','3')

Q49 - Q49

Har du i løpet av de siste 12 måneder fått ødelagt klær eller andre eiendeler av verdi av noen som var alkoholpåvirket?

- ❍ Nei, (1)
- ❍ Ja, 1-2 ganger (2)
- ❍ Ja, 3 ganger eller mer (3)
- ❍ Vil ikke svare (4)

CONDITION f('Q49').any('2','3')

true	false
Question Q50(Q50)	

Q50 - Q50

Hvor problematisk opplevde du at dette var?

- Helt uproblematisk (1)
- Nokså uproblematisk (2)
- Nokså problematisk (3)
- Svært problematisk (4)

END Condition f('Q49').any('2','3')

Q51 - Q51

Har du i løpet av de siste 12 måneder vært i situasjoner der du ble redd for at noen som var alkoholpåvirket skulle skade deg?

- Nei, (1)
- Ja, 1-2 ganger (2)
- Ja, 3 ganger eller mer (3)
- Vil ikke svare (4)

CONDITION f('Q51').any('2','3')

true	false
Question Q52(Q52)	

Q52 - Q52

Hvor problematisk opplevde du at dette var?

- Helt uproblematisk (1)
- Nokså uproblematisk (2)
- Nokså problematisk (3)
- Svært problematisk (4)

END Condition f('Q51').any('2','3')

Q53 - Q53

Har du i løpet av de siste 12 måneder blitt påført fysisk skade av noen som var alkoholpåvirket?

- Nei, (1)
- Ja, 1-2 ganger (2)
- Ja, 3 ganger eller mer (3)

- ❍ Vil ikke svare (4)

CONDITION f('Q53').any('2','3')

true	false
Question Q54(Q54)	

Q54 - Q54

Hvor problematisk opplevde du at dette var?

- ❍ Helt uproblematisk (1)
- ❍ Nokså uproblematisk (2)
- ❍ Nokså problematisk (3)
- ❍ Svært problematisk (4)

END Condition f('Q53').any('2','3')

Q55 - Q55

Har det i løpet av de siste 12 måneder hendt at du har vært bekymret for andres alkoholbruk?

- ❍ Nei, (1)
- ❍ Ja, 1-2 ganger (2)
- ❍ Ja, 3 ganger eller mer (3)
- ❍ Vil ikke svare (4)

CONDITION f('Q55').any('2','3')

true	false
Question Q56(Q56)	

Q56 - Q56

Hvor problematisk opplevde du at dette var?

- ❍ Helt uproblematisk (1)
- ❍ Nokså uproblematisk (2)
- ❍ Nokså problematisk (3)
- ❍ Svært problematisk (4)

END Condition f('Q55').any('2','3')

i152 - Nå følger noen spørsmål om hvilke konsekvenser alkoholbruk hos andre har hatt for deg.

Nå følger noen spørsmål om hvilke konsekvenser alkoholbruk hos andre har hatt for deg.

Q57 - Q57

I løpet av de siste 12 månedene, i hvor stor grad har alkoholbruk til familie, kjæreste eller andre personer du kjenner hatt negative konsekvenser for deg?

- I svært stor grad (1)
- I stor grad (2)
- I noen grad (3)
- I liten grad (4)
- Ikke i det hele tatt (5)
- Vil ikke svare (6)

Q58 - Q58

I løpet av de siste 12 månedene, i hvor stor grad har alkoholbruk til noen du ikke kjenner hatt negative konsekvenser for deg?

- I svært stor grad (1)
- I stor grad (2)
- I noen grad (3)
- I liten grad (4)
- Ikke i det hele tatt (5)
- Vil ikke svare (6)

Q59 - Q59

I løpet av de siste 12 måneder, i hvor stor grad har alkoholbruk til noen av dine arbeidskolleger hatt negative konsekvenser for deg?

- I svært stor grad (1)
- I stor grad (2)
- I noen grad (3)
- I liten grad (4)
- Ikke i det hele tatt (5)
- Vil ikke svare (6)

Q60 - Q60

I løpet av oppveksten, i hvor stor grad har alkoholbruk til noen i din nære familie hatt negative konsekvenser for deg?

- I svært stor grad (1)
- I stor grad (2)
- I noen grad (3)
- I liten grad (4)
- Ikke i det hele tatt (5)
- Vil ikke svare (6)

Q61 - Q61

Nedenfor er det noen utsagn om bruk av cannabis (hasj eller marihuana) til medisinske formål. Hvor enig eller uenig er du i disse utsagnene?

