Alcoholism: the mythical disease

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The idea that alcoholism is a disease is a myth, and a harmful myth at that. The phrase itself—"alcoholism is a disease"—is a slogan. It lacks definite medical meaning and therefore precludes one from taking any scientific attitude toward it, pro or con. But the slogan has political potency. And it is associated in the public consciousness with a number of beliefs about heavy drinking that do have meaning, and do have important consequences for the treatment of individuals and for social policy. These beliefs lack a scientific foundation; most have been decisively refuted by the scientific evidence.

This assertion obviously conflicts with the barrage of pronouncements in support of alcoholism's classification as a disease by health professionals and organizations such as the American Medical Association, by the explosively proliferating treatment programs, and by innumerable public-service organizations. So it may seem that a sweeping challenge to the disease concept can only be hyperbole, the sensationalist exaggeration of a few partial truths and a few minor doubts.

To the contrary: the public has been profoundly misled, and is still being actively misled. Credulous media articles have featured so many dramatic human-interest anecdotes by "recovering alcohol-
ics," so many "scientific" pronouncements about medical opinion and new discoveries, that it is no wonder the lay public responds with trusting belief.

Yet this much is unambiguous and incontrovertible: the public has been kept unaware of a mass of scientific evidence accumulated over the past couple of decades, evidence familiar to researchers in the field, which radically challenges each major belief generally associated in the public mind with the phrase, "alcoholism is a disease." I refer not to isolated experiments or off-beat theories but to massive, accumulated, mainstream scientific work by leading authorities, published in recognized journals. If the barrage of "public service" announcements leaves the public wholly unaware of this contrary evidence, shouldn't this in itself raise grave questions about the credibility of those who assure the public that alcoholism has now been scientifically demonstrated to be a disease?

One may wonder why it is important whether or not alcoholism is a disease. To begin with, "disease" is the word that triggers provision of health-insurance payments, employment benefits such as paid leave and workmen's compensation, and other government benefits. The direct cost of treatment for the "disease" of alcoholism is rapidly rising, already exceeding a billion dollars annually. Add in all related health costs and other kinds of benefits, and the dollar figure is well into the tens of billions annually. Alcoholism is, of course, profoundly harmful, both to the drinkers themselves and to others. But if it ceased to be characterized as a disease, all the disease-oriented methods of treatment and resulting expenditures would be threatened; this in turn would threaten the material interests of hundreds of thousands of alcoholics and treatment staffers who receive these billions in funds. The other side of the coin would be many billions in savings for taxpayers and those who pay insurance premiums.

It is not surprising that the disease concept of alcoholism is now vigorously promoted by a vast network of lobbies, national and local, professional and volunteer, ranging from the most prestigious medical associations to the most crassly commercial private, profit-making providers of treatment. This is big politics and big business.

Use of the word "disease" also shapes the values and attitudes of society. The selling of the disease concept of alcoholism has led courts, legislatures, and the populace generally to view damage caused by heavy drinkers as a product of "the disease and not the drinker." The public remains ambivalent about this, and the criminal law continues to resist excusing alcoholics for criminal acts. But
the pressure is there, and, of more practical importance, the civil law has largely given in. Civil law now often mandates leniency or complete absolution for the alcoholic from the rules, regulations, and moral norms to which non-diseased persons are held legally or morally accountable. Such is the thrust of a current appeal to the U.S. Supreme Court by two veterans, who are claiming certain benefits in spite of their having failed to apply for them at any time during the legally specified ten-year period after discharge from the army. Their excuse: alcoholism, and the claim that their persistent heavy drinking was a disease entitling them to exemption from the regulations. The Court's decision could be a bellwether.

What seems compassion when done in the name of "disease" turns out, when the facts are confronted, to subvert the drinker's autonomy and will to change, and to exacerbate a serious social problem. This is because the excuses and benefits offered heavy drinkers work psychologically as incentives to continue drinking. The doctrine that the alcoholic is "helpless" delivers the message that he might as well drink, since he lacks the ability to refrain. As for the expensive treatments, they do no real good. Certainly our current disease-oriented policies have not reduced the scale of the problem; in fact, the number of chronic heavy drinkers reported keeps rising. (It is currently somewhere in the range of ten to twenty million, depending on the definitions one uses.)

In the remainder of this discussion I will set out the major beliefs associated with the disease concept of alcoholism, and then summarize the actual evidence on each issue. I will also sketch an alternative perspective on chronic heavy drinking that is warranted by the evidence we have today.

