Social Factors Effects On Young People Alcoholism

“Drinking has been thoroughly integrated into mainstream culture today” (Thombs and Osborn, 2013, pp230). They execute that drinking alcohol has become an expected behaviour of social interactions and that if you were to be asked to “go for a drink”, then alcohol consumption is expected. However, it is important to discuss if this legal drug is abused and used without limits, it can have a detrimental effect on the lives of young people. As supported by the Advisory Council of Misuse and drugs (ACMD, 2019) who advise that excessive and inappropriate use of alcohol can result physical, social, legal and psychological issues.

It is useful initially to consider the effects of alcohol on an individual’s functioning. Short-term effects of alcohol on the body can start with, increased heart rate and the expansion of blood vessels, giving a warm, talkative and sociable feeling associated with moderate drinking, which would highly appeal in social situations for young people. After more units of alcohol the body experiences slower reaction times, poor judgements and decision making due to the effects of alcohol on the nervous system, slurred speech and blurred vision. This is due to the incapability of the liver to filter units of alcohol from the body quick enough. More units would affect coordination, putting an individual at risk of an accident. More than 12 units of alcohol can occur alcohol poisoning, this is when someone’s breathing, heart rate and gag reflex can be interfered with. Alcohol poisoning can cause a person to fall into a coma and could lead to their death. However, more severe long-term effects of excessive alcohol can result in high blood pressure, stroke, pancreatitis, liver disease, liver cancer, mouth cancer, head and neck cancer, breast cancer, bowel cancer, depression, dementia, sexual problems, such as impotence or premature ejaculation and infertility (The National Health Service, NHS, 2019). Also, Drinking is more harmful to adolescents as their brains are still developing and a lot of alcohol consumption in this critical growth period can lead to lifelong damage in brain function, particularly as it relates to memory, motor skills and coordination, (Marshall, 2014). Furthermore, these are just the physical repercussions of alcoholism; The NHS (2019) also discusses the short term social issues of an increase in violence and antisocial behaviour, loss of personal possessions, unsafe sex, unplanned time off work or studies. As well as long-term social repercussions of alcohol abuse such as domestic abuse, unemployment, family break-up and divorce and financial problems.

Initially, it is useful to understand why the misuse of alcohol within young people takes place. Socio-cultural models execute a key understanding of where alcoholism can originate from. Theories such as these consider the environmental influence on the individual, and the progression from an experimental user, to a recreational user, to ultimately a dependant user of alcohol. ‘Structural functionalism’ in relation to drug and alcohol abuse, suggests that this is a result of an individual conforming to rules and discourses of a social group. Heath (1988) suggests that within mainstreaming of sociodemographic groups, drug use and alcoholism ultimately promote solidarity and cohesion within social groups and cultures. This is supported by Thombs and Combs (2014, p239), “individuals will get intentionally ‘wasted, smashed, totalled or bombed’ because this type of behaviour is part of a ritual that is essential to group solidarity.” It is discussed that individuals will go to exceptional lengths to fit in and abide by social norms of a group situation, no matter how it affects their health.

However, ‘symbolic interactionism’ focuses more on someone’s intrinsic motivations of drug and alcohol use, in order to “make meaning in their own lives, derive meaning from them & attribute meaning to them” (Heir, 2005:87). This theory suggests that people use alcohol to create more significance and meaning within their lives. For example, Stephens (1991) argued that individuals use drugs, at least initially, because they receive recognition, validation & status from doing so. Similarly, Nugent and McNeill (2017) put forward the view that if youth feel excluded, for example if they they don’t belong in a specific social group, then drug and alcohol may become a form of community, status and security in otherwise very bleak circumstances. Additionally, Thombs and Osborn, (2013) discuss how the “time-out hypothesis” (p230) is an explanation of how young people use intoxicants as a means of escaping their social obligations, such as parents, studies or employment. As supported by MacAndrew and Edgerton (1969) as they observed that cultures are lenient and flexible in their expectations of norms and role obligations during drunkenness, asthough there is a level of expectation within cultures to behave this way. Stephens (1991) highlights that validation, recognition, status and meaning within social groups all originated from the ways that young people were able to ignore dangers and stand up to a challenge of potential dangers of substance use.

