Editorial

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In the last two decades research in the field of alcohol abuse and dependence has made unforeseen progress in Europe – both in quantity and in quality. Starting from the early concepts of alcoholism as a more or less biological disease, researchers in the UK and the USA soon preferred a pragmatically, empirically oriented perspective towards problems of addiction. They developed a specialised methodology and made available a wealth of knowledge. In Continental Europe it took some time to adopt these principles, transfer and refine the methods. Thus most of the aspects of European addiction research are reflections of subjects from the USA tailored to the situation in the respective countries. Meanwhile Europe has caught up in several respects to high scientific standards in genetics, pharmacology, epidemiology as well as in sociological and psychological research. But intensive interchange between European countries is scarce. The system of scientific communications might be seen as a wheel with the US Centres for Addiction Research as the hub. On its rim we find the European researchers linked to the USA by the spokes deriving their designs along these somewhat narrow lines. It happens that they miss important work done in their immediate neighbourhood. Browsing the references of the contributions to this issue the attentive reader will at once find this confirmed. Language barriers are only partly responsible for this. In fact the US scientific output is the result of a concentration of manpower and financial resources, whereas the Europeans are only beginning to build up their own infrastructure.

Now we have to take into account that alcohol consumption and dependence in the USA have a completely different historical, cultural and social background. This becomes obvious just from the much lower average annual consumption per head compared for example to Belgium, France or Germany. But to a great extent the onset and course of dependent drinking is influenced by exactly these factors, as is shown by the results of Larsen and Saglie in this issue. Up to now the search for biological and psychological predecessors of alcohol dependence has supplied ample evidence that the proportion of vulnerable persons is very high and outnumbers those actually becoming ill. Also treatment evaluations again and again lead to the conclusion that the outcome in the individual case is determined by the living situation after the therapy more than by the drinking behaviour in the time before or by the respective treatment procedure. If the assumption is true that the beginning and the course of the illness are fundamentally influenced by the social environmental conditions, principles for effective preventive measures and treatment interventions can be derived. This is a great chance for European research because the variety of the social conditions in a geographically limited area offers many opportunities for transcultural comparisons. At the present time these social conditions are undergoing a tremendous change. A huge experiment is

on its way to merge very different economical and social systems. There is a far-reaching change of values with a transition from ancient traditions to a system of values with outlines that will not be clear for a long time coming. The appearance of an alcohol dependent citizen will consequently change deeply. The natural history of alcoholism must be rewritten, as Vaillant stated. This historical chance should not pass unused. We are in need of interdisciplinary, multinational projects to fulfil this task.

A part of this change closer to our special field is the ongoing transformation of health care systems. Everywhere institutions of public welfare are replaced by ser-

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vices working as private enterprises. Comparisons of the existing health care systems with regard to the effects of their specific characteristics on diagnosis, therapy and outcome of alcohol dependence will result in suggestions for the direction of the necessary reformations. We are in demand of concerted actions with a reasonable financial support. From a general point of view public funding of addiction research is far behind the quantity and the relevance of the problem. Moreover it has been concentrated on the illicit drugs, following the public concern and the scientific interests. It is time now to shift back alcohol-related problems into the centre of our attention. WHO-Europe stated that a general reduction of alcohol consumption would lead to an unproportionally great improvement in the general state of health of the population of the industrialised countries. An ambitious programme was proposed to reduce the consumption rate by 25% until the year 2000.

For this creative concepts and consequent strategies are yet to be developed. They must be accompanied by stringent research, because all of the measures to be taken must be evaluated relatively to this goal. The respective contributions of measures of control by tax legislation or sales restrictions, health education, improvements in the general conditions of living, reductions of unemployment etc. can be assessed and serve as an example of many other fields of health promotion.

The variety of cultural and social influences on alcohol consumption and problems can be illustrated by a differentiation between European countries in a stratification from North to South. In Northern European countries many experiences were gathered with a general public control in order to avoid detrimental effects to individual health and to society in general. From these countries studies are published concerned with the hazards of even 'normal drinking' and with the predecessors of alcohol dependence. In the middle of Europe, geographically spoken, alcohol consumption even in large quantities, is part of everyday-life. Excessive drinking is widely tolerated. Interventions are postponed until at last punitive reactions to the violation of norms will follow in order to correct the deviation. In these countries addiction researchers direct their attention towards questions as how to design most effective treatment programmes and how to bring as many drinkers as possible into them. In Southern Europe high consumption of alcohol is common but mostly restricted to meal times. Social control is intact, so that problems of dependence seem to be less obvious and less disturbing. Research deals with the consequences and their treatments in the individual case. This classification surely is a bit speculative, but there is a correspondence with the contributions to this issue. It remains undecided, whether alcohol dependence is primarily deviant behaviour or a disease, whether it is

a disease of its own or a symptom of an underlying psychiatric problem. The transcultural point of view leads to a fresh outlook on the relative contributions of disease processes, life-style and problem solving behaviour, which are agglomerated in each single case of alcohol dependence. There is concurrent evidence that physicians are 'reluctant to screen, diagnose and treat or refer alcoholic patients' [Yersin et al., this issue]. This results from deficits in medical training. In the majority of the curricula of physicians and other health care providers aspects of addiction are underrepresented or even neglected. Especially France and Germany seem to lag far behind. 'Addiction Medicine' as a special discipline is a complete rarity, even if we find a small number of professorships in Sweden, Finland and the Netherlands. An acceleration of improvements in the prevention, treatment and harm reduction of alcohol-related problems is to be expected, if national 'Centres for the Study and Treatment of Alcoholism' were established in each country.