**UNIT**

# 1 Introduction: Alcohol Origins and Use

### Introduction

Welcome to the first unit of this module, which has been designed to present a contextual background to the topic of alcohol problems in the Southern African context. The first unit focuses on the history of alcohol in this region, as well as patterns of consumption and abuse.

Remember that alcohol is no ordinary commodity: so before looking at the consequences of problematic uses of alcohol, you need to think and read about its use and meaning to different people. This will lay the foundation for understanding the difficulties and challenges of designing appropriate legislation for control of alcohol, and for shifting patterns of alcohol use in different communities.

#### There are three Study Sessions in this unit:

Study Session 1: Alcohol: Origins of Use, and Value as a Commodity. Study Session 2: Patterns of Consumption.

Study Session 3: The Theories of Alcohol Use and Addiction.

In Session 1, we explore the history of alcohol use and production in colonial and post-colonial Southern Africa, the socio-political and cultural influences on the use of alcohol in developing countries, and the impact of industrialising alcohol production in these contexts.

Session 2 provides an overview of the concepts and measures used in researching alcohol problems, and stresses the importance of understanding social and cultural patterns of alcohol usage.

Session 3 focuses on the theories of alcohol use and health behaviour, and explores how one’s model of understanding alcohol problems influences the intervention strategies one is likely to choose.

### INTENDED LEARNING OUTCOMES OF UNIT 1

**By the end of this unit, you should be able to:**

* Discuss the origins and shifts in alcohol use in Southern Africa in relation to socio-political forces.
* Explain the production and consumption of alcohol as an economic activity.
* Identify and interrogate measures used in collecting alcohol related data.
* Identify the patterns of use and other critical factors which promote or limit the use of alcohol.
* Discuss cultural variables in the measurement of alcohol consumption.
* Explain and apply the different theories of addiction and dependence.
* Describe the influence of these theories on prevention and treatment approaches.
* Demonstrate insight into possible explanations for alcohol problems.

This unit is important in providing the essential conceptual tools you will need for addressing alcohol problems using a Health Promotion approach. Commit yourself to engaging with the tasks, as this is the best way to ensure that you have internalised new concepts and issues.

# Unit 1 - Session 1 Alcohol: Origins of Use, & Value as a Commodity

## Introduction

This session introduces you to the historical, political and socio-economic issues surrounding alcohol from the 1800s to the present. We ask you to consider how alcohol has been used in your own family and to engage in a quick survey of historical changes in the practices of alcohol production, control and usage in the colonial and post-colonial contexts.

We look in some detail at the economics of alcohol production in the developing country context, and who benefits from it, particularly in the Southern African context. This sets the scene for Sessions 2 and 3, where we consider how different communities use alcohol today, as well as the patterns of abuse which have developed from our socio-political past and persist in the present.

A good question to hold in mind while you study this session is:

*What political and economic roles has alcohol played, then and now?*

### Contents

1. Learning outcomes of this session
2. Readings
3. The origins of the use of alcohol
4. Alcohol as a commodity
5. Session summary
6. Further reading

### Timing of this session

This session requires you to complete three substantial readings totalling 64 pages and three tasks. It should take you about four hours to complete.

### LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Discuss shifts in alcohol use in Southern Africa in relation to socio-political forces.
  + Explain the production and consumption of alcohol as an economic activity.

### READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Publication details** | **Page numbers in**  **Reader** |
| Room, R., Jernigan, D.,  Carlini-Marlatt, B.,  Gureje, O., Makela, K., Marshall, M. Medina Mora, M., Monteiro, M., Parry, C., Patanen, J., Riley, L., Saxena, S. | (2002). Ch 2 - Drinking in Developing Societies: The Economic, Social and Cultural Context. In *Alcohol in Developing Societies: A*  *Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 21-36. | **339-348** |
| Ambler, C. &  Crush, J. | (1992). Ch 1 - Alcohol in Southern African  Labor History. In J. Crush & C. Ambler (eds). *Liquor and Labor in Southern Africa.* Pietermaritzburg: University of Natal Press: 1- 35. | **1-18** |
| Jernigan, D. H. | (1999). Ch 9 - Country Profile on Alcohol in Zimbabwe. In L. Riley & M. Marshall (eds.). *Alcohol and Public Health in 8 Developing*  *Countries.* Geneva: WHO: 157-175. | **167-178** |

### THE ORIGINS OF THE USE OF ALCOHOL

In order to understand the complexities of the meaning and use of alcohol in the world today, we need to trace its origin and the influences on its use. Alcohol is no ordinary commodity like milk or bread: because of its *psychoactive* properties, i.e. that it affects the brain and influences behaviour, it has been effectively used and abused across most societies in the world.

Before you start reading, it may be interesting to reflect on your own family’s values and experience (historical and cultural) of alcohol by doing Task 1.

**TASK 1 – Tracing alcohol use in your family**

Think of your grandparents or what you know of your great grandparents in the late 1800s and early 1900s.

1. Do you know what norms and values surrounded the use of alcohol in their time?
2. Were norms (like age, gender, time and place of drinking) influenced by factors outside of their immediate community, or did they follow their traditions only?
3. What was the drink of choice? Who produced it and how was it distributed?
4. Now think of your current family and answer the same questions for the present situation, before moving on to question (e).
5. What main factors have resulted in changes in alcohol consumption compared to 100 years ago?

Now compare your conclusions on the factors that have influenced these changes with those identified by Room et al (2002). This historical survey identifies trends in alcohol use which have arisen from our colonial history. As you read, take note of the economic and social trends which are identified as significant areas to investigate in a Health Promotion approach to alcohol use.

**READING:** Room, R. et al. (2002). Ch 2 - Drinking in Developing Societies: The Economic, Social and Cultural Context. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 21-36. See pp339-348 in the Reader.

For those of you working in developing contexts, the reading suggests that the contextual aspects of alcohol usage need to be well understood, and sensitively handled in the post-colonial era.

Room et al emphasise the historical links between alcohol and political control of groups of people in colonial Southern Africa. “Alcoholic beverages were … commonly used as a colonizing force to attract, pay, entertain and control indigenous labourers” (Room et al, 2002: 24). However, it is also significant

that historically, alcohol followed the same pattern of industrialisation as most other commodities and that colonies were “… turned into markets for alcoholic beverages …” (Room et al, 2002: 24).