However, in contrast to this, the ‘normalisation theory’ suggests that young people misuse use substances as a means of pleasure, excitement and enjoyment that reside within leisure-searching lifestyles. However, it is key to understand that in majority of circumstances, there is interplay between all three models and drug and alcohol use should be understood in terms of coactions between structure and agency. It is evident that within youth and student cultures, excessive and extreme drinking have become an current issue within society, (Martinic & Measham, 2008). Pre-partying or ‘pre-drinking’ has been defined by Pederson & Labrie (2007) as, consumption of alcohol prior to attending a pre-planned event. Jayne et al (2016) also suggest that when interviewing young people, alcohol was an imperative part to a successful night out, and they would use ‘drinking games’ to accelerate alcohol consumption. Furthermore, not only does Zamboanga et al (2015) suggest that excessive drinking poses increased health risks, but a study by Borsari et al. (2013) found that young people that participated in excessive drinking and drinking games often find that due to lower inhibitions, they engaged in unplanned sexual activity, resulting in ‘sexual regret’.

Alcohol is the world's third greatest instigator for disease and creates 4% of the global concern of health risks (Rehm et al., 2009). It is predicted that 2.5 million deaths annually a consequence of alcoholism, and 9% of deaths between 15- to 29-year olds are alcohol-related (WHO, 2011). Furthermore, a young person’s brain, primarily the hippocampus, may be particularly exposed to the effects of alcohol (Welch et al., 2013), therefore predisposing the young drinker to alcohol, mental health and neuro-cognitive problems which can perseverate into adulthood. Also, alcoholism, and particularly binge drinking, is associated with sleep disorders (Popovivi and French, 2013). Additionally, regular alcohol use, binge drinking and other high risk behaviours such as substance abuse, smoking and risky sexual activity develop in young people and all of these behaviours are relative to one another (Wiefferink et al., 2006). This is supported by McCambridge et al. (2011) that found a link between early alcohol use in young people, later dependence in adulthood and an association with mental health issues and social harms. Furthermore, Young people that drink alcohol before 15 year old are considered to be four times more likely to meet criteria for alcohol dependence, (Grant and Dawson, 1997). This is supported by the 2011 European School Survey Project on Alcohol and Other Drugs (ESPAD) was carried out in 37 countries (Hibell et al., 2012). The target age for the study was 15 years of age. The study found that 79% of students had consumed alcohol at least once in

the past 12 months and 57% had consumed alcohol in the past 30 days. Therefore, the negative effects of alcohol on young people overall are undeniable.

Moreover, it is therefore important to consider the link between alcoholism, parental control and a young person's home setting as perhaps a rooted issue within society. (Bremner et al., 2011) found that lower levels of parental guidance and supervision influenced excessive drinking in their adolescent children. They also found that children that are exposed to a family member that regularly becomes intoxicated and makes alcohol accessible, are more likely to have a positive attitude towards drinking alcohol. This is supported by Young et al (2007) through a longitudinal study in west Scotland that found that antisocial behaviour in ages 11-15 were the main indicator of alcohol misuse. Therefore, as a result of anti-social behaviour not being monitored and maintained by the children's parents and teachers, the children are at a greater risk of early alcohol exposure. Furthermore, Rose et al (2001) discuss that around half of the risk in a young person developing alcohol dependence is usually as a result of genetic predisposition. Young people with a family history of alcohol abuse are at high risk of developing an alcohol problem, and at a younger age, than their peers with no family history of alcoholism.

