Changing paradigms in the alcohol field

Abstract: *The popular movement against drinking in several countries a hundred years ago targeted drunkenness (inebriety, drukkenskap, onyckterhet), and the main argument was the trouble drunk persons inflict upon other people, especially the wives and children. The breakthrough after WW2 of the alcoholism theory shifted the emphasis to daily drinkers and the drinkers' personal problems. The "Public health perspective", launched in the 1970s, pointed out that a society's total consumption has a strong impact on the level of harm, and that alcohol policy influences consumption, but kept the focus on the drinker's own problems. In recent years, we have seen a renewed emphasis on alcohol's harm to others. This paper will discuss the background and implications of the different paradigms.*

The first paradigm: Targeting drunkenness and drunk behaviour

There will probably always be some people who want to make an effort to make society a better place to live in. In the 19th century, the choice of issues could not be based upon mass media, but on observations in the local environment. In several countries, drunk behaviour was probably among the important preventable problems people could observe in their neighbourhood. The main strategy seems to have been based on the same common sense as in today's fight against illicit drugs, the idea that reduced use of the intoxicant is the most efficient method to reduce the harm. Therefore, when observing many tragedies from alcohol, many people decided to not drink or serve alcohol, so they would not contribute to the tragedies.

The temperance movement became a powerful factor in several countries, primarily Northern Europe and North America, and to a somewhat less degree in Middle Europe. It is worth noting that this movement was very weak in areas with highest mortality from alcohol, the Mediterranean countries, where alcohol use traditionally is less associated with inconsiderate behaviour. During the alcohol struggles a hundred years ago, there was a heavy emphasis on the problems that drunk behaviour inflicted upon other people, especially the drinker's family. The temperance movement did not gain its popularity as a popular movement to protect the drinkers' livers, but rather as a movement to protect wives and children from reckless drunk behaviour. A typical Norwegian poster during the alcohol struggles a hundred years ago, did not explicitly mention alcohol at all, but only stated: *"Now, wives and children have suffered enough - now they deserve to be spared and to have some peace."* With a parallel to the tobacco issue, we might say that "passive drinking" was the driving force in the period when reducing alcohol consumption had broad popular support in several countries.

The second paradigm: The alcoholism theory

The prevailing paradigm shifted totally after WW2 with the popularity of Bill Wilson's theory of alcoholism as a disease, which was promoted to the health authorities and academic world by Jellinek. Since the 1980s, the terms dependency or addiction have often been used instead of alcoholism, but often, several of the same implications have been preserved.

Bill Wilson did not intend to influence alcohol policy, he only wanted to help drinkers (which he did). His theory was, however, perceived as stating that harmful drinking largely is due to a treatable disease in deviant drinkers, caused mainly by their individual characteristics, while the general drinking customs and the total alcohol consumption was perceived as unimportant for the level of harm. This logically led to the conclusion that the temperance movement was old-fashioned, almost ridiculous, and that abstaining from alcohol signalled being a wowser, not allowing one's fellow citizens to enjoy the pleasures of life.

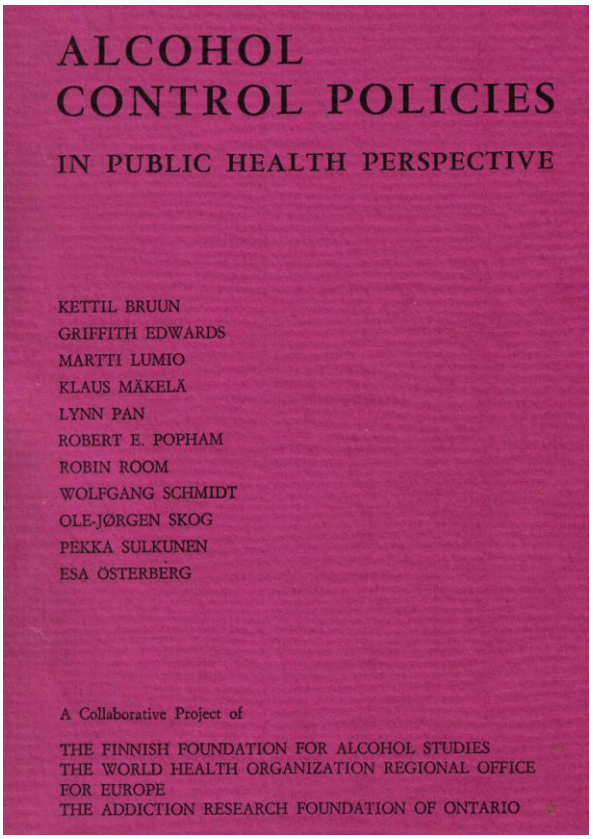
Perhaps even more important, the alcoholism theory shifted the main focus away from the problems that the drinker's behaviour inflicted upon other people, to the drinker's risk of harming himself. As Robin Room put it: "The idea that alcohol caused harm to others came to be seen as an old-fashioned temperance idea."[1]

