How the Meaning of the Word "Alcoholism" Has Changed

Introduction

In 1972 the National Council on Alcoholism published an article titled "Criteria for the diagnosis of alcoholism". This article was published simultaneously in the Annals of Internal Medicine and the American Journal of Psychiatry and became the official touchstone for the diagnosis of alcoholism by physicians and psychiatrists. In terms of quantity this article stated that a person weighing 220 lbs or more had to drink at least a quart of whiskey (24 standard drinks) per day for at least two days in a row to be classified as "alcoholic". The full criteria for different body weights is given in Table 1 below.

Table 1			
Weight lbs	Whiskey qt (43% etoh)	Pure ethanol oz	Standard drinks
220	1.0	13.76	24
200	0.9	12.38	21.5
180	0.8	11.01	19
160	0.7	9.63	17
140	0.6	8.26	14.5
120	0.5	6.88	12

In other words, in 1972 a person could drink a quart of whiskey or even more in a day and as long as they did not drink the following day and did not have other alcohol related problems such as DUI they could not be diagnosed as "alcoholic" or even as having an alcohol problem.

In 1980 with the publication of the DSM-III the American Psychiatric Association officially removed "Alcoholism" as a diagnostic category and replaced it with two new categories: Alcohol Dependence and Alcohol Abuse which we discuss in full detail on our web pages for them. Very simply put, Alcohol Dependence refers to a physical or psychological dependence an alcohol which makes it difficult to quit drinking, Alcohol Abuse refers to a pattern of alcohol use which leads to life problems such as DUIs or problems at work or at school but which is not accompanied by physical or psychological dependence. Alcohol Abuse is NOT considered a precursor or a milder form of Alcohol Dependence--experts today consider them to be two completely separate categories.

The creation of the two categories Alcohol Abuse and Alcohol Dependence was a definite step in the right direction. However, even though it was recognized that there is more than one type of pattern of problematic drinking, there was as yet only one accepted treatment methodology. The 12 steps of AA were prescribed for all alcohol problems in spite of the fact that there were no serious studies of their clinical efficacy.

Another step in the right direction came when recent editions of the DSM decided to introduce the following Course Specifiers--Early and Sustained Full remission and Early and Sustained Partial Remission--to the category of Substance Related Disorders aka Substance Use Disorders. This was the first acknowledgement by the medical and psychiatric community of the very commonly observed fact that many people reduce or otherwise moderate their substance use.

This was a vast improvement over the previously held idea that a full year of abstinence was required for an "alcoholic" to be considered "in remission". Even one drink of alcohol per year meant that an alcoholic was classified as "actively alcoholic".

In recent years the NIAAA and SAMHSA have introduced the concept of Binge Drinking as a third form of problematic alcohol use in addition to the already accepted diagnostic categories of Alcohol Dependence and Alcohol Abuse.