Conventional wisdom

Science, according to the conventional view, has established that there is a specific disease that is triggered by drinking alcoholic beverages. Not everyone is susceptible; most people are not. But (the argument continues) a significant minority of the population has a distinctive biological vulnerability, an "allergy" to alcohol. For these people, to start drinking is to start down a fatal road. The stages are well defined and develop in regular order, as with any disease, with the symptoms accumulating and becoming increasingly disabling and demoralizing. First comes what looks like normal social drinking, but then, insidiously and inevitably, come heavier and more frequent drinking, drunken bouts, secret drinking, morning drinking, and, after a while, "blackouts" of memory from the
night before. It begins to take more and more liquor to get the same effect—physical "tolerance" develops—and any attempt to stop drinking brings on the unbearable and potentially life-threatening "withdrawal" symptoms. Eventually, the crucial symptom develops: "loss of control." At that point, whenever the person takes a drink, the alcohol automatically triggers an inability to control the drinking, and drunken bouts become the rule. There follows an inevitable, deepening slavery to alcohol, which wrecks social life, brings ruin, and culminates in death. The only escape—according to this elaborate myth—is appropriate medical treatment for the disease.

The myth offers the false hope that as a result of recent "breakthroughs" in science we now basically understand what causes the disease—a genetic and neurophysiological defect. But fortunately, it is claimed, medical treatment is available, and generally produces excellent results. However, the argument continues, even after successful treatment the alcoholic can never drink again. The "allergy" is never cured; the disease is in remission, but the danger remains. The lifelong truth for the alcoholic is, as the saying goes, "one drink—one drunk." The possibility of a normal life depends on complete abstinence from alcohol. There are no "cured" alcoholics, only "recovering" ones.

That is the classical disease concept of alcoholism. As I have said, just about every statement in it is either known to be false or (at a minimum) lacks scientific foundation.

**Origins of the myth**

Before turning to the substance of the specific claims, it helps to be aware of the historical context. For it is important to recognize that the disease concept of alcoholism not only has no basis in current science; it has never had a scientific justification.

The understanding of alcoholism as a disease first surfaced in the early nineteenth century. The growing popularity of materialistic and mechanistic views bolstered the doctrine that drinking problems stemmed from a simple malfunctioning of the bodily machinery. The new idea was popularized by Benjamin Rush, one of the leading medical theorists of the day.

Rush's claim was ideological, not scientific, since neither Rush nor anyone else at that time had the experimental facilities or the biological knowledge to justify it. It seemed plausible because of its compatibility with the crude biological theories of the time, assumptions that we now know to be erroneous. Nevertheless, the idea seized the public imagination, in part because it appealed to
the growing mercantile and manufacturing classes, whose demand for a disciplining "work ethic" (especially among the working class) was supported by this new "scientific" indictment of drinking. We should realize that the nineteenth-century version of the doctrine, as advanced by the politically powerful temperance movement, indicted all drinking. Alcohol (like heroin today) was viewed as inherently addictive. The drinker's personal characteristics and situation were considered irrelevant.

The nineteenth-century temperance movement crested in 1919 with the enactment of the Prohibition Amendment; but by 1933 the idea of total prohibition had lost credibility, and the amendment was repealed. For one thing, the public no longer accepted the idea that no one at all could drink alcohol safely. In addition, the costs of prohibition—such as gangsterism and public cynicism about the law—had become too high. Most people wanted to do openly and legally, in a civilized way, what large numbers of people had been doing surreptitiously.

For the temperance impulse to survive, it had to be updated in a way that did not stigmatize all drinking on moral or medical grounds. Any new anti-alcohol movement had to be more selective in its target, by taking into account the desires of drinkers generally, as well as the interests of the now legal (and growing) alcoholic beverage industry.

A new sect arose with just the right formula. Alcoholics Anonymous, founded in 1935, taught that alcohol was not the villain in and of itself, and that most people could drink safely. (In this way the great majority of drinkers and the beverage industry were mollified.) A minority of potential drinkers, however, were said to have a peculiar biological vulnerability; these unfortunates, it was held, are "allergic" to alcohol, so that their drinking activates the disease, which then proceeds insidiously along the lines outlined earlier.

This contemporary version of the disease theory of alcoholism, along with subsequent minor variants of the theory, is often referred to now as the "classic" disease concept of alcoholism. Like the temperance doctrine, the new doctrine was not based on any scientific research or discovery. It was created by the two ex-alcoholics who founded A.A.: William Wilson, a New York stockbroker, and Robert Holbrook Smith, a physician from Akron, Ohio. Their ideas in turn were inspired by the Oxford religious movement, and by the ideas of another physician, William Silkworth. They attracted a small following, and a few sympathetic magazine articles helped the movement grow.
Alcoholism and science

What A.A. still needed was something that would serve as a scientific authority for its tenets. After all, the point of speaking of a "disease" was to suggest science, medicine, and an objective malfunction of the body. The classic disease theory of alcoholism was given just such an apparent scientific confirmation in 1946. A respected scientist, E.M. Jellinek, published a lengthy scientific article, consisting of eighty-plus pages impressively filled with charts and figures. He carefully defined what he called the "phases of alcoholism," which went in a regular pattern, from apparently innocent social drinking ever downward to doom. The portrait, overall and in its detail, largely mirrored the A.A. portrait of the alcoholic. Jellinek's work and A.A. proselytizing generated an unfa}ltering momentum; the disease concept that they promulgated has never been publicly supplanted by the prosaic truth.