Moreover, whilst considering how adult intervention within a home can effect youth and alcoholism, it is also vital to consider how a parent's misuse of alcohol can affect the young person. Patterson (1982) uses a model of crisis disruption of family management practices to explain how management skills such as child monitoring, house rules, appropriate and consistent consequences, and problem management are important within a home. If a parent's alcoholism prohibits implementing these management or supervision practices consistently, the child becomes confused and less well-adjusted, resulting in a low-quality parent-child relationship. This could consequently result in delinquent behaviours and the consumption of alcohol in the young person themselves. Additionally, a parent suffering from an addiction to alcohol can create an absence of adequate emotional support and poor relationship skills with their child/young person. Social control theory (Kobak et al, 1993), suggests adolescent problem behaviour and low emotion regulation are outcomes of caregivers' lack of physical and emotional availability throughout childhood. This supports 'attachment theory' in which communication and trust are essential for development and how such negative adult behaviours would be indicative of poor parent-child attachment, (Ainsworth, 1978).

In consequence of alcohol addiction and adolescent/youth issues surrounding alcohol, there are many facilities approaches to support users' addictions. Organisations such as 'Alcohol Anonymous' use medical models like a 12 step approach that focus on addiction as an illness. They do this by self-help groups, Meetings, sharing, support, sponsorship, service roles, adherence to philosophy, and serenity prayer & slogans as a model of abstinence for people recovering from alcohol dependence (Abraha and Cusi, 2012). The user's addiction is attributed to a loss of control with long term consequences. It's seen as a primary disease- not caused by other factors like psychological, social or emotional factors. It's a disease, which requires treatment and monitoring to be maintained across the patient's lifetime. A meta-analysis of 12 step treatments for adolescent substance abuse found that treatment was effective in reducing alcohol use (Tripodi et al., 2010). The number of participants included was relatively small (16), so the results should be interpreted with caution. However at a 12-month follow-up) the 12 step approach did appear to be associated with long-term change. Overall, this approach gives a platform for addicts to support each other and make meaning of their 'disease', to be able to function without alcohol long-term. However, this approach is criticised

as it has a long treatment process and requires a lot of dedication from an individual in order to not relapse as it is abstinence based. Consequently addicts become extremely reliant and ‘addicted to meetings. Also this approach isn’t beneficial to everyone as it is very based on religion and a means on ‘turning to god’; meaning atheists are unlikely to find it useful. This approach also ignores social aspects that are an issue to addicts as alcoholism is viewed as a ‘disease’. For example, Robins (1974), states that it was estimated that half of the enlisted men in Vietnam War had taken opiates. Most of the men used the drugs repeatedly over time in combat zone, as they were freely available. At least 20% stated they felt “addicted” to opiates. However, once returned home, less than 1% continued use. This study supports that social circumstances are a major determinant on ways people use drugs and that availability has such a powerful effect on drug taking.

However, psycho-social models take into account the complexity of the individual’s psychological, environmental, social, cultural & financial factors. Models such as these make the addict aware that it is their choice to do drugs and they have to take ownership of their choices. For example, Prochaska & Di Clemente’ s (1986) ‘Cycle Of Change’ which conveys that although the amount of time someone spends in a specific stage varies, everyone has to achieve the same stage-specific tasks in order to move through their addiction. The steps to this model are a basis of an individual changing their addictive behaviours, achieving it for a length of time, and then a relapse into previous behaviours. These models highlights the inevitable humanity of the difficulty of addiction and how an individual may need to go through this cycle numerous times, learn from their mistakes and behaviours, to really get to the root of their addiction. Similarly, Rollnick & Miller (1995) discuss how motivational interviewing with alcohol addicts by concentrating on motivation to change specific negative behaviour, with the assistance of interventions by GP’s.