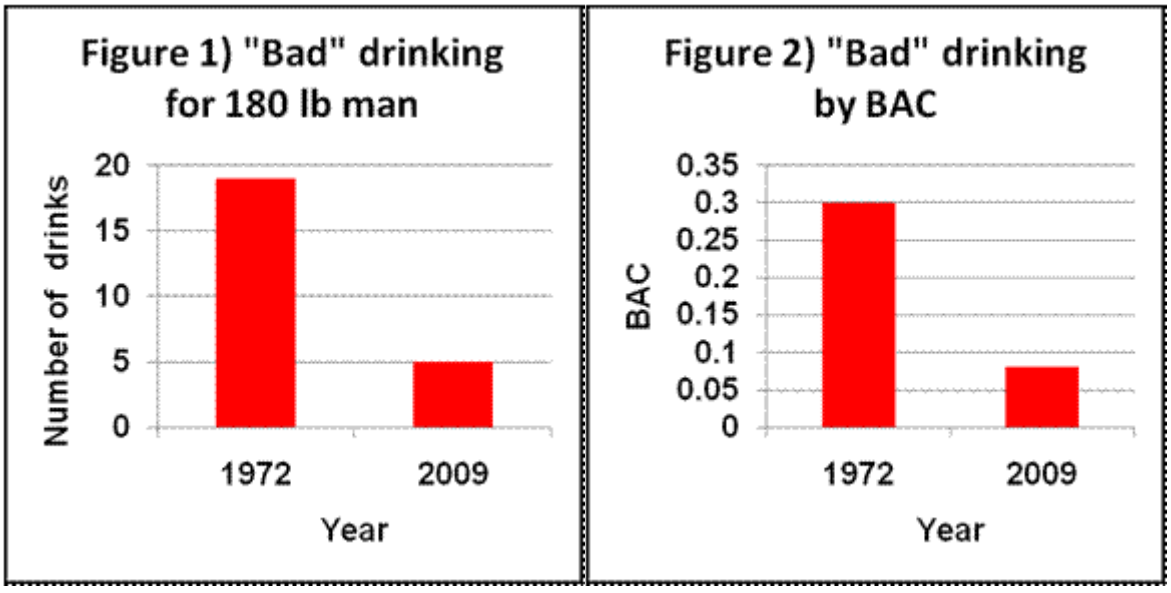
SAMHSA defines binge drinking as follows:

- Five or more drinks on the same occasion at least once in the past 30 days

NIAAA defines binge drinking as follows (NIAAA 2004):

- A “binge” is a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds to consuming 5 or more drinks (male), or 4 or more drinks (female), in about 2 hours.

As we can see there has been a tremendous change in the definition of "bad" drinking from 1972 to the current year of 2009. For a 180 lb man in 1972, "bad" drinking meant 19 drinks on a single occasion (and it didn't count if you didn't drink the following day). For a 180 lb man in 2009, "bad" drinking is 5 drinks on one occasion (within 2 hours). This is nearly a 4-fold difference. The 1972 definitions to not speak of BAC--however, if we assume that the drinker consumed his alcohol over an 8 hour period we arrive at a BAC of 0.3--which could be dangerous to a neophyte but which is harmless to a seasoned heavy drinker. We illustrate these differences graphically in Figure 1 and Figure 2;



We applaud the current system of discussing problematic drinking in terms or Alcohol Dependence, Alcohol Abuse, and Binge Drinking as being a major improvement over the 1972 system of dichotomously dividing alcohol use into the categories of "Alcoholism" vs. "Non-alcoholism". However, as Harm Reductionists we have certain objections to parts of the classificatory schema as well as the treatments and strategies derived from them.

One of the biggest problems is that absolutely no distinction is made between a binge of 5 drinks in one sitting and a binge of 25 drinks in one sitting. For example, in a 2003 article in the Journal of the American Medical Association, Naimi warns us that "Adverse health effects specifically associated with binge drinking include unintentional injuries (eg, motor vehicle crashes, falls, drowning, hypothermia, and burns), suicide, sudden infant death syndrome, alcohol poisoning, hypertension, acute myocardial infarction, gastritis, pancreatitis, sexually transmitted diseases, meningitis, and poor control of diabetes." Naimi uses the five drink definition of binge drinking. But five drinks at one sitting does not lead to alcohol poisoning, although 25 can. As harm reductionists we believe that it is essential to make the distinction between recreational intoxication and dangerous binging. This has consequences for all drinkers, but most particularly for young people.

Binge Drinking and Young People

Our belief is that the single best strategy to prevent harm to youth as a result of alcohol use is to educate youth about safe drinking practices, ways to avoid BAC spikes, and also that there is a tremendous difference between 5 drinks and 25 drinks. To that effect we have created A College Students' Guide To Safe Drinking.