Jellinek's portrait of the "phases of alcoholism" was not an independent scientific confirmation of A.A. doctrine. For as Jellinek explicitly stated, his data derived entirely from a sampling of A.A. members, a small fraction of whom had answered and mailed back a questionnaire that had appeared in the A.A. newsletter. The questionnaire was prepared by A.A. members, not by Jellinek; Jellinek himself criticized it, finding it scientifically inadequate. In addition, many A.A. members did not even subscribe to the newsletter, and so had no opportunity to respond. Jellinek obtained only 158 questionnaires, but for various reasons could actually use just 98 of them. This was a grossly inadequate set of data, of course, but it was all Jellinek had to work with.

Predictably, the data from these ninety-eight questionnaires generated a portrait of alcoholism that coincided with the A.A. portrait. Since Jellinek was a reputable scientist, it is not surprising that he pointed to the various limitations of the data base and the highly tentative nature of his conclusions. It is equally unsurprising that A.A. propagandists publicized the impressively charted and statistically annotated portrait drawn by Jellinek, but glossed over his scholarly reservations about the hypotheses and data.

The "alcoholism movement," as it has come to be called among those familiar with the facts, has grown at an accelerating rate. Its growth results from the cumulative effect of the great number of drinkers indoctrinated by A.A., people who passionately identify themselves with the A.A. portrait of "the alcoholic." A.A. has vigorously supported the idea of "treatment" for alcoholics; in turn, the
rapidly proliferating “treatment” centers for the “disease of alcoholism” have generally supported A.A. All this has generated a kind of snowballing effect.

By the 1970s there were powerful lobbying organizations in place at all levels of government. The National Council on Alcoholism (NCA), for example, which has propagated the disease concept of alcoholism, has been a major national umbrella group from the early days of the movement. Until 1982 the NCA was subsidized by the liquor industry, which had several representatives on its board. The alliance was a natural one: at the cost of conceding that a small segment of the population is allergic to alcohol and ought not to drink, the liquor industry gained a freer hand with which to appeal to the majority of people, who are ostensibly not allergic.

Health professionals further widened the net, and economic incentives came powerfully into play. Federal and local governments began to open their health budgets to providers of alcoholism treatment, and also to alcoholism researchers. Insurance companies are increasingly required to do the same. Today, treatment aimed at getting alcoholics to stop drinking brings in over a billion dollars a year. Alcoholism researchers now rely on what is probably the second largest funding source after defense—government health funds. And by now there are hundreds of thousands of former heavy drinkers who feel an intense emotional commitment; they supply a large proportion of the staffs of treatment centers.

Large and powerful health-professional organizations (such as the American Medical Association) now have internal constituencies whose professional power and wealth derive from their role as the authorities responsible for dealing with the “disease” of alcoholism. As usual, these interest constituencies lobby internally, and the larger organization is persuaded to take an official stand in favor of the meaningless slogan, “alcoholism is a disease.” Thus there are many health organizations that now endorse this slogan.

Judges, legislators, and bureaucrats all have a stake in the doctrine. They can now with clear consciences get the intractable social problems posed by heavy drinkers off their agenda by compelling or persuading these unmanageable people to go elsewhere—that is, to get “treatment.” Why should these public officials mistrust—or want to mistrust—this safe-as-motherhood way of getting troublesome problems off their backs while winning popular approval? The ample evidence that these “treatment” programs are ineffective, and waste considerable amounts of money and resources, is ignored.
The "phases of alcoholism"

The "phases-of-alcoholism" portrait of the alcoholic has been examined in detail in a number of major studies dating back to the 1960s. A recent summary of the scientific literature on this topic indicates that the typical drinking pattern is characterized by much fluctuating between levels of consumption. Thus, many drinkers with numerous and severe problems are found later to have markedly improved, or to have developed different problems. Some also deteriorate. Individual drinkers do not develop in any consistent pattern, nor do they remain stable in a single pattern. Some claim "loss of control"; others do not. Many report no social problems associated with their drinking (and so, not surprisingly, many heavy drinkers are not recognized as such by friends, colleagues, or even family).

One of the leading scientists in the field, Marc Schuckit, summarizes the evidence as to whether alcoholics drink persistently by pointing out that "in any given month, one half of alcoholics will be abstinent, with a mean of four months of being dry in any one-year to two-year period." In general, as George Vaillant has reported, the cumulative evidence is that during any reasonably long period (ten to twenty years), roughly one-third of alcoholics "mature out" into various forms of moderate drinking or abstinence. The rate of "maturing out" for heavy problem drinkers—including those not diagnosed as alcoholics—is substantially higher.

