

ALCOHOLISM: A SOCIAL CONSTRUCT

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Alcoholism as a specific disease was discovered about 200 years ago in North America. The disease is thought to be characterized by loss of control over drinking and by certain "symptoms," supposed to occur in a typical order during the "natural" history of the disease. The basic assumptions of the disease model are, however, untenable. Despite this, the model is still viable. There are at least four reasons for this: (1) The medical profession, originally against the conception of alcoholism as a disease, has been made to accept the disease concept, (2) Alcoholics Anonymous (AA) strongly believes in the disease ideology, (3) the disease model may relieve the moral stigma attached to socially unacceptable drinking, and (4) societies in which individual rights are highly esteemed prefer self-control to collective control. The benefits and disadvantages of the disease model should be considered.

Introduction

The idea of alcoholism as a specific disease seems to have been born about 200 years ago. Prior to that, alcoholism was equated with alcohol poisoning or it was seen as a symptom of mental disease. Severe and chronic drunkenness could be regarded as a vice; otherwise drinking, even heavy, was considered to be a natural and mostly harmless activity. Consumption of alcohol was high in many societies and in all walks of life, Chronic drunkenness was thought to be due to the drinker's excessive fondness and desire for liquor. No distinction was made between "desire" and "will." Man's will was thought free to choose between drinking and not drinking (Levine 1978).

A short history

The disease concept was born by the emergent temperance movement in North America late in the 18th century. Physicians were active, and the most eminent among them was Dr. Benjamin Rush (1745-1813). He argued that drunkards were "addicted" to spirituous liquors; they were drinking compulsively because their will was weak or "diseased." Drinking brought about, according to Rush, this weakness gradually, so that the paroxysms of drunkenness tended to increase in severity and frequency. The only cure available was total abstinence (Levine 1978).

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The early American temperance movement considered the drunkard as a victim of alcohol and helping them was one of the major activities in the movement. In the last decade of the nineteenth century the attitude begun to change. A new temperance generation gave priority to the goal of total abolishment of alcohol from society. Alcoholism consequently was regarded as less important, and the drunkard more a nuisance than a victim (Levine 1978). The idea of alcoholism as a disease was hibernating during the early years of the 20th century and during Prohibition (1920-1933).

Soon after Prohibition the disease model was reborn. The idea grew strong because two social movements found it useful and propagated it forcefully. The first of these was Alcoholics Anonymous (AA), a self-help group of drunkards that was founded in 1935 and was based largely on the ideas of primitive Christianity as modified by the Oxford Group (Glasser 1981).

AA, by and large, had a concept of alcoholism similar to the early temperance movement. The major difference was that the cause of alcoholism was considered to be more in the human being than in the beverage alcohol itself.

Soon after the birth of AA the scientific community began to show interest in the disease concept. Scientific activity centered around Yale University (Schneider 1978). The Quarterly Journal of Studies on Alcohol was started in 1940, the Yale Summer School of Alcohol Studies in 1943, and the Yale Plan Clinics in 1944. The eminent director of the Yale Center for Alcohol Studies, Elvin Morton Jellinek (1890-1963), later had ample opportunities to propagate the disease concept in several WHO Expert Committees.

Most of the new concepts were formulated within the scientific community. AA borrowed and adapted its ideology. In turn, AA forcefully propagated the disease concept, and played a central role when the National Council on Alcoholism was established in the USA in 1944 (Schneider 1978).

The evidence

The disease concept brought about a great deal of research aimed at verifying and further refining its ideas. Most of the results were not encouraging from the point of view of the concept. None of its central theses have been corroborated.

First, it was argued that even one drink is too much, arousing an irresistible desire for drink and provoking a compulsive drinking bout. Experimental evidence suggests, however, that the desire for drink is not provoked by small amounts of alcohol (Merry 1966, Eagle & Williams 1972) and that when alcohol is freely available, some alcoholics abstain, some resort to moderate drinking, and only some to heavy drinking (Gottheil et al. 1971, Gottheil et al 1973; Paredes et al. 1973). To explain these findings, it is currently argued that control over drinking is not lost but rather impaired (Edwards et al 1977). Some alcoholics have never, however, perceived a need to control their drinking (Chick 1980). It is worth noting also that control over drinking, if it exists, may be impaired at certain times and in certain situations both among normal and deviant drinkers (Storm & Cutler 1975).