In South Africa, home-brewed liquor from the rural areas was recognised as a popular beverage and commodity in the urban areas: it was therefore commercialised alongside the European-origin malt beer. Although this challenged the traditional role that women played in brewing the beer, it did not end their role in brewing and selling liquor in both rural and urban areas. In fact, many of the shebeens and taverns that serve as important places for socialising, are owned by women and enable their owners to make an income. Traditional home-brew is now often sold alongside commercially produced beer, wine and spirits. Another phenomenon which may arise from contextual factors is the emergence of different choices of drink being made by different classes of drinker. Working class people still tend to buy traditional and commercial beer, and sometimes cheap wine, while those aspiring to a middle class lifestyle choose only commercial liquor, particularly spirits.

The next reading by Ambler & Crush (1992) traces the use of alcohol in pre- colonial Africa and Europe, and describes the convergence of the two during the colonial era in the 19th and 20th centuries. The Temperance Movement which swept the world in the 1880s, during which authorities and temperance societies tried to ban the use of alcohol, also had some influence in Southern Africa.

Most striking again is the use of alcohol as a political tool of control by the white colonialists over the majority black population. The tension facing the authorities between the potential profits in selling liquor and the need to be in control of people’s behaviour and movements, is clearly described.

**TASK 2 – Consider the impact of the control of alcohol on our society**

As you read this chapter, take notes on the effect that past control of access and sale of liquor has had on Southern African societies today.

**READING:** Ambler, C. & Crush, J. (1992**).** Ch 1 - Alcohol in Southern African Labor History. In J. Crush & C. Ambler (eds). *Liquor and Labor in Southern Africa.* Pietermaritzburg: University of Natal Press: 4-35. See pp 1-18 in the Reader.

In Southern Africa today, it is clear that traditional norms on the use of alcohol have largely been eroded. This is identified as one of the many reasons for increased consumption of alcohol, especially in urban areas. In this regard, think of who produces and sells what alcohol, and the extent of economic gains: in other words, who benefits from the increased use of alcohol today?

Clearly liquor selling and use is an integral part of all communities in Southern Africa and needs to be accepted as such. Any attempt to regulate harmful consumption needs to take this history and economic reality into account. In relation to the economic aspect of the industry, we will discuss the current Liquor Act in South Africa in Unit 3, and the way in which it attempts to formalise the production and sale of liquor. In part, this Act attempts to increase the controls on liquor, while at the same time expanding its economic potential, by increasing the number of licensed sellers, and relaxing the times of operation.

### ALCOHOL AS A COMMODITY

The production and sale of alcohol is an important aspect of the economy in many countries, and developing countries are no different. However, owing to the transitional nature of their economies, much alcohol production and sale in developing countries takes place informally, making it difficult for the authorities to regulate and tax these transactions.

Some countries have state-run alcohol production, resulting in direct revenue to the government, such as the beer halls in Zimbabwe. Other countries have a few large commercial companies producing and selling liquor, which are directly taxed on their sales. These operate alongside and interact with many unregulated small outlets, such as in South Africa and Nigeria, where it is difficult for the government to ensure that tax is paid.

The economics of alcohol production and marketing is critical to understand: Task 3 offers you a chance to consider the issue in your local context before reading about it at national and global levels.

**TASK 3 – The economic importance of alcohol in your area**

Consider the town or city in which you live, and try to list all the different kinds of producers and sellers of liquor.

1. What proportion are informal sellers and what proportion are formal sellers?
2. Where do they get their stock? Is it brewed on site or is it bought from a wholesaler?
3. Do you know who owns the wholesaler and where the various liquors are produced? If not, try to find out.
4. What are the numbers of people benefiting from the production and sale of alcohol - ranging from the managing director and shareholders of the holding company, to the shebeen owner?
5. What is the geographical spread of liquor outlets? Are there more in working class areas than in middle class areas, or less?
6. What do you conclude about the importance of alcohol as a commodity in your area?

There is unfortunately a lack of research and ongoing surveillance data to confidently describe alcohol production, consumption and consequences in Southern African countries. This includes South Africa which is ranked as a middle-income country and therefore could be viewed as more able to monitor and control issues around alcohol. Understandably Zimbabwe, a low-income country with a legacy of political use of alcohol similar to South Africa, faces many more serious challenges than the control of alcohol.

The next reading by Jernigan (1999) highlights the dilemmas of Zimbabwe with regard to alcohol. Liberalisation of the market economy, under pressure from the International Monetary Fund (IMF) and World Bank, has resulted simultaneously in increased production and advertising of alcohol, and reduced controls on sales, especially in the rural areas. The article also describes the monopoly that exists on traditional and non-traditional alcoholic beverages and the relationship of these to the government of Zimbabwe, and to the South African monopolies.

**READING**: Jernigan, D.H. (1999). Ch 9 - Country Profile on Alcohol in Zimbabwe. In L. Riley & M. Marshall (eds.). *Alcohol and Public Health in 8 Developing Countries.* Geneva: WHO: 157-175. See pp167-178 in the Reader.

Jernigan applies his conclusions to developing countries in general, emphasising the need for “… monitoring, research and exchange of experience regarding alcohol policies in developing country contexts. … Without this [he concludes], there is a strong chance that, as in Zimbabwe, alcohol will be left to the market to regulate” (Jernigan, 1999: 171).

### SESSION SUMMARY

In this session, you have considered contextual influences on alcohol production and consumption. Through the readings, you have hopefully gained some insight into the socio-political history of alcohol and the economics of production and consumption in Southern Africa. If you consider the numbers of people that benefit from alcohol production, it is clearly not to be ignored as a commodity in the market. However, bear in mind that we have not yet discussed alcohol in a balanced way, by looking at the negative consequences of the use of alcohol and the costs thereof.

In the next session, we introduce you to the concepts used for measuring consumption and the importance of understanding the patterns of use in a community. We also consider the consumers’ perspective on when, how much, with whom, and where they choose to drink.

### FURTHER READING

* Mager, A. (1999). The First Decade of “European Beer” in Apartheid South Africa: The State, the Brewers and the Drinking Public, 1962-72*. Journal of African History,* 40: 367-388.
* Haworth, A. & Acuda, S. W. (1998). Sub-Saharan Africa. In M. Grant (ed.).

*Alcohol and Emerging Markets. Patterns, Problems and Responses.* USA. International Centre for Alcohol Policies: 19-56.

* Riley, L. & M Marshall. (1999). Country Profile on Alcohol in South Africa.

In *Alcohol and Public Health in 8 Developing Countries*. Geneva: WHO: 135-156.

# Unit 1 - Session 2 Patterns of Consumption

### Introduction

In the first session, we introduced the socio-political and economic issues related to alcohol production and consumption. In this session, the focus is on consumption and patterns of usage.