A number of factors are associated with rates of "natural" improvement (i.e., improvement independent of any formal treatment): higher socioeconomic class, greater education, regular employment, and being married are positively associated with higher improvement rates. Those who "mature out" at lower than average rates tend to be socially deprived and alienated. "None of this", says one specialist on the topic, "fits with the disease model of alcoholism insofar as that model implies keeping early symptoms and early problems and adding others as time passes." Certainly none of this fits with the concept of a disease whose pattern of development is uniform, and essentially independent of individual social and cultural characteristics.

Biological causes?

What does it mean to say that alcoholism is a disease? In public discussions in the news media, it is usually taken to mean that alcoholism has a single biological cause. "I believe [alcoholics] have a
genetic predisposition and a certain kind of biochemistry that does you to be an alcoholic if you use alcohol.” This is a characteristic remark, with what in this domain is a familiar kind of specious authority. The statement was printed in an alcoholism bulletin issued under the aegis of a University of California Extension Division Alcoholism Program. It appears in an interview with Kevin Bellows, a lay activist heading an international organization fighting alcoholism.

Lay activists are not alone in pressing this theme. When I was on a network talk-show recently, the physician on the panel—a man high in government alcoholism advisory councils—devoted most of his time to running through a list of recent research discoveries about the biological peculiarities of alcoholics. His thesis was that alcoholism is unquestionably a disease, and he plainly implied that it has a biological cause. What the lay audience does not realize is that the newly discovered biological phenomena can rarely be regarded as causes of chronic heavy drinking; instead, they are merely associated with chronic heavy drinking, or with intoxication. Nevertheless, the audience is led to infer that they play a causal role; in fact, we know that there are no decisive physical causes of alcoholism.

Long-term heavy drinking is undoubtedly an important contributing cause of bodily ailments—including major organ, nerve, circulatory, and tissue disorders. The illness and mortality rates of heavy drinkers are far higher than those of the population generally. Chronic heavy drinking is rivalled only by habitual smoking as a major contributor to the nation’s hospital and morgue populations. But all this is the effect of drinking; the drinking behavior itself is the cause. Stop the behavior and you stop its terrible physical effects.

Another abnormal physical condition associated with heavy drinking is the appearance of biological “markers.” These metabolic and other physiological conditions—statistically abnormal but not necessarily ailments in and of themselves—may often be present among alcoholics. More significantly, some of them are present in persons who are not and have not been alcoholics, but who have been identified on independent grounds as being at higher-than-average risk of eventually becoming alcoholics. Such “markers” can serve as warning signs for those at higher risk. It has been hypothesized that some of these biological “markers” may play a causal role in bringing about alcoholic patterns of drinking. The question is: What kind and what degree of causality are at issue?
One much discussed metabolic "marker" is the difference in the way those who are independently identified as being at higher risk oxidize alcohol into acetaldehyde and in turn metabolize the acetaldehyde. The toxic effects of acetaldehyde in the brain have led to speculation that it might play a key causal role in inducing alcoholism. Analogous claims have been made about the higher level of morphine-like substances that alcoholics secrete when they metabolize alcohol. As it happens (so often in these matters), there are serious difficulties in measuring acetaldehyde accurately, and the reported results remain inadequately confirmed. But these confirmation problems are problems of technique, and not of fundamental importance.

The substantive point, generally obscured by the excitement of new discovery, is that even if the existence of any such metabolic processes were confirmed, they still would not cause alcoholic behavior, because the metabolism of alcohol takes place only when there is alcohol in the body. Therefore, these metabolic products cannot be present in alcoholics who have not been drinking for a period of time, and in whom the total metabolic process in question is not presently taking place. Yet by definition, these individuals return to drinking and do so recurrently, in spite of the intermittent periods of sobriety. The metabolic phenomena bear only on drinking that is done while in a state of intoxication; the key question about alcoholism, however, is why a sober person, with no significant toxic product remaining in the body, should resume drinking when it is known to have such harmful effects.

The story of biological discoveries concerning alcoholism is always the same: many unconfirmed results are unearthed, but no causal link to repetitive drinking is ever established. There is one exception, however: the recent discoveries in genetics. A study of these, and of how they have been reported to the public, is revealing.

**Alcoholism and genes**

Several excellently designed genetic studies of alcoholism have recently come up with credible positive results; thus we have been hearing from activists, treatment-center staff members, and physicians that "alcoholism is a genetic disease." The reality—as revealed by the data—is very different from what this slogan suggests.

The course followed in these recent "decisive" studies has been simple: find children who were born of an alcoholic mother or father, who were put up for adoption very shortly after birth, and who thus spent little time with their biological parents. Then see whether
this group of children shows a higher rate of alcoholism in later life than a comparable group of adoptees whose biological parents were not alcoholics. Controlling all other relevant conditions so that they are the same for both groups, one can infer that any eventual differences in the group rates of alcoholism is attributable to their heredity, the one respect in which they differ. In all these studies, the prevalence of alcoholism was significantly greater among the biological sons of alcoholics, especially the sons of alcoholic fathers. Doesn't this suggest that alcoholism is hereditary?