Secondly, it has been argued that alcoholics have to abstain,

because they never can learn to drink moderately. However, a considerable minority of alcoholics has been observed to adopt moderate drinking habits for good (Lemere, 1953; Davies, 1962; Pattison, 1966; Kendell & Staton 1966; Rakkolainen & Turunen 1968), and it seems possible to teach moderate drinking habits successfully to some alcoholics (Cohen et al. 1971; Schaefer et al. 1971; Mills et al. 1971; Schaefer, 1972; Sobell and Sobell 1973).

Thirdly, Jellinek (1946, 1952) suggested that alcoholism has a natural history with four major phases and a typical ordering of "symptoms," so that "symptoms" of a later phase never occur in the course of preceding phases. In contrast to this, the ordering of "symptoms" found in a later study clearly differed from that suggested by Jellinek (Kivoranta 1969), where "Symptoms" were found to have a poor predictive power as regards the order of occurrence of other "symptoms" (Park 1973).

Fourthly, Jellinek (1960) postulated the existence of five separate types of alcoholism: alpha, beta, gamma, delta, and epsilon. Gamma and delta alcoholism were considered to be self-existent, genuine species of alcoholism. When Finnish alcoholics, commonly held to be pure gamma types, were classified according to Jellinek's criteria, only 21 per cent of them fell into the gamma group in the capital of the country and 1-2 per cent in the rural areas studied. The respective percentages for the delta type were 4 and 1-10 (Ahlstrom-Laakso, 1975).

The research thus provides little support for the idea of alcoholism as a specific disease. Consequently, the current formulations of alcoholism as a specific construct, now known as the alcohol dependence syndrome, are more modest, arguing that the syndrome occurs in degrees rather than being an all or none phenomenon. Stress is placed on the provisional and hypothetical nature of the concept (Edwards et al. 1977, Hodgson, 1980). Contrary to these assumptions, one study suggests that a unidimensional dependence syndrome does not exist (Chick 1980). Nonetheless, the concept of alcoholism as a disease is still widely taken for granted among laymen and medical professionals alike (Campbell et al. 1979; Orcutt et al. 1980). Furthermore, the alcohol dependence syndrome can still be found in the classification of diseases, injuries, and causes of death (World Health Organization 1977). Why? Probably since alcoholism as a disease has already established itself, a disease has been created. How? There are at least four underlying reasons.

The making of the disease

In the early days of AA and alcoholism research, perhaps only one per thousand medical practitioners supported the disease concept (Bacon, 1973). The active propagation of the concept induced, however, the American Medical Association to establish a committee on the question, and then to recommend in 1956 that alcoholism should be accepted as a disease (Schneider, 1978). Alcoholism research and AA had succeeded in selling this concept. Bearing this in mind, it is interesting (Schneider, 1978) that both Jellinek (1960, p.12) and latter Keller (1976), neither of whom was a medical doctor, both defended the disease concept by arguing that

medical professionals regard alcoholism as a disease and they certainly know what should be called a disease and what should not.

Secondly, AA seemed to be successful in its fight against drunkenness. While there was no sound scientific evidence of the effectiveness of AA, perhaps since the organization had a negative attitude towards research of this kind, AA had many members who had abstained for several years. This probably made it easy to approve of AA's ideology in which the disease concept held a prominent position. The disease concept may have facilitated abstinence by attributing responsibility for former drinking to the disease process and thus alleviating feelings of guilt and shame (Beckman, 1980). It is likely, however, that the disease concept is not necessary for AA to be effective, since it was not among the basic ideas AA obtained from the Oxford Group (Glasser, 1981). Probably it is the collective authority of the groups that make AA work rather than the disease ideology.

Thirdly, it was commonly assumed that alcoholism has a biological cause in man. At first the presumed defect was thought to be a kind of allergy, later other causes were suspected (Jellinek, 1960). No firm evidence was found. Still, the idea continued to arouse much enthusiasm, largely due to its social implications. If alcoholism was due to a biological defect, drunkenness could not be a symptom of a mental disorder (also a common line of thought), and alcoholics should not, therefore, be labelled as insane. And if the defect was a morbid change in the body, alcoholics should not be held morally responsible for their deviant drinking. It cannot possibly be a mere coincidence that those who treated alcoholics often emphasized the usefulness of the disease model in relieving the moral stigma attached to drunkards. The disease concept was an important weapon in the debate on the direction of social alcohol policy.