Since then, alcohol education has mainly warned that drinkers may be harmed and acquire problems *themselves*. Correspondingly, the key argument for alcohol policy now became to save the drinker from himself.

This paradigm changed the focus from an *event* occurring in many people's lives, drunkenness, to a *condition*, alcoholism or dependency, limited to a small, deviant minority. It gave the promise of reducing alcohol problems without the annoying political struggles of the past, and was of course embraced by the alcohol industry. When people now observed tragedies from alcohol, the common response was to call for treatment (in most cases in vain). The formerly important issue of whether to drink and serve alcohol was referred to the purely private arena, as it was not considered to have significant ripple effects.

One of the intentions of the disease theory of alcoholism was to obtain a less condemning and moralistic view of the harmful drinkers. This probably happened among those people who literally believed the drinking was a disease just like diabetes, but a historian maintains that in general, the opposite was the case.[2] The temperance movement had considered the heavy drinker as a victim of alcohol's enslaving properties and its easy availability in society. Later on, the root problem was no longer considered to be alcohol, but the poor qualities in certain deviant drinkers.

The third paradigm: The public health perspective



The third paradigm was introduced by prominent scholars in the so-called "Purple book" in 1975.[3] The book concluded that

"changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption: thus, control of alcohol availability becomes a public health issue."

This new perspective emphasised that many kinds of alcohol problems are strongly influenced by the total alcohol consumption and by the price and availability of alcoholic beverages. In an era dominated by Wilson/Jellinek's theory of the disease of alcoholism, this represented a dramatic shift of paradigm.

The main focus was on the drinkers' health problems. This was not a new perspective in the wine-consuming Mediterranean countries, but represented a shift of focus in Northern Europe and North America, where the reaction towards drinking had been more vigorous. These countries, where the drinking habits traditionally are more often associated with drunkenness and behaviour problems, had always had alcohol higher on the agenda - first with the temperance movement and later alcohol treatment and alcohol research. The public health perspective, like the alcoholism theory, contributed to shift the focus from social and behavioural problems to the drinkers' health problems.[4]

The conclusions in the "purple book" were presented with a sound and convincing scientific basis. But while the book directly recommended a restrictive alcohol policy, the intended consequences did not clearly occur. In the decades following "the purple book", a further liberalisation of alcohol policy and attitudes took place in the countries where regulating alcohol prices and availability had been employed to reduce consumption.

The fourth paradigm: A biological disease to be cured by drugs or vaccines

In Bill Wilson's disease theory of alcoholism, the description of the nature of the disease was extremely vague. It should probably be called "A disease of the will", as Mariana Valverde put it.[5] The cure was mainly spiritual.

But especially since the early '90s, extensive funding has been allocated to research aiming at finding a biological explanation of the behaviour and a pharmacological cure for the disease.

To the right is a cover page of Newsweek: "The Hunt for an Addiction Vaccine". The journal's health expert reports that "this emerging paradigm treats addiction as a chronic, relapsing brain disorder to be managed with all the tools at medicine's disposal. The addict's brain is malfunctioning, as surely as the pancreas in someone with diabetes." … "We are making unprecedented advances in understanding the biology of addiction," says an addiction expert.[6]

A corresponding article in Time Magazine states that "Addiction is a medical problem that needs to be treated as a medical problem." A professor of psychiatry says that because of the progress in understanding the biology of addiction, "the 21st century war against drug abuse can be waged as successfully as last century's global fight against infectious diseases."[7]