As you well know, there is plenty of variation in the consumption of alcohol from one person to the next. How do we measure and monitor the use of alcohol by an individual, or in a group, a community or at a societal level? What methods and indicators can be used by health promoters to measure these different levels of consumption, and what are some of the factors that promote or limit alcohol use? Hopefully by the end of this session you will be clearer about these issues, and the dilemmas we face in measuring alcohol use. There are a lot of tasks in this session: try to engage with them, to ensure that you grasp the “essential tools” or concepts you need for working in this field.

### Contents

1. Learning outcomes of this session
2. Readings
3. Concepts and measures of consumption
4. Identifying patterns of drinking
5. Norms for drinking
6. Session summary
7. References and further reading

### Timing of this session

This session contains eight fairly short readings totalling 32 pages, and six tasks. It is a very important session, so you should work through it thoroughly. It could take you at least four hours to complete.

### LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Explain some of the key terms used to describe alcohol consumption and patterns of use.
  + Identify and interrogate measures used in collecting alcohol related information.
  + Discuss cultural variables in the measurement of alcohol consumption.
  + Describe the patterns of use and other critical factors which promote or limit the use of alcohol.

### READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Publication details** | **Page numbers in**  **Reader** |
| Roche, A. M. &  Evans, K. R. | (1998). Ch 13 - The Implications of Drinking  Patterns for Primary Prevention, Education, and Screening. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 243-265. | **315-338** |
| Parry, C.D.H., Bhana, A., Myers,  B., Plϋddemann, Flisher, A.J., et al. | (2002). Alcohol Use in South Africa: Findings from the South African Community  Epidemiology Network on Drug Use (SACENDU) Project. *Journal of Studies on*  *Alcohol*, 63(4): 430-435. | **297-304** |
| Claasen, J. N. | (Sept. 1999). The Benefits of the CAGE as a  Screening Tool for Alcoholism in a Closed Rural South African Community. *South African Medical Journal,* 89(9): 976-979. | **57-62** |
| Flisher, A. J. et al. | (2001). Substance Use by Students in South Africa, Tanzania and Zimbabwe. *African*  *Journal of Drug & Alcohol Studies,* 1(2): 81-  97. | **121-130** |
| London, L., Nell, V.,  Thompson, M-L. & Myers, J.E. | (1998). Health Status Among Farm Workers  in the Western Cape – Collateral Evidence from a Study of Occupational Hazards. *South African Medical Journal,* 88(9): 1096-1101. | **187-194** |
| Croxford, J. &  Viljoen, D. | (Sept. 1999). Alcohol Consumption by Pregnant Women in Western Cape. *South*  *African Medical Journal,* 89: 962-965. | **63-68** |

|  |  |  |
| --- | --- | --- |
| Bennett, L. A.,  Janca, A., Grant, B.  F. & Sartorius, N. | (1993). Boundaries Between Normal and  Pathological Drinking: A Cross-Cultural Comparison. *Alcohol Health & Research World,* 17(3): 190-195. | **39-46** |
| Heath, D. B. | (2000). *Drinking Occasions: Comparative*  *Perspectives on Alcohol and Culture.* USA. International Centre for Alcohol Policies: 191- 198. | **149-154** |

### CONCEPTS AND MEASURES OF CONSUMPTION

Measuring the consumption patterns of alcohol at community or countrywide level is not an easy exercise. As discussed in Session 1, the production and sale of alcohol ranges from regulated to unregulated, which makes measurement at the point of sale difficult. In addition, consumption patterns vary considerably from person to person, as a result of a myriad of influences.

The terminology used in measuring drinking includes the following concepts amongst others: *dependent drinkers*, *risky drinking, drinking patterns, regular* and *harmful use of alcohol, absolute* and *average alcohol content* and *drinking occasions.* We will discuss the use of these concepts in the course of this session.

At this point it may be useful to define what we mean by *dependent drinking*

and *risky drinking*:

“Alcohol dependence” refers to a user’s experience of tolerance to alcohol, withdrawal symptoms such as an acute craving for alcohol and trembling, relief drinking to take away the withdrawal symptoms, loss of control, and/or compulsive drinking, which is a compelling need to consume alcohol.” (American Psychiatric Association, 1994)

*Risky drinking* refers to a drinking level that (at a particular time) that could lead to negative consequences., These are often dependent on the individual, his or her sex, alcohol tolerance and the environment.

Alcohol problems are usually discussed in terms of the quantities of alcohol used. Setting aside cultural norms of what constitutes problem drinking at this point, we face the dilemma of how to measure it. This is a conceptual dilemma which must be resolved at the outset and we will now explore it further.

#### Two Models for Measuring Alcohol Usage

It has been found that the total per capita intake of alcohol, or even the weekly or monthly intake by an individual, is not a particularly useful measure in addressing alcohol problems. Can you think why?

Faced with an individual’s total consumption or even their weekly or monthly intake, how can you know whether they are engaging in problem drinking? Do they drink most of their intake over one continuous occasion as in binge drinking, or do they drink a little each day? Total consumption is meaningless in this context. A more meaningful way to measure drinking is to focus on and measure *drinking occasions* or events when drinking takes place, rather than measuring total individual consumption.

Another way to measure alcohol intake is represented by Model A below. How useful do you think it would be to you in assessing problem drinking in a community? (Remember that the significance of a model is that it represents the way we understand something: it therefore influences the interventions we propose.) Model A is often used to elucidate drinking: it is a continuum stretching from *Non-use* to *Harmful use.* The scale implies little or no intake on the left and heavy usage on the right.

#### Model A

**A Model of Alcohol Usage**

Non-use Experimental use Occasional use Regular use Harmful use

(*The Public Health Bush Book*, 1999:1.53)

In this model, the continuum is based on the assumption that we can identify people’s average consumption and locate them on the continuum. The model also implies that *Harmful use* is one stage more serious than *Regular use*, implying that only very frequent use or dependence are the problem areas.

**TASK 1 – Analyse a model of alcohol consumption**

Why do you think Model A is problematic as a tool for identifying risky drinking in a community?

#### FEEDBACK

This model is questionable, because it equates drinking at the *harmful* level,

1. drinking which could result in problems) with high consumption or *dependent drinking*. In fact many people who use alcohol occasionally or experimentally, do so in a harmful way, perhaps in a binge fashion. In addition, there are many more risky drinkers than dependent drinkers, and the dependent drinkers are more likely to practise harm minimisation strategies.