	Helt uenig (1)	Delvis uenig (2)	Verken enig eller uenig (3)	Delvis enig (4)	Helt enig (5)	Vet ikke (6)
Jeg synes at voksne skulle få lov å bruke cannabis til medisinske formål dersom en lege har foreskrevet dette (1)	⌐	⌐	⌐	⌐	⌐	⌐
Jeg tror at cannabis har gunstige medisinske effekter (2)	⌐	⌐	⌐	⌐	⌐	⌐
Jeg tror at cannabis brukt til medisinske formål er avhengighetsskapende (3)	⌐	⌐	⌐	⌐	⌐	⌐
Jeg tror at cannabis brukt til medisinske formål er mer avhengighetsskapende enn mange registrerte medisiner på markedet (4)	⌐	⌐	⌐	⌐	⌐	⌐
Hvis en av mine nærmeste var syk eller hadde en lidelse som cannabis kunne lindre, ville jeg anbefale at cannabis ble foreskrevet for ham eller henne (5)	⌐	⌐	⌐	⌐	⌐	⌐
Jeg mener at all cannabisbruk, dvs. både medisinsk og annen bruk, burde legaliseres (6)	⌐	⌐	⌐	⌐	⌐	⌐

Q62 - Q62

Hvor sannsynlig tror du det er at legers foreskriving av cannabis til medisinske formål vil forårsake en økning i annen, dvs. ikke-medisinsk, bruk av cannabis?

- ❍ Ekstremt lite sannsynlig (1)
- ❍ Lite sannsynlig (2)
- ❍ Sannsynlig (3)
- ❍ Ekstremt sannsynlig (4)

Q63 - Q63

I løpet av de siste 12 måneder, omtrent hvor ofte har du drukket alkohol?

- ❍ Stort sett daglig (1)
- ❍ 4-5 dager i uken (2)
- ❍ 2-3 dager i uken (3)
- ❍ Omtrent en dag i uken (4)
- ❍ 2-3 dager i måneden (5)
- ❍ Omtrent 1 dag i måneden (6)
- ❍ Noen få dager (7)
- ❍ En dag (8)
- ❍ Har ikke drukket alkohol siste 12 måneder (9)

CONDITIO

f('Q63').any('1','2','3','4','5','6','7','8')

true | false

N Question ()

Q64 - Q64

I løpet av de siste 12 måneder, omtrent hvor ofte har du drukket så mye alkohol at du har følt deg tydelig beruset?

- Stort sett daglig (1)
- 4-5 dager i uken (2)
- 2-3 dager i uken (3)
- Omtrent en dag i uken (4)
- 2-3 dager i måneden (5)
- Omtrent 1 dag i måneden (6)
- Noen få dager (7)
- En dag (8)
- Aldri (9)

Q65 - Q65

I løpet av de siste 12 måneder, omtrent hvor ofte har du drukket alkohol på et serveringssted? Vi tenker da på alt fra restauranter og kafeer til barer, puber og nattklubber.

- Stort sett daglig (1)
- 4-5 dager i uken (2)
- 2-3 dager i uken (3)
- Omtrent en dag i uken (4)
- 2-3 dager i måneden (5)
- Omtrent 1 dag i måneden (6)
- Noen få dager (7)
- En dag (8)
- Aldri (9)

Q66 - Q66

I løpet av de siste 12 måneder, omtrent hvor ofte har du drukket alkohol i arbeidssammenheng? Vi tenker da på alt fra å gå ut sammen med kolleger til seminarer, jobbreiser og julebord.

- Stort sett daglig (1)
- 4-5 dager i uken (2)
- 2-3 dager i uken (3)
- Omtrent en dag i uken (4)
- 2-3 dager i måneden (5)
- Omtrent 1 dag i måneden (6)
- Noen få dager (7)
- En dag (8)
- Aldri (9)

Q67 - Q67

I løpet av de siste 12 måneder, omtrent hvor ofte har du drukket alkohol mens det har vært barn under 18 år til stede?

- Stort sett daglig (1)
- 4-5 dager i uken (2)
- 2-3 dager i uken (3)
- Omtrent en dag i uken (4)
- 2-3 dager i måneden (5)
- Omtrent 1 dag i måneden (6)
- Noen få dager (7)
- En dag (8)
- Aldri (9)

Q68 - Q68

Har du i løpet av de siste 12 mnd. vært på jobb, men følt deg ukonsentrert eller lite effektiv fordi du hadde drukket alkohol dagen før?

- Nei (1)
- 1-2 ganger (2)
- 3-4 ganger (3)
- 5-6 ganger (4)
- 7-8 ganger (5)
- 9-10 ganger (6)
- Flere enn 10 ganger (7)

Q69 - Q69

Har du i løpet av de siste 12 mnd. vært borte fra jobben 1-3 timer pga. bakrus fordi du hadde drukket alkohol dagen før?

- Nei (1)
- 1-2 ganger (2)
- 3-4 ganger (3)
- 5-6 ganger (4)
- 7-8 ganger (5)
- 9-10 ganger (6)
- Flere enn 10 ganger (7)

Q70 - Q70

Har du i løpet av de siste 12 mnd. vært borte fra jobben 1 hel dag pga. bakrus fordi du hadde drukket alkohol dagen før?