A neo-prohibitionist stance which attempts to scare kids away from engaging in recreational intoxication by lying to them about the dangers of 5 drinks is doomed to fail--just as we have witnessed attempts to scare youth away from marijuana by using "Reefer Madness" campaigns have failed. Once youth discover that you have lied to them about the effects of marijuana they will no longer believe what you say about the effects of heroin and will soon rush into addiction. Likewise if you lie to youth about the effects of five drinks they will soon rush to drink 25 drinks as a result. The one cardinal sin which we can commit against youth which will guarantee that they will abuse drugs and alcohol is to lie to them about drugs and alcohol.

Moreover we wholeheartedly reject SAMHSA and NIAAA's "gateway" theory of binge drinking which assumes that college age binge drinking must be suppressed because binge drinking in college leads to Alcohol Abuse or Alcohol Dependence later in life. this "gateway" theory of binge drinking is flatly contradicted by the evidence from the CDC report which clearly demonstrates that the vast majority of college age people who drink heavily later "mature out" of this phase when they grow older. This is no more realistic than the theory that marijuana use leads to heroin use or that mothers' milk leads to crack. Figure 6 illustrates the "maturing out" phenomenon graphically.

Moreover, as harm reductionists we see no need to condemn the recreational alteration of consciousness as evil. This need to condemn pleasure as evil seems to hark back to the anhedonic views of our Calvinist forefathers. We do not condemn recreational alcohol intoxication--we are interested in eliminating harms which result from careless or uninformed drug or alcohol use.

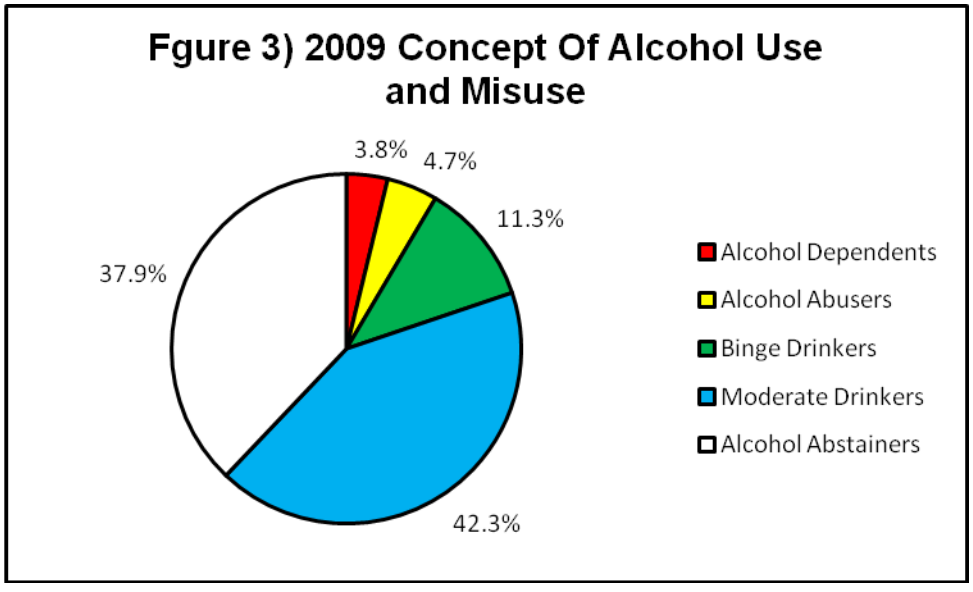
We see absolutely nothing inherently evil about attaining a BAC of 0.08 just as we see nothing inherently evil about eating a pork chop. Alcohol and red meat may not serve to prolong the lifespan, but for many people good drink and good meat are with that price.

Finally, we are concerned that we have seen many binge drinkers treated with the "one size fits all" notion that Alcoholics Anonymous is good for every alcohol problem/ in point of fact, we do not know what the effects of AA may be on binge drinkers or Alcohol Abusers. For all we know it might make them drink more.