Furthermore, another ‘psychosocial’ model is harm and risk reduction. This refers to universal prevention strategies that may address a population or group within a particular setting, like schools, colleges, families or communities). The aim of universal prevention is to deter or delay the onset of a disorder or problem by providing all individuals the information and skills necessary to prevent the problem. In school settings, it typically takes the form of alcohol and drug awareness, social and peer resistance skills, normative feedback or development of behavioural norms and positive peer affiliations. “Prevention programmes can be either specific curriculum delivered as school lessons or classroom behaviour management programmes, and can be educational, psychosocial or a combination.” (Abraha and Cusi, 2012). However, Visser (2013) argues that prevention is not enough and that during his research many young people do not consider their drinking habits to be problematic or harmful. During Visser’s (2013) research, adolescents discussed that they were not as concerned with the long-term health impacts as a result of heavy drinking. Whereas young people were concerned about more superficial concepts like weight gain or threats to their reputations, rather than actual health risks.

Interestingly, Thombs and Osborne (2013) put forward the view that labelling an addiction to alcohol as an ‘illness’ functions as a means of social control. This example of labelling has been described as a sophisticated form of propaganda that is created by professions (Gambrill, 2010). “Medicalization gives credibility to physicians’ and mental health professionals’ efforts to control, manage, and supervise the care given to persons with substance abuse problems.” (Thombs and Osborne, 2013, p226) They execute that there is a means of profitable endeavours like hospital admissions, insurance company billings, expansion of the client pool, consulting fees etc. Furthermore, a diagnosis of an addiction can paradoxically prohibit

individuals in day to day life. Robinson (2010) discusses how ‘labelling’ theory projects stereotypes onto someone and can actually result and act as a catalyst for relapses, if that’s how others are going to view them either way. Moreover, Thombs and Osborne (2013) also discuss how criteria for addiction are derived from cultural discourses. Therefore, people that drink alcohol are considered as ‘addicts’ because they deviate from the social norms. They discuss that from a sociological perspective, addictive behaviours are considered forms of social deviance rather than medical issues, therefore treatment is seen as an effort to persuade the addicted individual to conform to socially “correct” standards of conduct. Furthermore, Thombs and Osborne (2013) discuss how addiction is portrayed as a social construct as a diagnosis can completely change depending on factors such as the professional or social/historical context. For example, a diagnosis of a client may not be very different from a personal opinion, as it’s a diagnosis can be missing solid scientific evidence. Therefore a diagnosis is made on the values and beliefs of the practitioner. However, he practitioner’s own history, relative to his or her involvement in addictive behaviour, can consequently have an influence on the opinion of diagnosis. Similarly, Heath (1988) viewed that 150 years ago, Americans consumed three times more alcohol than they do now. Therefore the notion of what an alcoholic was then differs exceptionally from our conception today. Thus, Thombs and Osborne (2013) make note that perhaps these cultural factors also should sensitize clinicians as to the repercussions, both positive and negative, of applying the diagnosis/label of an ‘addict’ to someone, especially a young person. “In the best of cases, the diagnosis will motivate the client to change his or her behaviour. However, a diagnosis also could lead to overly intrusive treatment, social stigma, estrangement from family members, loss of employment, feelings of worthlessness and humiliation, or even exacerbation of existing problems in living.”(Thombs and Osborn, 2013, p228)

In conclusion, it is evident that there is a colossal and extensive sociological effect on excessive drinking in young people. Socio-cultural models highlight the effect of how a young person’s environment can act as a catalyst for alcoholism. This consequently emphasises why medical models to rehabilitation, such as the (AA) and the 12 steps of progression, are not always an effective method. Whereas after exploring some psychosocial means of rehabilitation, it could be argued that these methods tackle more of a wide range of an individual’s issues due to involving social contexts. Overall, it has become apparent that concepts around young people and addiction to alcohol are extremely versatile/complex and every individual’s circumstance is relative and individual to themselves, thus making it difficult to treat and diagnose. However, as discussed by Thombs and Osborn (2013), it is important to note that social constructs and labels, as well as being positive if needed, can also be especially detrimental to young people’s transitions, such as employment, if they are ‘labelled’ as an addict; therefore diagnosis ‘ are to be made with care and precaution.