To answer this question, let us consider the first of these reports, a 1973 article by Donald Goodwin and his colleagues. They concluded that about 18 percent of the biological sons of an alcoholic parent themselves became alcoholics, whereas only 5 percent of the biological sons of non-alcoholic parents became alcoholics—a statistically significant ratio of almost four to one, which in all probability is ascribable to heredity. This is what we typically hear about in the media, with or without the precise numbers.

Now let's look at the same data from a different angle, and in a more meaningful context. As simple arithmetic tells us, if 18 percent of the sons of alcoholics do become alcoholics, then 82 percent—more than four out of five—do not. Thus, to generalize from the Goodwin data, we can say that the odds are very high—better than four to one—that the son born of an alcoholic parent will not become an alcoholic. Put differently, it is utterly false, and perniciously misleading, to tell people with a parental background of alcoholism that their heredity "dooms" them to become alcoholics, or even that their heredity makes it probable that they will become alcoholics. Quite the contrary. Their alcoholic heredity does make it more probable that they'll become alcoholics than if they had non-alcoholic parents, but the probability is still low. This is to say that life circumstances are far more important than genes in determining how many people in any group will become heavy drinkers.

There is yet another important implication: since 5 percent of the sons of non-alcoholic parents become alcoholics, and since there are far more non-alcoholic parents than alcoholic ones, that 5 percent ends up representing a far larger total number of alcoholic sons. This is consistent with what we know anyway—the great majority of alcoholics do not have alcoholic parents.

The most recent (and influential) adoptee genetic study, reported by Cloninger and his colleagues, concludes with these words: "The demonstration of the critical importance of sociocultural influences in most alcoholics suggests that major changes in social attitudes
about drinking styles can change dramatically the prevalence of alcohol abuse regardless of genetic predisposition."

Given the possibly dramatic effect of social attitudes and beliefs, the media emphasis on genes as the cause of alcoholism has a pernicious, though unremarked, effect. As we have noted, only a minority of alcoholics have an alcoholic parent. Emphasis on heredity as the "cause" of alcoholism may give a false sense of assurance to the far greater number of people who are in fact in danger of becoming alcoholics, but who do not have an alcoholic parent. These potential alcoholics may feel free to drink heavily, believing themselves genetically immune to the "disease."

The Special Committee of the Royal College of Psychiatry put the matter in perspective by saying the following in its book-length statement on alcoholism: "It is common to find that some genetic contribution can be established for many aspects of human attributes or disorders (ranging from musical ability to duodenal ulcers), and drinking is unlikely to be the exception."

**Causes of alcoholism**

There is a consensus among scientists that no single cause of alcoholism, biological or otherwise, has ever been scientifically established. There are many causal factors, and they vary from drinking pattern to drinking pattern, from drinker to drinker. We already know many of the predominant influences that evoke or shape patterns of drinking. We know that family environment plays a role, as does age. Ethnic and cultural values are also important: the Irish, Scandinavians, and Russians tend to be heavy drinkers; Jews do not. The French traditionally drank modest amounts at one sitting, but drank more regularly over the course of the day. Cultural norms have changed in France in recent decades and so have drinking styles.

We have interesting anthropological reports about the introduction of European styles of drinking into non-European tribal societies. Among the Chichicastenango Indians of Guatemala, for example, there are two different ways of drinking heavily. When drinking ceremonially, in the traditional way, men retain their dignity and fulfill their ceremonial duties even if they have drunk so much that they cannot walk unassisted. When they drink in the bars and taverns where secular and European values and culture hold sway, the men dance, weep, quarrel, and act promiscuously.

The immediate social setting and its cultural meaning are obviously important in our own society. The amount and style of
drinking typically vary according to whether the drinker is in a bar, at a formal dinner party, a post-game party, or an employee get-together. It is known that situations of frustration or tension, and the desire for excitement, pleasure, or release from feelings of fatigue or social inhibitions, often lead people to drink. Much depends on what the individual has "learned" from the culture about the supposed effects of alcohol, and whether the person desires those particular effects at a particular moment.

But does any of this apply to alcoholics? The belief in a unique disease of alcoholism leads many to wonder whether the sorts of influences mentioned above can make much of a difference when it comes to the supposedly "overwhelming craving" of alcoholics. Once one realizes that there is no distinct group of "diseased" drinkers, however, one is less surprised to learn that no group of drinkers is immune to such influences or is vulnerable only to other influences.

**Do alcoholics lack control?**

In fact, alcoholics do have substantial control over their drinking, and they do respond to circumstances. Contrary to what the public has been led to believe, this is not disputed by experts. Many studies have described conditions under which diagnosed alcoholics will drink moderately or excessively, or will choose not to drink at all. Far from being driven by an overwhelming "craving," they turn out to be responsive to common incentives and disincentives, to appeals and arguments, to rules and regulations. Alcohol does not automatically trigger uncontrolled drinking. Resisting our usual appeals and ignoring reasons we consider forceful are not results of alcohol's chemical effect but of the fact that the heavy drinker has different values, fears, and strategies. Thus, in their usual settings alcoholics behave without concern for what others regard as rational considerations.

