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Socio-Psychological View of Alcoholism

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ABSTRACT : *Opinions on alcohol consumption, alcoholism, date back to the ancient history of mankind. Even mythologies of various nations argue that alcohol, especially wine, was donated to individual nations by deities. We have also learned, that their excessive enjoyment was punishable by law to death in ancient China, drinking was categorically forbidden by Confucius and Buddha in 5th, respectively 6th century BC. Social background of alcoholism was not always given the same attention. An interesting overview of views on alcoholism in Germany is given by Laquer at work Krankheit und soziale Lage (1913), which illuminates the particular sociological causes of alcoholism poverty.Classic writers in this field are also Grotjahn (1898) and Baer (1875).*

KEYWORDS : *Alcoholism, consumption, consumer, drinking, group pathology*

I. INTRODUCTION

The fortieth years of 19th century, are period of first flowering of reticence (temperance) associations in Slovakia.According to foreign models (especially the Irish movement led by T. Mathew) Abstinence Movement, began to organize with help of Czech-Slav Society led by Štúr, emerging societies were integrated into overall program of national revival.In 1850 was published a book written by A. Šoltés, in which author promotes association of members of these associations regardless of confession, nationality, gender, and even mentions also some alcoholism treatment options (Bagin, 1972, Encyklopédia Slovenska 1977, Duka Zólyomi, 1962).Temperance societies in Slovakia were created mainly on the initiative of teachers and clergy. Through contributions in magazines, theater plays and specific publications were to this educational work involved writers and national revivalists (S. Chalúpka, Ľ. Štúr, J. M. Hurban, M. M. Hodža, K. Kuzmány, J. Záborský etc...). For important milestones in the fight against alcoholism among us can be considered anti-alcohol laws from 1922 and 1948, assignation of anti-alcohol forces in 1956 and Act Nr. 120 dated from 1962.

II. SOCIALDIMENSION OF ALCOHOLISM

Social aspects of alcoholism are not denied.In Slovakia, unlike some other countries, we do not have a single system of statistical indicators of alcoholism, which would periodically capture development of individual indicators and allow time and international comparisons and also ongoing confrontation of socio-diagnostic findings with level of socio-technical precautions. Other uncharted territory is**epidemiology**of alcoholism. So far did the basic national representative socio-epidemiological research to further illumination of the social and regional distribution of alcohol consumption, patterns of drinking, degree of alcoholization and like was not made. Solms (1979) notes in this context that there are collective defense mechanisms that cause listlessness, trivializing and camouflage of alcohol problems: acting of resistance (defense mechanisms), which make possibility that alcohol consumption and its consequences,will get to social consciousness as a problem impossible.These resistances are also deeply rooted 'drinking habits as a result of faulty communication between "nonalcoholics" and "alcoholics" as a violation of the standards, which is usually the cause of disqualification and depreciation of alcoholics and particularly discharging "ordinary consumers" from liability for them.
Even in our society applies that there exist material and also immaterial conditions for maintenance and development of drunkenness and alcoholism. It is not just about "relics of the past" because social reality of alcoholism and drunkenness is much more complex.

III. SOCIOLOGICAL EXPLANATORY SCHEMES AND MODELS OF ALCOHOLISM

Development of social views on alcoholism

In development of societal views on alcohol and its role in individual and group pathology, several authors surveyed three phases:
• Moral phase (moralistic)
• Phase of alcoholism as a disease,

• Phase of multifactorial understanding of alcohol consumption consequences (concept of "alcohol related problems", emphasis on public health).

The moral aspect. In moral phase is alcoholism considered for social evil and alcoholics for demoralized, depressed people that need to be punished, and so bring to proper life.Negative social assessment formed alcoholic stereotype as "Drinker", in which medical criteria were neglected and attention was focused on irrelevant characteristics. Moral evaluation of alcoholic and alcoholism were closely associated with the period extension of alcoholism.