The idea that harmful drinking and drug use may be removed or significantly reduced through breakthroughs in biological research seems to be firmly based on three beliefs:

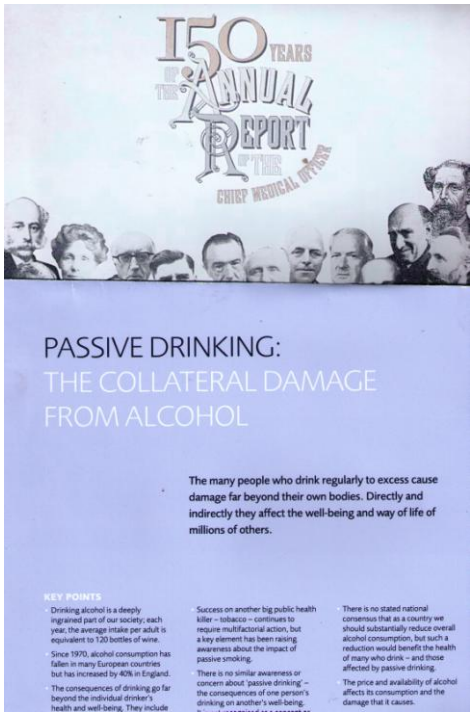
- that the users will be motivated to take a pharmacological agent which prevent them from intoxication, because harmful use of intoxicants in most cases is a kind of involuntary act

- that the dominating problem is habitual use or addiction, not single incidents of intoxication

- that addiction is primarily a bodily disease

None of these three beliefs seem to be well documented.

The fifth paradigm: "Passive drinking", harm to others



The 2008 annual report from the British chief medical officer had focus on five problems, and a special chapter was devoted to each of them. The first one was alcohol, with a chapter of 22 pages, but without the usual emphasis on alcohol's damage to the drinker. The title was: "Passive Drinking: The Collateral Damage from Alcohol". The report claimed that "Passive drinking is a term whose time has come".[8]

An editorial on this topic in Addiction last year stated that "The extent of this damage is not documented widely."[9] It is not surprising that studies and statistics reflect the prevailing paradigm on alcohol problems. Robin Room has remarked that the role of alcohol in social problems was more routinely recorded a century ago.

In the first decades of international alcohol research, the '60s and '70s, the topics studied seem to have been influenced by the prevailing alcoholism paradigm with emphasis on the drinkers' own problems, although certain topics like drunk driving, FAS and violence were also studied. But although FAS and drunk driving are extremely important for the victims, the victims are probably less than one per cent of the population. Studies of the frequency of drunk violence in the population were not performed. Thus, *the whole extent of the alcohol problems, the total number of people harmed, harassed or injured by drinking or drunk persons was largely unknown* until population studies of harm to others were published in the latest two decades.

In many cases, especially the early studies, questions about harm to others were a minor part of a broad questionannaire. But we got some good data in a Canadian study in 1992.[10] A Nordic study was published in 1999[11], an Australian study in 2002[12] and a Norwegian in 2004[13]. Another Canadian study, the Canadian Addiction Study was published in 2005[14], and later on, studies from Ontario and Nova Scotia. In 2009, an American study was published[15], and a New Zealand survey on physical and sexual assault[16]. And finally, the comprehensive Australian study (214 pages) which was recently published[17].

Last week, at the meeting (right here in Melbourne) on the WHO project on Alcohol's harm to others, rich and poor countries were encouraged to perform such population studies.

Passive drinking is one among several terms used. Others with more or less the same connotations are second hand effects, harm to others, externalities, collateral damage and social problems.

The population surveys on harm to others reveal the magnitude of the problems. The Canadian Addiction Survey concluded that during one year, 9 % of the population is harmed by one's own drinking, but 33 % is harmed by other people's drinking. As far as I can see, all the studies indicate that this is by far the most widespread problem from alcohol use.

Consequences of the various paradigms

After the Second World War, increasing economic resources have been made available for alcohol treatment, education and research, especially in Northern Europe and North America. In spite of these costly efforts, the measurable problems have increased.

The increase in consumption and problems has often been attributed to increased spending power, urbanisation and modernisation. But all these factors were also strongly present in the preceding period, from the last part of the 19th century till the middle of the 20th century, when the struggle to reduce drinking problems was very successful.