But when alcoholics in treatment in a hospital setting, for example, are told that they are not to drink, they typically follow the rule. In some studies they have been informed that alcoholic beverages are available, but that they should abstain. Having decided to cooperate, they voluntarily refrain from drinking. More significantly, it has been reported that the occasional few who cheated nevertheless did not drink to excess but voluntarily limited themselves to a drink or two in order to keep their rule violation from being detected. In short, when what they value is at stake, alcoholics control their drinking accordingly.
Alcoholics have been tested in situations in which they can perform light but boring work to "earn" liquor; their preference is to avoid the boring activity and forgo the additional drinking. When promised money if they drink only moderately, they drink moderately enough to earn the money. When threatened with denial of social privileges if they drink more than a certain amount, they drink moderately, as directed. The list of such experiments is extensive. The conclusions are easily confirmed by carefully observing one's own heavy-drinking acquaintances, provided one ignores the stereotype of "the alcoholic."

Some people object that these experiments take place in "protected" settings and are therefore invalid. This gets things backwards. The point is that it is precisely settings, circumstances, and motivations that are the crucial influences on how alcoholics choose to drink. The alcohol per se—either its availability or its actual presence in the person's system—is not decisive.

Indeed, the alcohol per se or its ready availability seems to be irrelevant to how the alcoholic drinks. Among the most persuasive experiments demonstrating the irrelevance of alcohol to the alcoholic's drinking are several studies in which alcoholic subjects were deceived about whether they were drinking an alcoholic or non-alcoholic beverage. Alan Marlatt and his colleagues, for example, asked a group of alcoholics to help them "taste-rate" three different brands of the same beverage. Each individual subject was installed in a private room with three large pitchers of beverage, each pitcher supposedly containing a different brand of the same beverage. Their task, of course, was phony. Unknown to them, the subjects had been assigned to one of four groups. One group was told that the beverage in the three pitchers was tonic water—which was true. But a second group was told that the beverage was a tonic-and-vodka mix—though in fact it, too, was pure tonic water. Those in the third group were told that the beverage was tonic-and-vodka—which in fact it was. Those in the fourth group were told that it was simply tonic water—whereas in fact it too was tonic-and-vodka. The subjects were left alone (actually observed through a one-way window) and allowed to "taste" the drinks at will, which they did. The total amount drunk and the rapidity of sips were secretly recorded.

The results of this study (and several similar ones) were illuminating. First, none of the alcoholic subjects drank all the beverage—even though, according to the disease theory, those who were actually drinking vodka ought to have proceeded to drink uncontrol-
lably. Second, all of those who believed they were drinking vodka—whether they really were or had been deceived—drank more and faster. Conversely, all of those who believed they were drinking pure tonic—though some were actually drinking vodka—drank less and more slowly. The inference is unambiguous: the actual presence or absence of alcohol in the system made no difference in the drinking pattern; what the alcoholics believed was in the beverage did make a difference—in fact, all the difference.

These results fit into a more general pattern revealed by similar experiments on other aspects of alcohol-related behavior in both alcoholics and non-alcoholics: change the beliefs about the presence of alcohol (or the effect it is supposed to have), and the behavior changes. But the alcohol itself plays no measurable role.

Mark Keller, one of the early leaders of the alcoholism movement, has responded to such evidence by redefining (or as he would say, "reexplaining") the key concept of "loss of control." We are now told that this concept never connoted an automatically induced inability to stop drinking. Like other sophisticated advocates of the disease concept, Keller now means that one "can't be sure." The alcoholic who has resolved to stop drinking may or may not stand by his resolution. We are told that "loss of control" is compatible, though unpredictably, with temporary, long-term, or indefinite remission. Here medical terms such as "remission" provide a facade of scientific expertise, but the substance of what we are told is that "loss of control" is consistent with just about anything. This precludes prediction, and of course explains nothing. If it retains any empirical content at all, it amounts to a platitude: someone who for years has relied on a certain way of handling life's stresses may resolve to change, but he or she "can't be sure" whether that promise will be fully kept. This is reasonable. But it is not a scientific explanation of an inner process that causes drinking.

Similarly, the idea that "craving" causes the alcoholic to drink uncontrollably has been tacitly modified. It was plausible in its original sense, which is still the popular understanding: an inordinately powerful, "overwhelming," and "irresistible" desire. But the current experimental work regards "mild craving" as a form of "craving." Of course the whole point of "craving" as an explanation of a supposed irresistible compulsion to drink is abandoned here. But the word is retained—and the public is misled.