If this model were to be used in isolation to understand a situation of alcohol consumption, it is likely that interventions would target the *Regular users* in particular, to prevent them from reaching the *Harmful use* end of the

continuum. This suggests that there would be little or no focus on the broad range of drinkers, nor on occasional or experimental binge drinkers, nor on the specific occasions of drinking. Such interventions would only target a small number of people rather than the occasions when people from across the spectrum indulge in risky drinking.

Thus far we have noted that neither total nor average consumption are particularly helpful in identifying problem or harmful drinking, which is what we are mainly interested in. This model is therefore not that helpful.

#### Model B

A more recent model discussed by Roche & Evans (1998) in the reading mentioned below advocates a shift away from a focus on average consumption, to a focus on *drinking patterns* and the risks involved in some of them. The concept of a *drinking pattern* implies describing the amount, regularity and context in which alcohol is used, while *drinking occasions* are those events during which alcohol is used “in one sitting”. In using this model, our interventions would aim to reduce the potential harm of *drinking occasions,* regardless of the individual’s average or total intake, and to promote the beneficial aspects of low levels of social drinking in a safe environment.

To assist you in reading the paper with focus, try Task 2. The paper covers more than we are presently addressing in this session, but you will also find it helpful when you start your first assignment; so remember to return to it.

Focus on the eight conceptual shifts that have influenced the way alcohol problems are addressed, as well as on the discussion of “Contextual Issues”. Take note of Table 13.1 on page 249, in which the authors describe three levels of perspective on alcohol problems: their model focuses on the *meso* or middle level perspective. This perspective implies that one should “[f]ocus on particular episodes of drinking in which individuals or community are harmed or placed at risk” (Roche & Evans, 1998: 249). The section on “The Continua of Risk” presents their model, which is seen as “alternative or complementary” to the traditional model (Roche & Evans, 1998: 254).

Roche, A. M. & Evans, K. R. (1998). Ch 13 - The Implications of Drinking Patterns for Primary Prevention, Education, and Screening. In M. Grant & L. Litvak (eds). *Drinking Patterns and Their Consequences.* USA: International Centre for Alcohol Policies: 243-265. See pp 315- 338 in the Reader.

**Task 2 – Using a complementary model to measure alcohol problems**

* 1. Summarise the conceptual shifts in describing alcohol problems which are covered in this paper: what does each imply about the data we collect to describe or measure alcohol problems?
  2. What do you believe to be the value of the meso level perspective when dealing with alcohol related problems?

c) What sort of data must be collected in the “risk level” model presented by the authors?

#### FEEDBACK

Here is some selective feedback:

1. We have summarised the conceptual shift termed “Alcohol as an Exception to Population Health Control Concepts”. Alcohol, because of its nature, (intoxicating, able to produce dependence in some individuals), does not fit the usual Public Health approach of advocating reduction at the population-wide level: instead of gathering data on average or total consumption, this shift implies that patterns of use and drinking occasions should be described.
2. The meso level perspective focuses on patterns of consumption and drinking occasions, thereby addressing the specific risks caused by this particular substance.
3. You will find these data listed at the bottom of page 254.

In order to describe patterns of alcohol use in a community or society, we need to pose a series of questions relating to the *when, where, who, how, what,* and *why* of alcohol use. The trends in alcohol use that shift over time can also be traced through answering these questions for different decades. Read the short chapter by Heath to understand the contribution of qualitative data in the understanding of alcohol patterns.

**READING**: Heath, D. B. (2000). *Drinking Occasions: Comparative Perspectives on Alcohol and Culture.* USA: International Centre for Alcohol Policies: 191-198. See pp 149-154 in the Reader.

The dilemma as to which model is more useful or whether they should be used in combination will be discussed again in Unit 2; but keep it in mind when reading about the measures currently being used to quantify alcohol use, and their consequences. The next important concept that we will discuss is the alcohol content in different drinks.

#### Alcohol Content and Risky Drinking

*Absolute alcohol content* (or pure alcohol) is a quantity measured as a percentage of a volume of an alcoholic beverage. Different countries use slightly different measures for a “standard drink”. The amount of alcohol per standard drink (usually a commonly used size for serving each type of beverage) is calculated as a percentage, and as an absolute amount in grams (ranging between 6g and 16g of pure alcohol, but more usually around 11g or 12g). The range of different alcohol contents is detailed in the table below.

**HOW MUCH ALCOHOL IS THERE IN ONE DRINK?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drink** | **Average alcohol content (%volume)** | **Size of one drink (typical serving)** | **Absolute alcohol content (g)** |
| Malt beer (lager) | 5% | 340ml | 12 |
| Sorghum beer | 3% | 500ml | 12 |
| Cider | 6% | 340 ml | 16 |
| Cooler / grape | 5-10% | 340ml | 12 |
| Wine | 12% | 120ml | 11 |
| Sherry | 17% | 50ml | 7 |
| Liqueur | 30% | 25ml | 6 |
| Brandy, whisky,  gin, vodka, cane | 43% | 25ml | 11 |

(Adapted from Parry & Bennetts, 1998: 129)

To quantify the amount of absolute alcohol taken by a person, the type of drink and the number of *standard drinks* needs to be recorded. A calculation can then be done to find the *absolute alcohol intake*, e.g. two glasses (120ml) of wine (11g) = 2 x 11g = 22g of alcohol.

When *blood alcohol concentration (*BAC) is measured, it is expressed in g/ml. The legal limit for driving in South Africa is 0.05g/100ml or 50mg/100ml. This is roughly the level after drinking two beers, or two glasses of wine, or a double tot of spirits.

*Risky drinking* can be understood as: five (5) or more standard drinks for males on any one occasion, and three (3) or more standard drinks for females on any one occasion. However, depending on the safety of the environment and the tolerance of the individual, negative consequences could arise after even fewer drinks e.g. A man doing scuba diving could have impaired judgement after only two drinks, resulting in his drowning.

#### Sources of Data

It is necessary to use various sources of data when describing levels and patterns of consumption of alcohol. These sources may be based on routine data collection such as police statistics, occasional surveys, or health service records, treatment centres and mortuaries. Inevitably many of these sources measure the consequences of alcohol abuse and only indirectly, the amount

of alcohol consumed, e.g. Measuring the blood alcohol level of bodies in a mortuary gives an indication of the level of alcohol use before death.

While it is possible to gather information on alcoholic beverage sales from the formal liquor companies and to calculate crude per capita alcohol use over a specific period of time, this does not, as we have seen, give sufficient information on the nature of drinking habits, nor on the consequences of harmful drinking.

To get a broader overview of the range of sources of data, read the article by Parry et al (2002) which presents the findings of a study of alcohol usage in South Africa over a four year period. Focus on the questions in Task 3 as you read.