Alcoholism as a disease. Alcoholism beginning to be understood as a disease in 18th century.Currently, there is a broad spectrum of health care worldwide such as counseling, social, religious and other services to help alcoholics and their families (psychiatric or anti-alcoholics ambulatory and in-patient facilities, counseling, specialized institutes, detoxification, or sobering-up stations, day and night care centers, rehabilitation homes, shelters, social and therapeutic clubs, self-help groups, voluntary organizations and others). However, concept of alcoholism as a disease, is vulnerable.Its sensitive issue is not only diagnostic confusion, but also not always successful treatment outcomes, further biologisation of excessive drunkenness and disproportionate medicination of alcoholism.Other negative effects of alcoholism medicination sees Chromý (1984) in "deactivation of non-health institution" - if the event declared to be disease, other disciplines (eg. pedagogy ethics) are not motivated to examine the issue from their perspective and inadvertently shed responsibility for its development.

Multifactorial approach to problems associated with alcohol consumption. In relation to limitation of alcoholism as a disease concept, in the 70's broader understood approach to problem of alcoholism, which is based on numerous forms of alcohol consumption effects, began to form (Tongue, 1972).This approach corresponds to the term „alcohol – related problems“ encompassing the whole range of negative consequences of alcohol consumption at individual, small group and whole society level. Comprehensive understanding of the problems of alcoholism is a good basis for cooperation between different specializations for statistical monitoring and research. Alcoholism extends beyond the health and alcohol-related problems in this understanding affect whole society, not just people with alcohol abuse and alcohol dependence.Social control of availability of alcohol, early intervention and widely based prevention and education in terms of social responsibility for alcoholism and the health of population are emphasized.

IV. BROAD LINES OF SOCIOLOGICALCONSIDERATION

First sociologically oriented work about alcoholism dates back to 19th century and arose on the field of social medicine. Since that time, the alcoholism exists mainly as "alcoholism of poverty", research efforts were focused on detecting links between alcoholism and social status of alcoholics.Since alcohol is historically one of the oldest drugs, its consumption has become interest of cultural anthropology. Even in primitive societies, alcohol consumption had special role - for example, it allows release of tension on various occasions (successful harvest etc.).Drinking alcoholic beverages have been part of many religious and other ceremonies, festivals, rituals, this symbolic mission have alcohol preserved to this day (Tongue, 1972).Upon the occurrence and persistence of alcoholism, attitudes of the culture or population groups to alcohol and its consumption are considered for important socio-psychological factors. Among the strongest predictors of problem drinking are: very favorable attitudes toward drinking which increase problem drinking in population, while attitudes rigorously refusing excessive use, intoxication and consumption exceeding standards at all generally reduce problem drinking.Antons a Schulz (1976) recall that sociological theory does not define a clear line between consumerist behavior and pathological consumption,which develops on the basis of attitudes to drinking.Sociologists have does not question, unlike psychologists why a person becomes an alcoholic, but rather why and how given society produces a number of alcoholics. From sociological point of view are also examined treatment and follow-up treatment of alcoholics, while socio-psychological determinants of relationship therapist - patient, the patient's adaptation to the role of abstaining alcoholic socio-therapeutic activity clubs for follow-up treatment of alcoholismetc. come to forefront(Bútora, 1979 – 1980). Sociology of alcoholism in these cases partly overlaps with sociology of mental disorders, which examines processes, by which, one ranks among psychiatric patients and consequences of this inclusion on his social relations, status in family and society (Chromý, 1984).

PRIORITY SOCIOLOGICALEXPLANATORY SCHEMES AND MODELS OF ALCOHOLISM

There are several dozens of alcoholism definitions as a disease; sociologically oriented interpretive schemes and models of alcoholism are, however, only a few (Robinson, 1976), the most important by White and Warburg are:

- Socio-cultural model,
- Alcohol distribution model,
- System dynamics model.

Socio-cultural model. From a sociological point of view it is part of the structural-functional approach to the problem of alcoholism, examines the extent and type of drinking in given society determined by structure of social standards and "social definition" of alcohol. Socio-cultural model highlights the different cultural background that determines the nature of consumption in the population.It stresses the need to examine the patterns of drinking and drinking habits in different populations or population groups.Central paradigm (sociological model) of socio-cultural model is therefore normative and cultural conditioning the extent of drinking and drinking problems in population.