There have been other adjustments in response to new evidence, designed to retain the "disease" terminology at whatever cost. We now read that "of course alcoholism is an illness that consists of not
just one but many diseases, having different forms and causes." We also hear—in pronouncements addressed to more knowledgeable audiences—that alcoholism is a disease with biological, psychological, social, cultural, economic, and even spiritual dimensions, all of them important. This is a startling amplification of the meaning of "disease," to the point where it can refer to any human problem. It is an important step toward expanding the medicalization of human problems—a trend that has been deservedly criticized in recent years.

**A useful lie?**

Even if the disease concept lacks a scientific foundation, mightn't it nevertheless be a useful social "white lie," since it causes alcoholics to enter treatment? This common—and plausible—argument suffers from two fatal flaws.

First, it disregards the effects of this doctrine on the large number of heavy drinkers who do not plan to enter treatment. Many of these heavy drinkers see themselves (often correctly) as not fitting the criteria of "alcoholism" under some current diagnostic formula. The inference they draw is that they are therefore not ill, and thus have no cause for concern. Their inclination to deny their problems is thus encouraged. This can be disastrous, since persistent heavy drinking is physically, mentally, and often socially destructive.

Furthermore, since most people diagnosable as alcoholics today do not enter treatment, the disease concept insidiously provides an incentive to keep drinking heavily. For those many alcoholics who do not enter treatment and who (by definition) want very much to have a drink, the disease doctrine assures them that they might as well do so, since an effort to refrain is doomed anyway.

Moreover, a major implication of the disease concept, and a motive for promoting it, is that what is labeled "disease" is held to be excusable because involuntary. Special benefits are provided alcoholics in employment, health, and civil-rights law. The motivation behind this may be humane and compassionate, but what it does functionally is to reward people who continue to drink heavily. This is insidious: the only known way to have the drinker stop drinking is to establish circumstances that provide a motivation to stop drinking, not an excuse to continue. The U.S. Supreme Court currently faces this issue in two cases before it. And the criminal courts have thus far resisted excusing alcoholics from criminal responsibility for their misconduct. But it's difficult to hold this line when the AMA insists the misconduct is involuntary.
The second flaw in the social "white lie" argument is the mistaken assumption that use of the word "disease" leads alcoholics to seek a medical treatment that works. In fact, medical treatment for alcoholism is ineffective. Medical authority has been abused for the purpose of enlisting public faith in a useless treatment for which Americans have paid more than a billion dollars. To understand why the treatment does no good, we should recall that many different kinds of studies of alcoholics have shown substantial rates of so-called "natural" improvement. As a 1986 report concludes, "the vast majority of [addicted] persons who change do so on their own." This "natural" rate of improvement, which varies according to class, age, socioeconomic status, and certain other psychological and social variables, lends credibility to the claims of success made by programs that "treat" the "disease" of alcoholism.

Many of the clients—and, in the expensive programs, almost all of the clients—are middle-class, middle-aged people, who are intensely motivated to change, and whose families and social relations are still intact. Many, often most, are much improved by the time they complete the program. They are, of course, delighted with the change; they paid money and went through an emotional ordeal, and now receive renewed affection and respect from their family, friends, and co-workers. They had been continually told during treatment that they were helpless, and that only treatment could save them. Many of them fervently believe that they could never have been cured without the treatment.

The sound and the fury signify nothing, however; for the rates of improvement in these disease-oriented treatment programs do not significantly differ from the natural rates of improvement for comparable but untreated demographic groups. That is to say, these expensive programs (which cost between $5,000 and $20,000) contribute little or nothing to the improvement. Even so, the claims that patients leave their programs improved are true; to the layman such claims are impressive. The reality, however, is less impressive, since over half a dozen major studies in the past two decades have concluded that the money, time, and trust expended on these treatments are badly spent.

There is some disagreement about the effectiveness of more modest forms of treatment. Some reports—for example, a major study done by Saxe and his colleagues for the Congressional Office of Technology Assessment—conclude that no single method of treatment is superior to any other (a judgment made by all the major studies). But according to the Saxe study, the data appear to
show that “treatment seems better than no treatment.” That is, some help-oriented intervention of any kind—it doesn’t matter which—may contribute modestly to improvement. The now classic British experiment led by Griffith Edwards showed that an hour or so of firm and sensible advice produced overall results as good as those produced by a full year of the most complete and sophisticated treatment procedures in a first-class alcoholism hospital and clinic. Such conclusions have led a number of authorities (including a World Health Organization committee in 1980) to argue for brief informal counseling on an outpatient basis as the preferred method in most cases.

Note, however, that what is now recommended is not really medical treatment. Physicians may still control it, and the institutional setting may be “outpatient,” but the assistance provided is merely brief, informal, common-sense advice. The medical setting merely adds unnecessary expense.

So much for the optimistic view about “treatment.” A British report concludes that “it seems likely that treatment may often be quite puny in its powers in comparison to the sum of [non-treatment] forces.”