Neither the alcoholism theory nor the belief in biological research gives arguments for reducing the total consumption. With their one-sided emphasis on the deviant characteristics of certain individuals, both these paradigms give us a carefree opportunity to let the total consumption increase. In many countries, consumption has doubled after WW2. We know now, through the Purple Book, the ECAS study and other research, that this large increase in consumption was bound to increase the level of harm.

The paradigm of "passive drinking" and the research on this topic may have different consequences, for two reasons. Let us take a look at data from my country Norway. It is a country with 4.7 million inhabitants and a moderate total consumption, but the drinking style has traditionally been characterized by frequent drunkenness. I have converted the percentages to the actual number of individuals.

Health problems among drinkers, last year:

Deaths *(estimate)*	1000-1400
Accidents *(survey data)*	70 000
Diseases *(data lacking)*	Several thousands

Harassed/annoyed/damaged by drunk people, last year: (survey data)

Harassed in public	554 000
Harassed in private	271 000
Physically hurt	114 000
Damage of clothes etc.	176 000
Scolded out	524 000
Afraid of drunk person in public place	447 000
Kept awake	777 000
At least one of the problems	1 466 000

The Norwegian data also confirm that passive drinking is by far the most widespread problem. This does not, however, necessarily mean that it is the most *serious* problem. Maybe 1000 persons dying is worse than 100 000 persons being physically hurt. But perhaps more important, a large number of *innocent* people are harmed. Admittedly, the risk of being harmed by other people's drinking is highest among heavy drinkers. But according to the Canadian Addiction Survey, 28% of non-drinkers and 31% of light drinkers have been

harmed by other people's drinking last year.

Whether a specific human activity mainly is dangerous for the health and well-being of the individual him/herself *or* is troublesome and dangerous for other people, has decisive consequences for the society's handling of the activity. This was already expressed in the French Declaration of Human Rights in 1789, which stated that *"Liberty is the right to do anything that does not harm other people."*

This common moral code may explain why the struggle to reduce smoking and drinking has had little effect in the periods when the emphasis has been on the danger of harming oneself. The struggle has been more effective when the emphasis has been on harming others. The political willingness to protect individuals against harassment and damage from others is far stronger than the willingness to protect people against their own behaviour.

In general, people tend to demand their right to take risks and live dangerously. Therefore, our society allows mountaineering, parachuting and other types of behaviour that mainly imply risks for oneself. On the other hand, weapons and motor car driving are strictly regulated because of the potential danger to other, non-culpable individuals.

If the main problem from drinking is the drinker's potential harm to himself, the use may be seen as a personal issue, an activity with which the society is not necessarily entitled to interfere. Alcohol control policy may be seen as reflecting a nanny mentality.

But the individual's right to freedom does not include the right to inflict harm upon other people. If the most prevalent problem with alcohol use is inconsiderate and rude behaviour, limiting the use is a very natural task for society.

Thus, an editorial in Addiction last year stated that "Focusing on the second-hand effects of drinking has substantial potential in moving the alcohol policy agenda forward." Greenfield et al. wrote in their study on "externalities from alcohol consumption" that the publication of data on harm to others "could elevate political will for effective alcohol controls." And the Chief Medical Officer in Britain pointed out that in the success on another big public health killer, tobacco, "a key element has been raising awareness about the impact of passive smoking".

But we might also ask: Is this an addiction problem, or a dependency problem? We do not have data on the drinking habits of those whose drinking harms others. But epidemiological data on drinking problems seems to indicate that single incidents of drinking are a larger problem in our society than addiction. One example among many is found in the Canadian Addiction Survey. Among those who reported harm from their drinking last year, only 33% drank as much as five drinks at least once a week. The majority who either drank less or less often, or both, can hardly be called addicted, dependent or alcoholics. Even drinking five drinks once or more a week does not necessarily justify the label of being addicted.

So it is possible to conclude that

- drunkenness, not addiction, is the main problem related to alcohol, and that
- in several countries, passive drinking is the most widespread, if not necessarily the most serious problem, and most definitely the prime basis for regulating alcohol the alcohol trade.

This is, in fact, not very different from the view of many of our great grandparents!

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