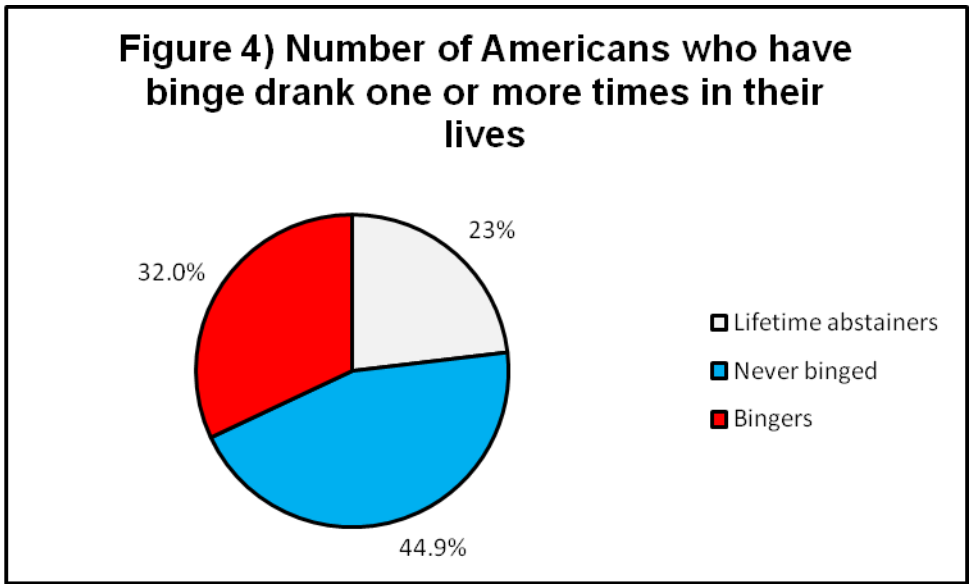
How Many "Bad" Drinkers Are There?

On page 20-21 of the AA "Big Book" Bill Wilson tells us that even people who have withdrawal symptoms bad enough to require medical attention may not be "true alcoholics". It seems that the kind of drinker that Bill Wilson calls an "alcoholic" in the "Big Book" is the kind of a person who has full blown withdrawal when s/he stops drinking. This is not just minor or moderate alcohol withdrawal where a person may shake or sweat or have rapid pulse or may even hallucinate but yet be aware that the hallucinations are unreal. This is major alcohol withdrawal where the drinker suffers delusions and believes the hallucinations to be real and has seizures and has major blood pressure spikes which can result in heart attack or death. Doctors tell us that this kind of major alcohol withdrawal only shows up in about one out of three hundred Americans. If we are generous we might estimate that one in a hundred Americans fit Bill Wilson's description of an alcoholic in 1939--surely no more than this.

However, the NIAAA tells us that currently 8.5% of the US population suffers from an Alcohol related Disorder, 3.8% suffer from AD and 4.7% suffer from AA. An additional 11.3% of Americans are current binge drinkers according to data from the CDC (2004)--which means that almost 20% of Americans have some sort of a problem with alcohol whether it is Alcohol Abuse, Alcohol Dependence or binge drinking.. This breakdown of types of problematic drinking is illustrated graphically in Figure 3.