The more pessimistic reading of the treatment-outcome data is that these elaborate treatments for alcoholism as a disease have no measurable impact at all. In a review of a number of different long-term studies of treatment programs, George Vaillant states that “there is compelling evidence that the results of our treatment were no better than the natural history of the disease.” Reviewing other major treatment programs with long-term follow-ups, he remarks that the best that can be said is that these programs do no harm.

New approaches

In recent years, early evaluation studies have been reexamined from a non-disease perspective, which has produced interesting results. For example, it appears that the heaviest and longest-term drinkers improve more than would be expected “naturally” when they are removed from their daily routine and relocated, with complete abstinence as their goal. This group is only a small subset of those diagnosable as alcoholics, of course. The important point, though, is that it is helpful to abandon the one-disease, one-treatment approach, and to differentiate among the many different patterns of drinking, reasons for drinking, and modes of helping drinkers.
ALCOHOLISM: THE MYTHICAL DISEASE

Indeed, when we abandon the single-entity disease approach and view alcoholism pluralistically, many new insights and strategies emerge. For example, much depends on the criteria of success that are used. The disease concept focuses attention on only one criterion—total, permanent abstinence. Only a small percentage of alcoholics ever achieve this abolitionist goal. But a pluralistic view encourages us to value other achievements, and to measure success by other standards. Thus, marked improvement is quite common when one takes as measures of success additional days on the job, fewer days in the hospital, smaller quantities of alcohol drunk, more moderate drinking on any one occasion, and fewer alcohol-related domestic problems or police incidents. The Rand Report found that about 42 percent of heavy drinkers with withdrawal symptoms had reverted to somewhat more moderate drinking with no associated problems at the end of four years. Yet, as non-abstainers, they would count as failures from the disease-concept standpoint.

The newer perspective also suggests a different conception of the road to improvement. Instead of hoping for a medical magic bullet that will cure the disease, the goal here is to change the way drinkers live. One should learn from one’s mistakes, rather than viewing any one mistake as a proof of failure or a sign of doom. Also consistent with the newer pluralistic, non-disease approach is the selection of specific strategies and tactics for helping different sorts of drinkers; methods and goals are tailored to the individual in ways that leave the one-disease, one-treatment approach far behind.

Much controversy remains about pluralistic goals. One of the most fiercely debated issues is whether so-called “controlled drinking” is a legitimate therapeutic goal. Some contend that controlled drinking by an alcoholic inevitably leads to uncontrolled drinking. Disease-concept lobbies, such as the National Council on Alcoholism, have tried to suppress scientific publications reporting success with controlled drinking, and have excoriated them upon publication. Some have argued that publishing such data can “literally kill alcoholics.” Authors of scientific studies, such as Mark and Linda Sobell, have been accused of fraud by their opponents (though expert committees have affirmed the scientific integrity of the Sobells’ work). Attacks like these have been common since 1962, when D. L. Davies merely reviewed the literature and summarized the favorable results already reported in a number of published studies—and was severely criticized for doing so. But since that time hundreds of similar reports have appeared. One recent study concludes
that most formerly heavy drinkers who are now socially adjusted become social drinkers rather than abstainers.

In any case, the goal of total abstinence insisted upon by advocates of the disease concept is not a proven successful alternative, since only a small minority achieves it. If doubt remains as to whether the controversy over controlled drinking is fueled by non-scientific factors, that doubt can be dispelled by realizing that opposition to controlled drinking (like support for the disease concept of alcoholism) is largely confined to the U.S. and to countries dominated by American intellectual influence. Most physicians in Britain, for example, do not adhere to the disease concept of alcoholism. And the goal of controlled drinking—used selectively but extensively—is widely favored in Canada and the United Kingdom. British physicians have little professional or financial incentive to bring problem drinkers into their consulting rooms or hospitals. American physicians, in contrast, defend an enormous growth in institutional power and fee-for-service income. The selling of the term "disease" has been the key to this vast expansion of medical power and wealth in the United States.

What should our attitude be, then, to the long-term heavy drinker? Alcoholics do not knowingly make the wicked choice to be drunkards. Righteous condemnation and punitive moralism are therefore inappropriate. Compassion, not abuse, should be shown toward any human being launched upon a destructive way of life. But compassion must be realistic: it is not compassionate to encourage drinkers to deny their power to change, to assure them that they are helpless and dependent on others, to excuse them legally and give them special government benefits that foster a refusal to confront the need to change. Alcoholics are not helpless; they can take control of their lives. In the last analysis, alcoholics must want to change and choose to change. To do so they must make many difficult daily choices. We can help them by offering moral support and good advice, and by assisting them in dealing with their genuine physical ailments and social needs. But we must also make it clear that heavy drinkers must take responsibility for their own lives. Alcoholism is not a disease; the assumption of personal responsibility, however, is a sign of health, while needless submission to spurious medical authority is a pathology.