Alcohol distribution model. This interpretative model has muddle through in 70s and also seeks to examine different alcohol consumption and different degree of problems that are connected with it, according to the various population groups.The starting point isnot social standards, but the volume of alcohol consumption in population. The central idea of model is that with increase of alcohol consumption in population also drinking problems are increasing. By repeated observations can be concluded that:

- countries with a high consumption of alcohol have most likelihood of morbidity related to alcohol (alcohol abuse and somatic damage, especially liver cirrhosis, Bruun, et al., 1975),
- The bigger the number of drinkers, the more will be alcoholics and the greater the incidence of economic and other damage caused by alcohol,
- presence and distribution of alcohol are determined by the overall level of consumption in given population (Schmidt et al., 1971, de Lint et al., 1971),
- alcohol consumption per capita per year provides reliable estimated number of alcoholics,
- there is close correlation between mortality from liver cirrhosis and overall level of alcohol consumption (with increased consumption, mortality from cirrhosis increases, albeit with delay).

Central paradigm (sociological model) of this model is that the extent of problems associated with alcohol consumption in population determines level of alcohol consumption.

System dynamics model of alcoholismaccording to White and Wartburg. This model was also considered during description of alcoholic subculture in Slovakia.Under alcoholic subculture is understood strongly rooted positive place of drinking in society, while under the influence of positive evaluation macrostructure changes microstructure by coercion.Thus generated environment changes behavior and attitude of individual, which in turn affects surroundings again, creating a cyclical dynamism (White et al., 1972, Miššík, 1985).

V. EPIDEMIOLOGY OF ALCOHOLISM

For alcoholism, unlike many other diseases, there is still no reliable and globally accepted methodology allowing to develop descriptive type epidemiological studies.

Reports about drinking in population (surveys). For most important factors of consumer behavior are considered the amount of alcohol consumed on one occasion (Q – Quantity) and frequency of opportunities to drink (F – Frequency). These data are obtained from respondents and therefore subjective.Several verification tests confirm their reliability.Summary index calculated from amount of consumed alcohol and frequency of drinking for some time (Quantity – Frequency Index) ignores the individual alcoholic beverages (beer, wine, spirits etc.) and generally classifies consumers as strong, medium and light (Straus et al., 1953).

Screening techniques for detection of problem drinking. While reports about drinking in population check total prevalence and distribution of alcohol, screening methods focus on prevalence of problem drinking in population.They are used as a guide for individual diagnosis, especially in epidemiological investigations in the wider population in certain areas or population groups.World's increased attention to screening in recent decades is linked to growth of alcohol consumption and endangered population growth.Protection of public health naturally requires searching for simple and effective method for early detection of alcoholism or its abuse (Armyr et al., 1984, WHO, 1983).

Note: From socio-psychological perspective is interesting construction industry, because there's share of social factors on major problems with drinking evident: work in isolated groups, possibility of changing the pace of work, spatial remoteness of work, drinking habits, stereotypes and drinking rituals tied to the profession, availability of alcohol, many opportunities, cracks in organization of work due to unresolved supplier-customer relationships, tolerance of alcohol consumption given the willingness of drinkers to replace backlogs in necessary overtime shifts, poor control at work, commuting to work outside of home, weakened social relationships with primary social groups, reduced social control outside workplace, atmosphere of hotels and hostels for workers, common stereotypes of leisure etc.We have indicated the usefulness of sociological lens by analysis of sociological explanatory schemes of alcohol consumption and alcoholism epidemiology. Since we decided to use primary macro sociological approach, we circumvent other important areas, including in particular alcohol at work and company, alcoholism and profession, economic damage from alcoholism, youth alcoholism, alcohol and transport, alcohol and crime.The picture would be more complete if other important topics such as position of alcohol in culture, literature and art, examination of various temperance measures effectiveness (legislative, educational, health education), tracking historical transformations of alcohol consumption etc. were processed.