**READING:** Parry, C. D. H. et al. (2002). Alcohol Use in South Africa: Findings from the South African Community Epidemiology Network on Drug Use (SACENDU) Project. *Journal of Studies on Alcohol*, 63 (4): 430-435. See pp 297-304 in the Reader.

**TASK 3 – Limitations in various methods of describing alcohol use.**

As you read the article by Parry et al (2002), try to answer this question: *To what extent is SACENDU able to provide an accurate picture of alcohol consumption and its effects in South Africa?*

Use these sub-questions to do your analysis:

* + 1. Identify all the studies and sources referred to in this paper, the methods used and the population which falls into the samples.
    2. Which sources have inherent biases in them, and which are less biased?

c) Are there other sources or methods which you think could provide better information on which to base policies and interventions?

#### FEEDBACK

Check your responses to questions (a) and (b) here.

1. The main sources of information referred to in this paper are:
   1. The South African Demographic and Household Survey.
   2. An epidemiological study on foetal alcohol syndrome (FAS).
   3. A study of the drinking habits of a group of people in jail.
   4. AOD (Alcohol and other drugs) treatment centres’ profile of their patients.
   5. National Violence and Injury Surveillance study.
   6. Survey of high school students’ drinking habits.
   7. Study of the blood alcohol content in a sample of people arrested.
2. Limitations and possible biases in the studies:

A major issue in any behaviour-related study is the use of *self reported*

information. Drinking alcohol is a behaviour that is likely to be under reported, owing to the stigma of drinking too much, or not being in control of one’s behaviour. It is also difficult to quantify alcohol intake because of: differing alcohol content in different beverages (ranging from 3% to 49%), styles of drinking (e.g. passing a vessel around), and the sizes of glasses or other vessels used. The studies where blood alcohol level is measured, or a breathalyser is used, give a more accurate picture of the person’s current alcohol intake but cannot be used to describe the pattern of drinking of the individual.

The majority of the studies focus on the major cities and therefore exclude most of the rural population. In some provinces, the rural population is higher than the urban, and therefore a significant section of the population is not reflected in the studies, e.g. in the Eastern Cape and Limpopo Provinces.

Another issue is whether the data on treatment in a particular year is representative of a population. Although treatment centres report various trends in the types of drugs used, ages of patients, etc, one needs to consider critically what part of the population gets admitted to treatment centres, or uses an outpatient facility. Poorer people, women with dependents and people in outlying areas are likely to experience problems in accessing these services. So again, the trends should be viewed with caution as they do not represent all those *who may need* treatment, but only *those who have accessed* treatment.

What did you conclude about the SACENDU initiative?

In the absence of data that is collected in a systematic and standardised way, and bearing in mind the limitations of each of the data sources contributed at SACENDU meetings, the information can be used to understand only *some* trends, and inform policy on *some specific problems*.

#### Screening for Alcohol Problems and Alcohol Dependence

By now you will have realised that a person can have problems as a result of using alcohol without necessarily being dependent on it (or being classified as an “alcoholic”).

The CAGE screening tool (which stands for **C**utting down, **A**nnoyance at criticism, **G**uilty feelings and use of **E**ye-openers) is commonly used in the screening of people to detect possible alcohol problems or dependence. As can be seen in the article by Claasen (1999), the tool can also be used as part of a survey to gather information at the level of alcohol problems in a particular community.

**READING:** Claasen, J. N. (Sept. 1999). The Benefits of the CAGE as a Screening Tool for Alcoholism in a Closed Rural South African Community. *South African Medical Journal,* 89 (9): 976-979. See pp 57-62 in the Reader.

When combined with a few other questions, the CAGE screening tool can provide a clearer picture of the place, time, amount, alcohol of choice and company in which people drink. These patterns, as well as the extent of problematic drinking, could be established through this sort of cross sectional survey, bearing in mind the difficulty of getting honest answers from people.

Other commonly used screening tools are the MAST (Michigan Alcoholism Screening Test) and the AUDIT (Alcohol Use Disorders Identification Test). Both of these use responses to a number of questions related to a person’s drinking patterns. The scoring is designed to give the clinician or researcher a sense of the level of use of alcohol in terms of potential harm to the individual or others around them. The MAST is more useful in identifying dependent drinkers while the AUDIT is used for categorising levels of problem drinking.

### IDENTIFYING PATTERNS OF DRINKING

A critical part of understanding alcohol use is analysing data based on specific groups of people who live, work or naturally congregate together. Most such studies, focusing on individual beliefs and behaviour regarding alcohol, engage specific age groups or those in particular settings, and involve the surveillance of alcohol patterns and consequences.

In this section, we will explore two studies, one of which focuses on drinking patterns within a particular age cohort (Flisher et al, 2001), while the other (London et al, 2001) concentrates on a particular setting, a fruit farm in the Western Cape.

If the young people in the Flisher study and the farm workers in the London study had only been asked about their average weekly consumption, it is likely that no problematic drinking would have been identified. It is the binge nature of drinking practised by both these groups that results in high levels of risky drinking. It is therefore necessary to collect information that describes *how much is drunk in one occasion* and *how frequent these occasions are*. The *factors encouraging more risky drinking* are also of interest if meaningful preventive interventions are to be made.

#### Measuring Usage by Age Group

In developing countries, we are particularly concerned about the beliefs and behaviours of young people regarding alcohol. The factors influencing the

experimentation and regular use of alcohol amongst youth are complex and need to be examined from various angles.

The paper by Flisher et al (2001) demonstrates how classroom based surveys can be used to gauge the knowledge, beliefs and practices of school-going youth. If repeated every few years, the trends of *age of first use of substances*, frequency, amount consumed and gender differences can then contribute to the design of educational and life skills programmes. Appropriate policies around access to and control of the amount of alcohol consumed, and the enforcement thereof, could also be made more realistic.

Factors such as access to money, religious norms and the stage of societal development are all used to explain the differences between the rates of use of substances in the three cities in Flisher et al’s paper, i.e. Cape Town, Harare, and Dar es Salaam, and the difference of use between the sexes. It must be noted, however, that since the studies for each city were not identical, and the analysis for this paper is based on extrapolation, the results are difficult to generalise beyond these particular cities or urban areas.

**READING:** Flisher, A. J. et al. (2001). Substance Use by Students in South Africa, Tanzania and Zimbabwe. *African Journal of Drug & Alcohol Studies,* 1 (2): 81-97. See pp 121-130 in the Reader.