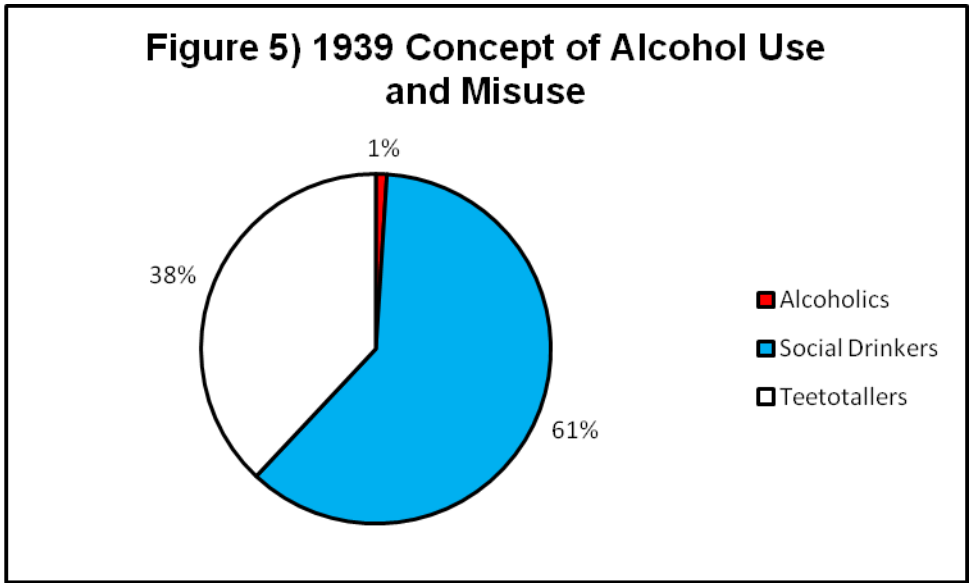


Moreover, other data from this same CDC report suggests that 32% of Americans have engaged in binge drinking (five or more drinks) at least once in their life--which we illustrate in Figure 4.



Note that Figure 3 represents current patterns of use whereas Figure 4 illustrates lifetime patterns of use. We have extrapolated longitudinal data from cross-sectional data to construct Figure 4, but we should be within the ballpark as there have been no real radical changes in drinking behavior within our lifetimes.

By way of contrast Figure 5 illustrates how problem drinking ("alcoholism") was viewed in 1939 when Bill Wilson published AA's "Big Book".



Rejecting the Disease Theory

In the final analysis we feel compelled from a Harm Reductionist point of view to reject the disease theory entirely. We feel that the risks and harms associated with alcohol use can only be dealt with rationally and practically if they are considered to be continuous variables rather than the categorical variables which we currently use. The categories of binge drinking, Alcohol Dependence and Alcohol Abuse may at times be useful but ultimately we believe that they are but useful fictions which can become harmful when misapplied.

We see the risks associated with alcohol use as lying on a continuum which we plot on the alcohol risk chart and the harm reduction pyramid.

Are People Drinking More?

No. the evidence shows that there has been a steady decline in alcohol consumption in the United States from the 1980s to the present. In 1980 Americans consumed 2.76 gallons of ETOH per capita whereas in 2005 they consumed only 2.23.
http://pubs.niaaa.nih.gov/publications/Surveillance92/CONS09.pdf

Maturing Out

The data show that the majority of people mature out of drug or alcohol problems on their own without treatment. Figure 6 is from NIAAA 2008