The problem of alcohol in our society is still not understand nor as disease, nor certain addiction.This problem, problem of alcoholism, can not only be considered as medical problem, but as we indicated also sociological, socio-psychological and finally, clinical psychology problem. This is cross-disciplinary approach to problem of alcoholism. On this basis, is also based prevention.
The Government of Slovak Republic by its resolution no. 583 from 8 August 1995 and resolution no. 298 from 21 April 1999 accepted**National Programme for the Fight Against Drugs.**Its essence lies in the prevention of spread and creation of drug addiction in Slovak republic. The aim is to prevent human and economic losses caused by drug addiction and achieve positive change in drug addiction and alcohol is the cheapest and most accessible drug, which can be accessed anywhere.Its expansion did not avoid the Slovak Army. It is possible to find parallels with paragraph about construction industry which we have listed.

VI. ALCOHOLISM FROM THE VIEW OF MEDICINE

Although references to the harmful effects of drunkenness can already be found in the works of Hippocrates, Aristotle, Galen and Avicenna, a breakthrough in medical appreciation of alcoholism came to on turn of 18th and 19th centuries.Initial formulation of alcoholism as a disease is attributed to founder of American psychiatry Benjamin Rush (1784), who understood alcoholism as "demolition of will" which leads to poverty, misery and crime.That meant some progress compared to the original view that alcoholism is a bad habit (therapeutic methods in those days were alert and cold shower). In 1804 in England, Thomas Trotter defined drunkenness as mental disorder, which treating consists of total abstinence.Swede Magnus Huss introduced the term chronic alcoholism in 1849.At the beginning of 20th century was already available extensive knowledge of alcoholism, particularly in the US, and Russia, but paid them little attention was paid to it. E.M. Jelinek decisively contributed to elaboration of classification of alcoholism and problems related to it on the World Health Organization forum in mid-40.In addition, he has earmarked four stages, respectively phases of alcoholism development, yet also distinguished five types of alcoholism.

1. **Type alpha –**exclusively psychological dependence on alcohol. Drinking is not in accordance with social habits, the effect of alcohol is used to "mitigate" physical or mental difficulties, it is missing progression, loss of control, or the inability to abstain.
2. **Type beta –**due to socially conditioned drinking and disorders of nutrition,physical complications such as polyneuropathy, gastritis (inflammation of stomach lining), liver cirrhosis are developing. This type lacks any psychic and physical addiction.
3. **Type gamma –**as a result of alcohol abuse, so called tissue tolerance to alcohol occurs, cellular metabolism adapts to alcohol, and withdrawal symptoms gradually appear craving for alcohol (physical addiction) and loss of controlled drinking. Clear development from psychological to physical addiction.
4. **Type delta** – except for loss of control have all symptoms of previous type, failure to abstain is not obvious. There is no severe drunkenness, but rather maintained "certain" level of alcohol.
5. **Type epsilon –** periodic alcoholism, in Europe and Latin America, known as dipsomania.

Jelinek refers to alcoholism in terms of disease only to gamma and delta types (gamma is typical in US, Canada, Anglo-Saxon countries in central and EasternEurope; delta is typical for Romanic wine countries).He draws attention to possibility of migrating from alpha and beta types to gamma type.

Jelinek in his work defined alcoholism as "any use of alcohol, causing some damage to an individual or society."From this determination comes definition of an alcoholic as a person to whom alcohol consumption causes persistent problem in any area of his life.Individual is addicted on alcohol if excessive alcohol

consumption, usually of compulsive character, causes him clear fading of mental and physical health, social relationships, social activity or function.Excessive drinking, episodic drinking with no signs of loss of control, without psychological and physical dependence, without withdrawal symptoms, cannot be medically considered as alcoholism in terms of disease, but drunkenness (which may be just as socially dangerous). Difference between drinkers and alcoholics is caught in French proverb:**"Drinker is one who could stop drinking, but**

does not want to, alcoholic is one who would also like to stop, but cannot."

Since 1979, in business terminology was term alcoholism replaced by term alcohol dependence syndrome.It is defined as group of variations in behavior, cognition and physiological processes that result from repeated use of alcohol, including:

- strong craving for alcohol, compulsive urge to drink alcohol,
- impaired control over alcohol use,
- persistent use of alcohol despite evidence of harmful effects,
- altered tolerance to alcohol,
- physical withdrawal syndrome.