**TASK 4 – Measures of alcohol consumption**

After reading this paper on substance use by students, answer the following questions:

1. What are the main measures of substance use in the questionnaires?
2. What do the different time periods imply?
3. What are the main conclusions of the study and how would this inform prevention programmes in those places?
   1. **Measuring Usage in Relation to Setting**

**FEEDBACK**

Another important way to conduct research on people who drink is through a focus on the occupational setting. This article by London et al (2001) describes a study assessing the occupational hazards for a group of male fruit farm workers in the Western Cape. Alcohol consumption was found to be an important co-factor in poor nutrition, rate of head injuries and exposure to pesticides. Focus on Task 5 while you read it.

**READING:** London, L., Nell, V., Thompson, M-L & Myers, J.E. (1998). Health Status Among Farm Workers in the Western Cape – Collateral Evidence from a Study of Occupational Hazards. *South African Medical Journal,* 88 (9): 1096-1101. See pp 187-194 in the Reader.

**TASK 5 – Assessing further measures of alcohol consumption**

While reading this paper, which includes a focus on alcohol use by male farm workers, answer the following questions:

1. What are the main measures of alcohol use in the study?
2. Are the data collection tools more reliable than the questionnaires used in the previous study? Why?
3. What does the information about the length of time spent working in the agricultural setting tell us?
4. What role could the patterns revealed in this study play in guiding a Health Promotion intervention in this context?

#### Measuring Drinking Patterns with Surveys & Self-reported Habits

FEEDBACK

Respond to (d)?

The article by Croxford & Viljoen introduces you to a survey method of assessing drinking patterns, based entirely on self-reported data; it also introduces the phenomenon of foetal alcohol syndrome (FAS).

**READING:** Croxford, J. & Viljoen, D. (Sept. 1999). Alcohol Consumption by Pregnant Women in Western Cape. *South African Medical Journal,* 89: 962-965. See pp 63-68 in the Reader.

The study reported in the article aimed to assess alcohol use by pregnant women in three under-resourced areas of the Western Cape – two of them small towns and one within the Cape Metropole. The sample of 636 women was drawn from 17 antenatal clinics across the three areas, and each woman was interviewed once only. In this study, the collection of demographic information was important in order to establish whether, amongst these pregnant women, there are subgroups (for example based on age, socio- economics or geographical location) that drink more heavily than others.

The results provide a useful description of women attending clinics in predominantly *coloured* areas. The dominant characteristics of the group were: between 20 - 30 years of age; single (57%); Christian (72.8%); with formal education between 8-10 years. As high as 42.8% admitted to varying degrees of alcohol ingestion during pregnancy with beer being the drink of choice (91.5%); the drinking pattern was of a “binge” nature. Smoking was reported by 45.6% altogether, and 29.6% admitted to smoking and drinking. This left only 41.2 % of women using neither alcohol nor cigarettes.

This is important data on which to base interventions to reduce drinking in pregnancy, and can also serve as a baseline to compare to after a few years.

It is also alarming to realise from the data that up to 9.5% of the women were at risk of having a child with FAS or a milder version thereof (ARND – alcohol related neurological defects).

Even though honesty is an issue when it comes to self-reported data relating to alcohol use and smoking, the authors report that it seemed not to be a concern in this study.

### NORMS FOR DRINKING

One of the issues that every researcher should be aware of when measuring alcohol consumption is the concept of what is regarded as *normal drinking in a particular community*. The relationship between alcohol and culture, and specifically what is viewed as *normal* and *not-normal* drinking, differs widely in different areas of the world. It is also important to recognise that people are strongly influenced by such norms, e.g*. We keep spirits for special occasions like dances, and people get very drunk.*

The reading by Bennett et al (1993) provides an insight into “how people from different cultures differentiate between normal and pathological drinking” (Bennett, 1993: 190), which is in itself a major influence on drinking patterns.

**READING:** Bennett, L. A., Janca, A., Grant, B. F. & Sartorius, N. (1993). Boundaries Between Normal and Pathological Drinking: A Cross-Cultural Comparison. *Alcohol Health & Research World,* 17 (3): 190-195. See pp 39-46 in the reader.

The paper also summarises what we covered in our discussion of patterns of consumption. Although there are no simple explanations or descriptions of drinking patterns for any community, the author gives some means to answering the *when, where, who, how, what* and *why* of alcohol use. As you read it, try to answer the questions in Task 5.

**TASK 6 – The effects of alcohol: descriptors used in your community.**

After reading this paper, consider the following questions:

1. What are the main questions that have been asked in this paper on the effects of alcohol?
2. Apply the same questions to members of your own community and write down your responses in a similar way to the results in tables 2 and 3.
3. Which community in the study is most similar to your community and why do you think this is so?
4. What are some of the factors which influence drinking patterns?

#### FEEDBACK

When doing a situational analysis in order to plan any intervention related to alcohol problems, it is essential to have a sense of the prevailing norms around drinking alcohol. If people in the community do not view risky drinking in the same way as you do, you will have difficulty involving them in any prevention or harm reduction programme. Any interventions need to bear in mind the status of the drinkers as well as the facilitating and inhibiting factors in relation to *who drinks where* and *how much* on any occasion.

### SESSION SUMMARY

In this session, we have looked at a range of data sources and methods for measuring and describing alcohol use, through a number of studies. Hopefully you have recognised that there are limitations in all the sources of data, but that together they can provide quantitative and qualitative information to understand the alcohol problems and possible prevention possibilities.

Hopefully you are convinced that it does not help to just monitor the average consumption of a population as this tells us nothing about the *where, when, how much* and *why* of individual and group drinking habits. In this regard, remember that more harm is caused by drinkers who occasionally become intoxicated (risky drinkers) than dependent drinkers.

You may have concluded that both quantitative measurements and qualitative descriptions are necessary in order to have a full picture of alcohol use patterns in any community or target age group. You will possibly also have noted that some methods are more accurate than others, but that they may carry the disadvantage of cost or skill required to use them, e.g. Gamma- glutamyltransferase (GGT) tests.

You have also started to apply some research questions to your own community and should have begun to build a picture of their patterns of alcohol consumption. In addition, you should be able to identify the economic forces that operate in that context, from the information in the previous session.

In the final session of Unit 1, we introduce you to the debates around alcoholism and the effect that different models of understanding people with alcohol problems has on our prevention and treatment approaches.