- Nei (1)
- 1-2 ganger (2)
- 3-4 ganger (3)
- 5-6 ganger (4)
- 7-8 ganger (5)
- 9-10 ganger (6)

- ❍ Flere enn 10 ganger (7)

END Condition f('Q63').any('1','2','3','4','5','6','7','8')

Q71 - Q71

Har du noen gang selv prøvd cannabis? Cannabis inkluderer hasj, marihuana og cannabisolje.

- ❍ Ja (1)
- ❍ Nei (2)
- ❍ Vil ikke svare (3)

CONDITION f('Q71')=='1'

true	false
Question Q72(Q72)	

Q72 - Q72

Hvor mange ganger har du brukt cannabis de siste 12 måneder? En gang tilsvarer én joint/pipe, to ganger tilsvarer to joints/piper og så videre.

- ❍ 0 ganger (1)
- ❍ 1-5 ganger (2)
- ❍ 6-10 ganger (3)
- ❍ 11-50 ganger (4)
- ❍ Mer enn 50 ganger (5)

END Condition f('Q71')=='1'

Q76 - Q76

Hvis du fikk en uforutsett utgift på kr. 10 000,-, hvor stort problem ville dette vært for din økonomi?

- ❍ Svært problematisk (1)
- ❍ Nokså problematisk (2)
- ❍ Litt problematisk (3)
- ❍ Nokså uproblematisk (4)
- ❍ Helt uproblematisk (5)
- ❍ Vet ikke / Vil ikke svare (6)

Q77 - Q77

Er du i et parforhold?

- ❍ Gift/registrert partner (1)
- ❍ Samboende (2)
- ❍ Har kjæreste, men bor ikke sammen (3)
- ❍ Har ingen partner/kjæreste (4)

Q78 - Q78

Hvor mange barn under 18 år bor du sammen med? Regn både med de du bor sammen med på heltid og på deltid

☐

Q79 - Q79

Bor du i tettbygd eller spredtbygd strøk?

- ❍ I eller like utenfor større by (Oslo, Bergen, Trondheim, Stavanger) (1)
- ❍ I eller like utenfor mellomstor eller liten by (2)
- ❍ Større tettsted (ikke by) (3)
- ❍ Lite tettsted/bygdesentrum (4)
- ❍ Spredtbygd strøk (5)

Q80 - Q80

Hvilket parti ville du stemt på dersom det var valg i morgen?

- ❍ Rødt (1)
- ❍ Sosialistisk venstreparti (2)
- ❍ Arbeiderpartiet (3)
- ❍ Senterpartiet (4)
- ❍ Miljøpartiet de grønne (5)
- ❍ Kristelig folkeparti (6)
- ❍ Venstre (7)
- ❍ Høyre (8)
- ❍ Fremskrittspartiet (9)
- ❍ Felleslister/andre lister (10)
- ❍ Stemt blankt (11)
- ❍ Vet ikke (12)
- ❍ Vil ikke svare (13)

CONDITION

f('Q63').any('1','2','3','4','5','6') && f('Q64').any('1','2','3','4','5','6')

true

Question ()

false

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i177 - De følgende spørsmålene handler om ditt planlagte alkoholbruk kommende helg.

De følgende spørsmålene handler om ditt planlagte alkoholbruk kommende helg.

Q81 - Q81

Har du planer om å drikke alkohol kommende helg?

- ❍ Nei (1)
- ❍ Kanskje (2)
- ❍ Ja (3)

CONDITION f('Q81')=='1'

true	false
Question ()	

Q82 - Q82

Har du gjort en beslutning om at du ikke skal drikke alkohol førstkommende helg, eller er det bare det at du ikke har konkrete planer om å drikke?

- ❍ Beslutning (1)
- ❍ Ingen plan (2)

Q83 - Q83

Vi vil gjerne stille deg noen få spørsmål i en oppfølgingsundersøkelse som sendes ut rett i etterkant av denne undersøkelsen. Denne undersøkelsen vil kun ha noen få spørsmål. Vi trenger ditt samtykke til å sende deg den undersøkelsen.

- ❍ Ja takk, jeg samtykker i å få en oppfølgingsundersøkelse (1)
- ❍ Nei takk, jeg ønsker ikke å få en oppfølgingsundersøkelse (2)

END Condition f('Q81')=='1'

END Condition f('Q63').any('1','2','3','4','5','6') && f('Q64').any('1','2','3','4','5','6')

kommentar - Har du synspunkter eller kommentarer til undersøkelsen du nå har besvart?

Har du synspunkter eller kommentarer til undersøkelsen du nå har besvart?