VII. CLINICAL COURSE OF ADDICTION

The first phenomena of clinical development include regular drinking.Regularity of contact with drug is significant in view of exposure, and access to drug itself is essentially social or individual.In countries where alcohol is easily available, sociogenic factors get into the front.

Psychogenic approach follows primarily from the psychotropic effects of alcohol that can act sedative-hypnotic, anxiolytic (anti-anxiety), abreactivly (on abreaction).Exposure to alcohol is primarily determined by socionics, sometimes your mood (neurosis, reactive state), and compensatory mechanisms of abnormal personality, causing repeated and regular returns to alcohol as a drug. Adequate exposure to drug determines phenomenon of increasing tolerance to alcohol, which is formed in parallel or with only small delay from regular consumption. Both are developing gradually, in interval of several years.In terms of so called domestication (homing) of drug, we cannot, even when regularityof drinking is apparent, talk about addiction.You cannot talk about it even after first „palimpsests“ (visions or bounded memory lapses, respectively black outs), which are initially random, usually at considerable drunkenness.We can only assume that where individual approach to alcohol expressed as "hidden" (solo) drinking begins to outweigh,reveals more than normal relationship to alcohol, especially when neither negative circumstances, lead to regulation or interruption of drinking.It gradually develops so called drinking stereotype, where contact with alcohol may be continuous or episodic, formed by working rhythm and external factors.Speaking about drinking stereotype, we cannot circumvent relationship of individual to alcoholic beverages in connection with procuring - alcocentric behavior, because for addicted is alcohol primary value.Besides shopping and other stocks creating at home or workplace, it partly includes activities concerning unimpeded consumption (hiding of drinking, escaping into anonymity, changing work) or negation of activity (previous interests, aversion to work or postponing it, absence), averting from family and legendary lying.Withdrawal syndrome is autonomous mechanism determining relationship to drug addicted individual.This is failure of adjustment mechanisms, in conditions of long-term interaction with alcohol, which occur not only by deprivation of drug but also by its overdose or due to general weakening of body (fatigue, infection, injury, etc.). We traditionally distinguish physical and mental component of withdrawal syndrome.

Physicalcomponenthas to be shown during "alcoholising" or soon after its discontinuation characterized by need of "physical comfort" and compulsive need for alcohol.

Mental componentmanifests itself in abstinence period, up to 3-6 months after treatment. Its essential expression is need for "psychological comfort", revealing mainly in stressful situations or in situations evoking memories of drinking. Question is to what extent is important that the patient stood up to his problems, whether he is rationalizing them, or drinks "still further".**Rationalisation**relieves feelings of guilt, psychological stress related to confronting social pressure (family, employer), with expression of superiority, selectively aggressive behavior (to those who shame drinking), divergention from friends, from family, changes in employment and environment, reinterpretation of human relations, relations with dominating bitterness, resignation, or vice versa targeted aggression with jealous reactivity.In terminal (final) stage formation of psycho-alcoholic complex disorders occur.Basic manifestations include thought disorder with impaired chronology and weakening judgment, suggestibility, memory disorders, emotional lability, irritability, explosiveness, suspiciousness, jealousy, volatility of attitudes, narrowing of interests, weakening of ethical qualities with indiscretions, pretentiousness, indifference, and selfishness.

In relation to alcohol, declining tolerance occurs, which means that even drinking of small amount of alcohol usuallyleads to clear drunkenness. Regular and typical is multi-day drinking in "roundups" form, resulting in exhaustion, sometimes deeper metabolic breakdown with frequently occurring prolonged (chronic, protracted) depression.Drunkenness come into stereotyped course – dominated by moodiness and tendency to diffuse (overall) aggression. However, aggressionis not considered for homogeneous phenomenon. In practice, it is appropriate to distinguish between selective and diffuse aggression.Selectivity of aggressive manifestations indicates a certain "preservation" of personality and is usually addressed to family or current conflicts.Diffusion of aggression, its constancy, especially if previously lacked, is important sign of brain damage and altered personality.When monitoring psychosexuality of alcoholics disorders with long-lasting decrease in potency or peculiar jealous tendencies are frequent.Alcohol related physical disorders illustrate complex of psycho-organic disorders. Clinical course is often speeded up on basis of liver disorders and chronic inflammation of liver and stomach.Accelerating effect has especially head injuries and epileptic seizures.Overally it is invertible (non-returnable) character of health complications, or by original nomenclature, **chronic alcoholism.**For a man with such people is typical hoarse voice, diversified speech, striking restlessness in face, especially around mouth, with stereotyped licking or munching, chewing, intensifying in heat of passion or at the mention of alcohol. Noticeable are also other features such as strong tremors throughout the body, failure to maintain balance, conjunctives congestion, and coarse permeated skin with typical "red" in the face.