### REFERENCES AND FURTHER READING

* American Psychiatric Association. (1994). *Diagnostic and statistical manual mental disorders*, fourth edition. Washington, DC: American Psychiatric Association.
* *The Public Health Bush Book: A Resource for Working in Community Settings in the Northern Territory.* (1999). Darwin: Northern Territory Health Services.
* Parry, D. H. C. & Bennetts, A. L. (1998). *Alcohol Policy and Public Health in South Africa*. Cape Town: Oxford University Press.
* WHO. (1999). *Global Status Report on Alcohol.* Geneva: Substance Abuse Department, Social Change & Mental Health, WHO.

# Unit 1 - Session 3

**Theories of Alcohol Use and Addiction**

### Introduction

Although most of this module focuses on moderate alcohol use consumed in a risky pattern, it is also important to discuss consumption which occurs as a result of a dependency relationship between an individual and alcohol.

Much of the emphasis in the past was on “the alcoholic”, while little emphasis was placed on other consumers. Before you read any further, choose the description of alcoholism which you believe to be correct:

A person who is addicted to alcohol (an alcoholic):

* + has a disease called “alcoholism” or
  + has developed a habit that cannot be controlled.

This question remains debatable, so read the interesting articles that follow and then reflect on your own understanding of alcohol addiction.

While we are focusing on individual alcohol use, we will also apply two of the well-established theories of Health Behaviour, in order to understand the interrelationship of various factors in the decision to drink and the level of drinking.

### Contents

1. Learning outcomes of this session
2. Readings
3. Models for understanding alcohol problems
4. Theories of Health Behaviour
5. Session summary
6. Further reading

**Timing of this session**

In this session there is only one task, and the task requires you to start addressing issues in your local context. There are also four fairly long readings totalling 63 pages. Allow at least four hours to complete the session.

### LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Explain and apply the different theories of addiction and dependence, i.e. the medical, psychological and sociocultural theories.
  + Describe how these theories influence prevention and treatment approaches.
  + Apply selected theories of Health Behaviour to alcohol use.
  + Demonstrate insight into possible explanations for alcohol problems.

### READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Publication details** | **Page numbers in the**  **Reader** |
| Fingarette, H. | (1988). Ch 3 - What Causes Alcoholism? In  *Heavy Drinking: The Myth of Alcoholism as a Disease.* Berkeley, California: University of  California Press: 48-69. | **95-108** |
| Edwards, G.,  Marshall, E. J. & Cook, C. C. H. | (1997). Ch 11 - Drinking Problems and the Life Course. In *Treatment of Drinking*  *Problems: A Guide for the Helping Professions.* Cambridge, UK: Cambridge  University Press: 175-185. | **79-86** |
| Tones, B. K. &  Tilford, S. | (2001). Ch 2 - Selecting Indicators of  Success: The Importance of Theories of Change. In *Health Promotion: Effectiveness, Efficiency and Equity.* Cheltenham, UK: Nelson Thornes: 74-93. | **437-446** |
| Morojele, N. | (1997). Ch 12 - Adolescent Alcohol Misuse. In  C. de la Rey, N. Duncan & T.Shefer & A. van Niekerk (eds). *Contemporary Issues in*  *Human Development. A South African Focus.*  Johannesburg: International Thomson: 207- 232. | **257-270** |

### MODELS FOR UNDERSTANDING ALCOHOL PROBLEMS

Many academic modules on substance abuse would begin with the theory of alcohol consumption and alcoholism as it applies to individuals. In this module we have purposely covered the *environmental approach* (meaning socio-

political, cultural and economic issues) to addressing alcohol problems first. The reasons for this will become clearer as we proceed through the units. However, the main reason is that we are taking a Health Promotion approach, focusing on alcohol use and problems from a risky drinking/harm reduction perspective and balancing the environmental variables with individual factors.

It is, however, necessary to understand the theories which are applied to alcohol problems: this will enable you to choose which model you personally accept as the most useful explanation for alcohol dependence, and to identify the most likely set of factors influencing this behaviour.

Read the chapter by Fingarette (1988) in which the author questions the various explanations of alcoholism; then review your answer to the question we asked when we began this session.

**READING:** Fingarette, H. (1988). Ch 3 - What Causes Alcoholism? In *Heavy Drinking: The Myth of Alcoholism as a Disease.* Berkeley, California: University of California Press: 48-69. See pp 95-108 in the Reader.

Whether you believe in the concept of *an alcoholic,* and that it is a disease with genetic influence and physiological explanations, will directly influence your approach to prevention and treatment. Many treatment programmes, including the Alcoholics Anonymous organisation, base their approach on the premise that if a person has had the problem of alcohol dependence, they will remain an “alcoholic in recovery” forever. This is what we call the Disease Model: it tends to focus on the individual and that “pathology” to the exclusion of the culture and context in which the person drinks.

An alternative perspective is to view alcohol consumption on a continuum, where anyone may drink at a light, moderate or heavy level, occasionally or regularly. Authors such as Fingarette prefer to explain drinking patterns from a social and cultural perspective and reject the notion of a univalent disease. For them there is no single causal explanation. This is called the Sociocultural Model and suggests that heavy drinkers, whose drinking is causing problems, need to be individually understood and not automatically classified as “mentally ill” with alcoholism.

A combination of the psychological hypothesis and the sociocultural explanation is most likely to lead to a treatment approach that balances the necessity for individual counseling with making changes in the norms the people under treatment accept and the context of their drinking.

The DSM IV Criteria for making a diagnosis of alcohol dependence are stated in the reading by Morojele (1997: 213). This classification system for mental health problems attempts to aid clinicians and researchers to diagnose problems in a standardised way. But as Morojele suggests in the article you will read later in this session, the classification system is not always applicable

to adolescents. It may also not be applicable to those of other ages in populations outside of Western developed countries. As you read about the DSM IV Criteria, consider the example of an unemployed man with no pattern of daily activities: he probably does not drive and does not own anything substantial. Most of the criteria are not applicable to him, despite the fact that he spends a lot of time drinking every day, and is at risk of developing long- term health problems.

**READING:** Edwards, G., Marshall, E. J. & Cook, C. C. H. (1997). Ch 11 - Drinking Problems and the Life Course. In *Treatment of Drinking Problems: A Guide for the Helping Professions.* Cambridge, UK: Cambridge University Press: 175-185. See pp 79-86 in the Reader.

Despite there being little consensus between various follow-up studies of people with alcohol dependence, Edwards proposes some factors which could be used to indicate potential for recovery in the long term: these include baseline characteristics, acceptance of a treatment goal, treatment and AA support and natural processes of recovery. Rather than supporting any intensive treatment, Edwards proposes that “… it is the nudging of the person towards a more constructive way of seeing things, the encouragement of self- actualisation and the enhancement of self-efficacy, help with choice of appropriate goal, and the alliance between therapeutic intervention and natural processes of change, that research suggests are in the long-term the most potent contributions which treatment can make to recovery” (Edwards, 1997: 182). We will revisit this approach in Unit 4, when we discuss the role of service providers in carrying out “Brief Interventions” with people with alcohol problems.