Finally, the disease concept appealed to the middle class who had lost the fight for a liquor-free society and who esteemed individual rights and preferred self-control to collective control (Levine 1978). The disease model was thought to imply that while alcoholics were not responsible for their presumed defect, they had the obligation to seek help and treatment for their disease and to do their best to achieve remission. All the others could, on the other hand, drink when they so wished, if they did not behave abnormally. Thus the focus of alcohol policy was transferred from the domain of law and taxation to the restoration of the self-discipline of deviant drinkers by medical and social welfare authorities.

Scientifically, it seems impossible to assign any specific content to the term "alcoholism" beyond that referring either to heavy or deviant drinking or both, if it is not denoting to alcohol intoxication or to a withdrawal state, both of which are clearly medical diagnoses. The existence of a specific defect causing deviant drinking remains to be demonstrated. However, as long as various social needs continue to supply the term with specific connotations serving those needs, the concept is likely to survive.

It might be interesting to analyze and to weigh the advantages and disadvantages associated with the disease concept against each other. On the beneficial side, it could be argued that the disease

concept has (1) destigmatized drunkards, (2) made societal responses toward deviant drinkers more humane, (3) stimulated research, and (4) increased understanding in treatment. On the detrimental side, the disease concept has been criticized for (1) creating a hinderance to the advancement of scientific knowledge on alcohol and problems related to it, (2) dominating attempts to understand and cope with problem drinking (Verden and Shatterly 1971), (3) neglecting the inquiry into the causes of drinking other than overcoming tolerance or relieving withdrawal, and (4) medicalization of treatment for alcohol problems (Shaw, 1979). A thorough discussion of the positive and negative sides of the disease concept lies beyond the scope of this article. It is worth noting, however, that a great majority of laymen would feel uncomfortable if they were required to be in the company of an alcoholic frequently (Orcutt et al. 1980). Stigma is still a common occurrence. And secondly, it seems unlikely that the disease model would alone suffice as a basis of action against medical and social problems related to alcohol in contemporary societies in which the consumption of alcohol has increased considerably during recent decades. A more general self-control model, health education, is becoming increasingly important, and so are collective control measures aiming at the reduction of the availability of alcohol and at increases in the price of alcoholic beverages.

REFERENCES

- Ahlström-Laakso, S.
 1975 *Drinking habits among alcoholics*. Forssa: Finnish Foundation for Alcohol Studies, Vol. 21.
- Beckman, L. J.
 1980 "An attributional analysis of Alcoholics Anonymous." *Journal of Studies on Alcohol*, 41:714-726.
- Bacon, SD.
 1973 "The problems of alcoholism in American society." In *Social disability: alcoholism, drug addiction, crime and social disadvantage*, (Ed.) Malikin, D. New York: New York University Press: 8-30.
- Campbell, E. J. M., J. G. Scadding, and R. S. Roberts
 1979 "The concept of disease." *British Medical Journal*, 2:757-762.
- Chick, J.
 1980 "Is there a unidimensional alcohol dependence syndrome?" *British Journal of Addiction*, 75:265-280.
- Cohen, M., I. A. Liebson, L. A. Faillance, and R. P. Allen
 1971 "Moderate drinking by chronic alcoholics." *Journal of Nervous and Mental Disease*, 153:434-444.
- Davies, D. L.
 1962 "Normal drinking in recovered alcohol addicts." *Quarterly Journal of Studies on Alcohol*. 23:94-104.
- Edwards, G., M. M. Gross, M. Keller, J. Moser, and R. Room (Eds.)
 1977 *Alcohol-related disabilities*. WHO Offset Publication No. 32. Geneva: World Health Organization.
- Engle, K. B., and T. K. Williams
 1972 "Effect of an ounce of vodka on alcoholics' desire for alcohol." *Quarterly Journal of Studies on Alcohol*, 33:1099-1105.
- Hodgson, R. J.
 1980 "The alcohol dependence syndrome: a step in the wrong direction?" A discussion of Stan Shaw's critique. *British Journal of Addiction*, 75:255-263.