VIII. CAUSES OF ADDICTION

They can be internal (psychogenic, biological) and external (social).

Biological causes(eg. genetic, metabolic, neurohumoral) are usually applied through psychological mechanisms directing neuropsychotropic effects of alcohol to increase likelihood of recurrence drinking. About congenital disposal (at least in part of alcoholics) testify results of genetic research.For monozygotic twins is incidence of alcoholism almost 2 times higher than for dizygotic.For children of alcoholics is risk of alcohol addiction also many times higher, even if they are raised by adoptive parents from childhood.Also racial factors are not negligible, specifically metabolic variations in degradation of alcohol in Japanese, probably involved in less common occurrence of alcoholism in Japan.

Psychogeniccauseslie in potential anxiolytic (anti-anxiety), antidepressant, euphorigenic and stimulatory effects of alcohol and its effects increasing dominance and sociability.Some people (especially women, or emotionally unstable personalities) begin to drink alcohol excessively, for example, to suppress anxiety, agitation, detuning, lethargy, feelings of inferiority, as a mean of facilitating rapprochement with people (including sexual contacts If these effects are sufficiently strong and reliable, they enhance susceptibility to recurrent drinking in susceptible individuals.

Sociogenic causesapply in individuals living in environment where drinking alcohol is common, even glorified and enforced.Individual drinks in order to not differentiate from others, or not to fail to isolation.This is particularly true of young people dependent on group with drunken habits and prestigious drinking (who can endure more and last longer). Inefficient positive educational impact, boredom, lack of internal or external motivation and lack of opportunities to better use of time, reinforce dependence on such drinking group. Another group of "vulnerable" form employees in jobs, who regularly come into contact with alcohol.

Alcohol, by dissolving fats, increases "fluidity" (throughput) of cell membranes lipid bilayer, thus changing operating conditions of functional units of membrane proteins (receptors, ion channels, enzymes, etc.). Its action is physical and it interacts with membranes of all cells in body, which is fundamentally different from mechanism of action of most psychotropic substances which need a bond with specific receptors to their action.
Effect of alcohol is at first expressed in nervous system because its operation depends on optimal functioning of membranes.Prolonged alcohol abuse causes atrophy (loss of brain cortex tissue) brain ventricles enlargement, extension of space between "brain cells", which is probably implicated in development of memory disorders.With age and duration of abuse atrophy emphasizes, the most affected areas of cerebral cortex are front areas. Atrophy of brain may not always correlate with degree of intellect damage.Chronic excessive drinking significantly reduces the number and shortens the length of dream phases of sleep, which are important for physical regeneration.Sleep of alcoholics, as well as drinkers is usually fragmented, these people often suffer from insomnia.In withdrawal syndrome, the number of dream phases, long suppressed by alcohol increases and their occurrence is associated with nightmares.Manifestations of biochemical or morphological damage caused by alcohol are individual, manifold.This variability can be explained perhaps just by different interdependencies of various exogenous (external) and endogenous (internal) pathogenic factors.