### THEORIES OF HEALTH BEHAVIOUR

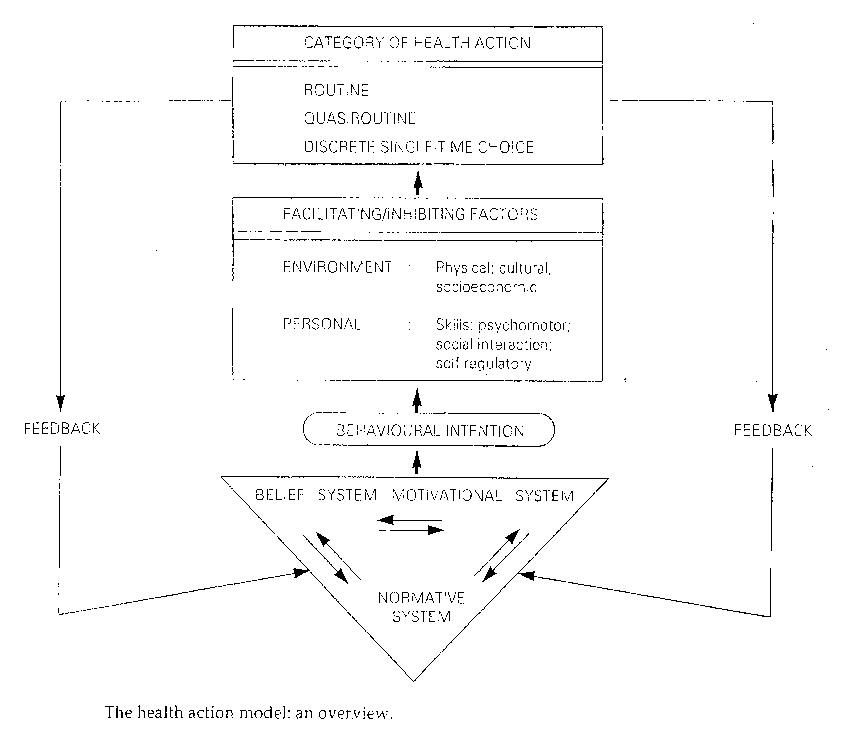
Whether your interest in alcohol and health is at the individual level or the broader population level, it is necessary to be able to describe the factors that promote and inhibit alcohol use at the individual level. Since alcohol use can vary so much from one person to the next, one needs to be able to describe these individuals as part of a sub-group, and have an understanding of what the critical factors are that influence their drinking pattern, in order to plan appropriate interventions.

An important stage in the development of a Health Promotion response to alcohol related problems is to have a theory through which to understand the underlying factors or determinants. Various health behaviour models were dealt with in the *Health Promotion II* module and will not be revised here. However, I have found the Health Action Model proposed by Tones and Tilford to be useful when describing the factors influencing alcohol use, and understanding possible points for intervention.

This chapter by Tones and Tilford (2001) was also included in the *Health Promotion II* module, so you may recognise it. Although it is quite densely written, and is not specific to alcohol issues, the references to drug use can be applied equally well to alcohol use. After looking at the diagram on page 78, focus your reading on the “Theory at a micro level” on pages 84-93, and the critique thereof on page 77 under “Gaining insights into client characteristics”.

**READING:** Tones, B. K. & Tilford, S. (2001). Ch 2 - Selecting Indicators of Success: The Importance of Theories of Change. In *Health Promotion: Effectiveness, Efficiency and Equity.* Cheltenham, UK: Nelson Thornes: 74-93. See pp 437-446 in the Reader.

Below is another version of the Health Action Model (HAM) which was presented at a short course at UWC by Sylvia Tilford in 2002.



Tilford, S. (2002). Health Action Model. Slide from School of Public Health *Winter School,*UWC.

The next reading has been included because Morojele (1997) gives some explanation and theoretical argument for substance use by adolescents, and its potential harmful consequences. In addition to reading the content of what she writes, take note that this paper provides an example of how to apply

theory to a particular group. You could use it as a model when you conduct your own research.

Morojele’s focus on adolescents is also important in that the population pyramid in developing countries indicates that a third or more of the population is under 15 years old. It is partly for this reason that we have included in this unit the survey of student substance use in Session 2 as well as the reading by Morojele. While the article by Flisher et al (2001) gave some self-reported rates of use of various substances, Morojele’s chapter goes further towards theorising in relation to the determinants of substance usage. Focus your reading primarily on pages 215-224 and consider whether you are convinced by his theoretical application and proposed intervention strategies.

**READING:** Morojele, N. (1997). Ch 12 - Adolescent Alcohol Misuse. In C. de la Rey, N. Duncan & T.Shefer & A. van Niekerk (eds). *Contemporary Issues in Human Development. A South African Focus.* Johannesburg: International Thomson: 207-232. See pp 257-270 in the Reader.

**TASK 1 – Apply the Health Action Model to a familiar group.**

Select a specific group within your community for consideration, e.g. young men, adult farm workers, pregnant women or teachers.

a) Refer to the Health Action Model diagram and attempt to explain the factors that influence the drinking of alcohol among your chosen group. Insert key words that describe your target group under each of the main sections of the diagram provided.

#### FEEDBACK

Your work on this task could be used in your second assignment, so check the assignment requirements and file your work on this task for future use.

### SESSION SUMMARY

In this session we have considered different arguments relating to ways of understanding alcohol problems, and emphasised the influence that this understanding has on your intervention strategy. We have also introduced several theories of Health Behaviour which can be applied to the study of alcohol problems, and you applied one of them to members of a familiar community of drinkers.

This concludes the first unit of this module, which has hopefully given you a foundation in three important areas in the study of alcohol problems:

* Contextual aspects of alcohol usage.
* Useful measures and data in researching alcohol usage.
* Key theories of alcohol usage and Health Behaviour and their influence on intervention strategies.

In the second unit, we focus on the harm and benefits of alcohol use and consider various Health Promotion approaches to alcohol problems.

### FURTHER READING

* Edwards, G., Marshall, E. J. & Cook, C. C. H. (1997). Ch 1 - Causes of Drinking Problems. *Treatment of Drinking Problems: A Guide for the Helping Professions.* Cambridge, UK: Cambridge University Press.