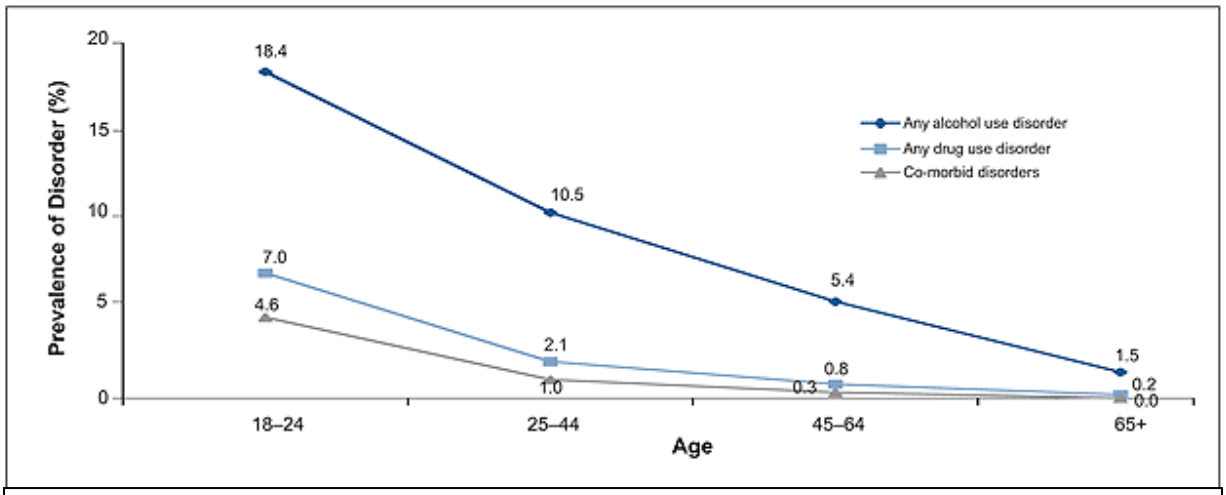


Figure 6: Prevalence of alcohol and drug use disorders by age in the United States

According to the NIAAA (NIAAA Five Year Strategic Plan) only 7.1% of people with Alcohol Use Disorders receive treatment yet nearly all untreated AUDs get better with time.

REFERENCES:

Centers for Disease Control and Prevention. (CDC). (2004). Health Behaviors of Adults: United States, 1999–2001. National Center for Health Statistics. Vital Health Stat 10(219). (Schoenborn CA, Adams PF, Barnes PM, Vickerie JL, Schiller JS.)
http://www.ncbi.nlm.nih.gov/pubmed/15791896
Free Full Text: http://www.cdc.gov/nchs/data/series/sr_10/sr10_219.pdf

Delirium Tremens: Overview - eMedicine
http://emedicine.medscape.com/article/166032-overview

The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence: United States, 1991–1992 and 2001–2002
Pages 223-234
Bridget F. Grant, Deborah A. Dawson, Frederick S. Stinson, S. Patricia Chou, Mary C. Dufour, Roger P. Pickering
http://www.ncbi.nlm.nih.gov/pubmed/15194200

Naimi TS, Brewer RD, Mokdad A, Clark D, Serdula MK, Marks JS. Binge drinking among US adults. JAMA 2003;289(1):70–75.
Free Full Text: http://jama.jamanetwork.com/article.aspx?articleid=195701

National Council on Alcoholism. (1972). Criteria for the diagnosis of alcoholism by the Criteria Committee, National Council on Alcoholism. The American Journal of Psychiatry. 129(2):127-35.
PubMed Info: http://www.ncbi.nlm.nih.gov/pubmed/5041051
Abstract: http://ajp.psychiatryonline.org/article.aspx?Volume=129&page=127&journalID=13

National Council on Alcoholism. (1972). Criteria for the diagnosis of alcoholism by the Criteria Committee, National Council on Alcoholism. Annals of Internal Medicine. 77(2):249-58.
PubMed Info: http://www.ncbi.nlm.nih.gov/pubmed/4641659
Abstract: http://annals.org/article.aspx?articleid=686758

National Institute on Alcohol Abuse and Alcoholism. (1995). Alcohol Alert No. 30: Diagnostic Criteria for Alcohol Abuse and Dependence.
Free Full Text: http://pubs.niaaa.nih.gov/publications/aa30.htm

National Institute of Alcohol Abuse and Alcoholism. (2004). NIAAA council approves definition of binge drinking. NIAAA Newsletter; No. 3, p. 3.
Free Full Text:
http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter_Number3.pdf

National Institute of Alcohol Abuse and Alcoholism. (2004a). Alcohol Abuse Increases, Dependence Declines Across Decade: Young Adult Minorities Emerge As High-Risk Subgroups.
http://www.nih.gov/news/pr/jun2004/niaaa-10.htm

National Institute on Alcohol Abuse and Alcoholism. (2008). Alcohol Alert No. 76: Alcohol And Other Drugs
http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm

Substance Abuse and Mental Health Services Administration (SAMHSA). Results from the 2002 National Survey on Drug Use and Health: National Findings. NHSDA Series H–22, DHHS Pub. No. SMA 03–3836. Rockville, MD: SAMHSA, Office of Applied Studies, 2003.
Free Full Text: http://www.oas.samhsa.gov/nhsda/2k2nsduh/Results/2k2Results.htm.