Exogenous factors are: daily doses of alcohol, period of alcohol abuse and its continuity (for illustration - for men,daily consumption of 132 grams of alcohol within 10 to 20 years leads toliver cirrhosis, while for women daily consumption of 52 grams of alcohol within 5 years leads to liver cirrhosis), nutrition factors, lack of protein, minerals, chemical impurities in alcoholic beverages (methanol, aromatics, oils, formaldehyde, histamine, phenols and other hepatotoxins).Also endogenous factors act individually, differently.These include: previous liver disease (e.g. infectious hepatitis), body weight, co-existing disease (diabetes, renal insufficiency, hormonal disorders etc.), and immunological and genetic defects.Individual is also the time in which excessive drinker "reshape" to addiction.In general, if he begins to drink as 25-year-old he will become alcoholic in about 10 years, when he starts at 20 in about five years, when he starts at 15, even after about five months! Additional numbers are certainly striking and warning. Slovakia, in recent years with average consumption of about 10 liters of "pure" alcohol per capita per one year (including children, women, elderly people), ranks among countries with highest alcohol consumption in the world. It is estimated that about 30% of drinkers have obvious problems with alcohol (at least in one area of life); about 10% is addicted to alcohol."Dangerous" rise of alcoholism was recorded amongst women While 10 years ago, the ratio of women to men alcoholism was 1:10,and statistics from almost three years ago show, the ratios of 1:4 - 1:3.It is estimated that about 1/3 of completed suicides in Slovakia is related to alcoholism, 25% of all patients admitted to hospitals are being treated due to complications incurred as a result of excessive drinking. Every third to fourth judgment of imprisonment, one of three fatal car accident, every six divorce is related to alcohol.Every fourth child from "alcoholic" family requires psychiatric care, or finds self in educational home.

Individual abusing alcohol was in the past, within the legislative systems evaluated as morally corrupted, so as individual arbitrarily and from understandable motivation (hedonism) violating moral rules.He was always considered to be responsible for his drinking that appeared to be reprehensible, but understandable to surrounding.Alcoholism is from moral point of view immoral, it is result of tolerant attitude of society to consumption of substance causing evil; it is also result of weak will of individuals, unable to resist its charms.
The criticism against the moralistic perspective not implies that the alcoholic should be "removed" from moral criteria.Understanding alcoholism as a disease is attempt to throw off burden, which makes the path to recovery difficult for patient, from him.**From moral weakness thus became illness** requiring medical treatment, care and support of surroundings. Adoption of concept of alcoholism as a disease aimed to legitimate social support of treatment and rehabilitation of alcoholics, replacing punitive attitude of society by constructive one.Concept of alcoholism as a disease facilitates often intolerable situation for those who decide to take role of patient, and this does not absolve them from responsibility, but binds to necessary cooperation. General acceptance of disease was also necessary to put an end to very misleading myth, that alcoholics are degraded individuals from "beer tent" who interfere public order and are frequent customers of detention stations, misdemeanor commissions and court hearings.Medical reformulation of alcohol abuse is seeking characteristics and limits of the loss of control reduced will decision-making and non-motivation, instead of unbridled hedonism. Level of medical diagnosis is complicated matter because it is a dynamic diagnosis, having its development, which may not be linear and only progressing.

We can determine addiction on basis of one examination very rarely.It always depends on established trust, therefore, whether patient will want to speak openly about his problems with drinking, if he is aware of altered drinking control or will admit withdrawal symptoms (their origin), which are often awkward and embarrassing.This is failing especially if patient expects that doctor's "finding" could be crucial for assessment of his working competence.Understandably he tries to deny what would he could "harm" him and boycotts advisory examinations.In addition, many clients not consider their drinking problem for most negative aspect, but rather fact that it must be treated. Quality of therapeutic relationship is thus crucial to establish correct diagnosis, which is always ultimately comprehension of biological, psychological and social knowledge.
Medicinisation of alcoholism and other drug addictions, however means, exclusion of this problem from needed comprehensive understanding. Serious consequence of "medicinisation"is deactivation of non-health institutions, which in many cases means that the physician is often, when assessing working competence, manipulated into sanctioning decisions, thereby takes responsibility attached to others.Also, too much reliance on model of a disease has negative impact on less effective prevention policies.Focus is on the most affected, while early stages escapes. Some experts in alcohology believe that medical concept of alcoholism is "unfortunate",because it makes all distance themselves from alcoholism.Like old moralistic thinking on the problem only change its form for "more scientific".

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