- Glaser, F. B.
1981 "The origins of the drug-free therapeutic community." *British Journal of Addiction*, 76:13-25.
- Gottheil, E., L. O. Corbett, J. C. Grasberger, and F. S. Cornelison
1971 "Treating the alcoholic in the presence of alcohol." *American Journal of Psychiatry*, 128:475-479.
- Gottheil, E., H. D. Crawford, and F. S. Cornelison
1973 "The alcoholic's ability to resist available alcohol." *Diseases of the Nervous System*, 34:80-84.
- Jellinek, E. M.
1946 "Phases in the drinking history of alcoholics." *Quarterly Journal of Studies on Alcohol*, 7:1-88.
- Jellinek, E. M.
1952 "Phases of alcohol addiction." *Quarterly Journal of Studies on Alcohol*, 13: 673-684.
- Jellinek, E. M.
1960 *The disease concept of alcoholism*. Highland Park, N.J.: Hillhouse.
- Keller, M.
1976 "The disease concept revisited." *Journal of Studies on Alcohol*, 37:1694-1717.
- Kendell, R. E., and M. C. Staton
1966 "The fate of untreated alcoholics." *Quarterly Journal of Studies on Alcohol*, 27:30-41.
- Kiviranta, P.
1969 *Alcoholism syndrome in Finland*. Helsinki: Finnish Foundation for Alcohol Studies, Vol. 17.
- Lemere, F.
1953 "What happens to alcoholics." *American Journal of Psychiatry*, 109:674-676.
- Levine, H. G.
1978 "The discovery of addiction: changing concepts of habitual drunkenness in America." *Journal of Studies on Alcohol*, 39:143-174.
- Merry, J.
1966 "The 'loss of control' myth." *Lancet*, 1:1257-1258.
- Mills, K. C., M. B. Sobell, and H. H. Schaefer
1971 "Training social drinking as an alternative to abstinence for alcoholics." *Behavioral Therapy*, 2:18-27.
- Orcutt, J. D., R. E. Cairl, and E. T. Miller
1980 "Professional and public conceptions of alcoholism." *Journal of Studies on Alcohol*, 41:652-661.
- Paredes, A., W. R. Hood, H. Seymour, and M. Gollob
1973 "Loss of control in alcoholism: an investigation of the hypothesis, with experimental evidence." *Quarterly Journal of Studies on Alcohol*, 34:1146-1161.
- Park, P.
1973 "Developmental ordering of experiences in alcoholism." *Quarterly Journal of Studies on Alcohol*, 34:473-488.
- Pattison, M. E.
1966 "A critique of alcoholism treatment concepts with special reference to abstinence." *Quarterly Journal of Studies on Alcohol*, 27:49-71.
- Räkköläinen, V., and S. Turunen
1968 "Kohtuuttomasta kohtuulliseen juomiseen." *Sosiaalilääketieteellinen Aikakauslehti*, 6:191-195.
- Schaefer, H. H., M. B. Sobell, and K. C. Mills
1971 "Baseline drinking behaviors in alcoholics and social drinkers, kinds of drinks and sip magnitude." *Behaviour Research and Therapy*, 9:23-27.
- Schaefer, H. H.
1972 "Twelve-month follow-up of behaviorally trained ex-alcoholic social drinkers." *Behavior Therapy*, 3:286-289.
- Schneider, J. W.
1978 "Deviant drinking as disease: alcoholism as a social accomplishment." *Social Problems*, 25:286-289.
- Shaw, S.
1979 "A critique of the concept of the alcohol dependence syndrome." *British Journal of Addiction*, 74:339-348.
- Sobell, M. B., and L. C. Sobell
1973 "Individualized behaviour therapy for alcoholics." *Behavior Therapy*, 4: 49-72.

Storm, T., and R. Cutler

1975 "Notes toward the analysis of loss of control in normal and pathological drinkers." *British Journal of Addiction*, 70:151-155.

Verden, P., and D. Shatterly

1971 "Alcoholism research and resistance to understanding the compulsive drinker." *Mental Hygiene*, 55:331-336.

World Health Organization

1977 *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*. Vol. 1. (9th revision). Geneva 1977.